

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, 13 January 2016 at 2.00 p.m.

Present: Ros Micklem (Chair), Gail Casey, Martin Rooney, Heather Cameron and Allan Macleod.

Attending: Jeanne Middleton, Chief Financial Officer; Chris McNeill, Head of Community Health and Care; Soumen Sengupta, Head of Strategy, Planning and Health Improvement; Jackie Irvine, Head of Children's Health, Care and Community Justice; Colin McDougall, Chief Internal Auditor; Peter Lindsay, Senior Audit Manager (Audit Scotland); Laurence Slavin, Senior Auditor (Audit Scotland) and Nuala Borthwick, Committee Officer (West Dunbartonshire Council).

Also Attending: Non-Voting Members of the Partnership Board - Barbara Barnes and Anne McDougall.

Apology: An apology for absence was intimated on behalf of Jonathan McColl.

Ros Micklem in the Chair

WELCOME AND INTRODUCTIONS

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

DECLARATIONS OF INTEREST

It was noted that there were no declarations of interest in any of the items of business on the agenda at this point in the meeting.

MINUTES OF PREVIOUS MEETING

The Minutes of Meeting of the West Dunbartonshire Health and Social Care Partnership Audit Committee held on 30 September 2015 were submitted and approved as a correct record.

Having heard the Chair, Ms Micklem, the Committee agreed:-

- (1) that a rolling action list would be maintained to ensure that Members did not lose track of actions arising at meetings of the Audit Committee; and
- (2) to acknowledge the work of officers such that West Dunbartonshire Health and Social Care Partnership Board was the first Integrated Joint Board in Scotland to have Audit Committee arrangements in place.

FINANCIAL GOVERNANCE UPDATE

A report was submitted by the Chief Financial Officer seeking approval:-

- (a) of the Scheme of Delegation arising from the Partnership Board's Financial Regulations;
- (b) for the Partnership Board to join the Clinical Negligence & Other Risks Indemnity Scheme (CNORIS); and
- (c) to endorse the integrated approach towards business continuity.

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

- (1) to approve the delegation of expenses incurred by Members and authorised by the Chief Officer and Chief Financial Officer and that national guidance would be sought from the Scottish Government on expenses arrangements for members of the Partnership Board;
- (2) to approve the Partnership Board's joining of CNORIS;
- (3) to endorse the integrated approach towards business continuity; and
- (4) that a presentation on the structure of business continuity planning would be provided at the next meeting of the Audit Committee scheduled to be held on Wednesday, 23 March 2016 to ensure Members are satisfied that there was rigorous continuity planning processes in place.

RESERVES POLICY

A report was submitted by the Chief Financial Officer providing information on the proposed Reserves Policy and the purposes for which reserves may be held.

After discussion and having heard 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, the Committee agreed to approve the Reserves Policy.

NHS GREATER GLASGOW & CLYDE HEALTH BOARD – HEALTH & SOCIAL CARE INTEGRATION: SEPTEMBER 2015 OPENING BUDGET REPORTS

A report was submitted by the Chief Financial Officer providing information on the report from NHS Greater Glasgow & Clyde Health Board's 2015/16 Opening Budget report. It was noted that the Health Board's report included the West Dunbartonshire Health & Social Care Partnership Health Care budget.

After discussion and having heard 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, the Committee agreed:-

- (1) to note the budget setting approach followed by NHS Greater Glasgow & Clyde;
- (2) to note the due diligence work undertaken as the basis for the 2015/16 Health Care budget;
- (3) to note that the opening budgets for each Integration Joint Board detailed within the report was consistent with the budgeting approach undertaken in prior years;
- (4) to note that the NHS Greater Glasgow & Clyde financial plan and budgeting approach had been considered and approved at Health Board level;
- (5) to note that further work was required to enable agreement of remaining elements of proposed delegated budgets and to identify all required savings/plans to address cost pressures; and
- (6) to note that all budgets, as tested, would 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.

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.

The Action Plan agreed with the Care Inspectorate Action Plan in response to the inspection report on Willox Park was circulated (tabled) at the meeting.

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

- (1) that future reports would provide information to assist those members unfamiliar with care establishments included in reports, e.g. the capacity of care homes and any issues associated with the premises or the service;
- (2) to congratulate the staff at Langcraigs Care Home in achieving grades of a consistently high level; and
- (3) to note the content of the report and the work undertaken to ensure grades awarded reflected the quality levels expected.

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 providing a routine update on the most recent Care Inspectorate assessments for four independent sector support services operating within the West Dunbartonshire area.

After discussion and having heard the Head of Community Health and Care, the Head of Strategy, Planning and Health Improvement and the Head of Children's Health, Care and Criminal Justice in further explanation of the report and in answer to Members' questions, the Committee agreed to note the content of the report.

DECLARATION OF INTEREST

At this point in the meeting, Councillor Rooney declared a financial interest of his spouse in the undernoted report, given that his spouse was a member of staff at a care home in West Dunbartonshire, and intimated that he proposed to take part in the decision on this item.

CARE INSPECTORATE REPORTS FOR OLDER PEOPLE'S CARE HOMES OPERATED BY INDEPENDENT SECTOR IN WEST DUNBARTONSHIRE

A report was submitted by the Head of Strategy, Planning and Health Improvement providing a routine update on the most recent Care Inspectorate assessments for three independent sector residential older peoples' Care Homes within West Dunbartonshire.

After discussion and having heard the Head of Community Health and Care, the Head of Strategy, Planning and Health Improvement and the Head of Children's Health, Care and Criminal Justice in further explanation of the report and in answer to Members' questions, the Committee agreed:-

- (1) that future reports would provide information to assist those members unfamiliar with care establishments e.g. the capacity of care homes; the trend of grades awarded to independent sector care providers and the specific associated budget implications; and

- (2) otherwise to note the content of the report.

CARE INSPECTORATE REPORT FOR CHILDREN & YOUNG PEOPLE'S SERVICES OPERATED BY WEST DUNBARTONSHIRE COUNCIL

A report was submitted by the Head of Children's Health, Care and Criminal Justice providing information on the most recent inspection report for one of the Council's own residential services for children and young people.

The Action Plan agreed with the Care Inspectorate in response to the inspection report on Craigellachie Children's Home was circulated (tabled) at the meeting.

After discussion and having heard the Head of Children's Health, Care and Criminal Justice in further explanation of the report and in answer to Members' questions, the Committee agreed:-

- (1) to note the work undertaken to ensure grades awarded are sustained and reflect the high quality of care expected; and
- (2) otherwise to note the content of the report.

TRANSFORMING CARE IN CLYDEBANK – INITIAL AGREEMENT

A report was submitted by the Head of Strategy, Planning and Health Improvement presenting the Initial Agreement prepared for a new Clydebank Health and Care Centre.

After discussion and having heard the Head of Strategy, Planning and Health Improvement 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 endorse the Initial Agreement for a new Clydebank Health and Care Centre; and
- (2) to note the Committee's support for such a high quality and integrated facility being delivered as soon as was practically possible.

Note: Councillor Rooney left the meeting during consideration of the above item of business.

INTEGRATED CARE FUND MID YEAR REPORT

A report was submitted by the Head of Community Health and Care providing an update on the use of the Integrated Care Fund for the first half of the 2015-16 financial year.

Annex A Integrated Care Fund 2015/16 – Progress towards Outcomes and Annex B Integrated Care Fund – Indicators of Progress were circulated (tabled) at the meeting.

After discussion and having heard the Head of Community Health and Care, the Committee agreed that an updated version of the report would be provided to the next meeting of the Health & Social Care Partnership Board on Wednesday, 17 February 2016.

INTERNAL AUDIT - UPDATE

The Chief Internal Auditor updated the Committee on the current internal audit service provided to the Partnership Board.

It was noted:-

- (1) that preparation was underway for the Audit Plan 2016/17, with the intention being to submit the draft plan to the next meeting of the Audit Committee on 23 March 2016; and
- (2) that the Chief Financial Officer would work with the internal auditors of the Health Board, the Council and the Partnership Board to ensure that there was clarity and consistency with respect to the appropriate auditing of the work of the Partnership Board and the Health & Social Care Partnership.

AUDIT SCOTLAND REPORT ON NHS IN SCOTLAND 2015

A report was submitted by the Chief Financial Officer providing information on the recently published Audit Scotland report on NHS in Scotland 2015.

After discussion and having heard the Senior Audit Manager (Audit Scotland) and the Head of Strategy, Planning and Health Improvement in further explanation of the report and in answer to Members' questions, the Committee agreed:-

- (1) that the emphasis within the report on workforce planning was timely given that the Partnership's Workforce and Organisational Development Strategy had been endorsed at the previous meeting of the Partnership Board; and
- (2) otherwise to note the findings of the Audit Scotland report.

FORTHCOMING AUDIT SCOTLAND REPORT – SOCIAL WORK IN SCOTLAND

A report was submitted by the Head of Strategy, Planning and Health Improvement advising of a national audit of Social Work in Scotland that has been initiated by Audit Scotland and was of direct relevance to the work of the Health and Social Care Partnership.

After discussion and having heard the Head of Strategy, Planning and Health Improvement and the Senior Audit Manager (Audit Scotland) in further explanation of the report, the Committee agreed:-

- (1) to note the work being undertaken by Audit Scotland; and
- (2) to direct the Chief Officer to bring a report to the Audit Committee on this national audit once the final report was published.

AUDIT SCOTLAND REPORT ON HEALTH & SOCIAL CARE INTEGRATION

A report was submitted by the Head of Strategy, Planning and Health Improvement providing information on the recently published Audit Scotland report on Health and Social Care integration.

After discussion and having heard the Head of Strategy, Planning and Health Improvement and the Senior Audit Manager (Audit Scotland) in further explanation of the report and in answer to Members' questions, the Committee agreed:-

- (1) to acknowledge the work undertaken by officers in delivering the considerable progress that had been already been made within West Dunbartonshire with respect to issues raised within the report and as recognised by the Senior Audit Manager (Audit Scotland);
- (2) that officers give consideration to how best to provide Members with a more detailed overview of the actions being taken to progress key issues noted within the report;
- (3) 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.; and
- (4) otherwise to note the findings of the Audit Scotland report.

The meeting closed at 4.07 p.m.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP**Audit Committee: 23rd March 2016**

Subject: Equality Act 2010 Mainstreaming Report**1. Purpose**

- 1.1** To present to the Audit Committee's attention the Mainstreaming Report prepared with respect to the obligations placed on Integration Joint Boards by the Equality Act 2010, and the statutory requirement on all IJBs to publicly publish such a document by the 30th April 2016.

2. Recommendation

- 2.1** The Audit Committee is asked to:

- Endorse the Mainstreaming Report, and the equality outcome measures set out within it.
- Confirm that the Head of Strategy, Planning & Health Improvement make the report publicly accessible on-line ahead of the statutory requirement publication deadline of the 30th April 2016.

3. Background

- 3.1** The Equality Act 2010 strengthens, harmonises and streamlines 40 years of equalities law in relation to the nine "protected characteristics" of age; disability; gender; race; religion and belief; sexual orientation; gender reassignment; pregnancy and maternity; and marriage and civil partnership (noting that the latter refers only to the need to eliminate discrimination in the area of employment). The Equalities and Human Rights Commission (EHRC) in its role as regulator, scrutinises and enforces the implementation of Equalities Duties.
- 3.2** Given its legal status, the Partnership Board is obliged to play its part in addressing the general public sector duties outlined in the Equality Act 2010, i.e. to have due regard to:
- Eliminate discrimination, harassment and victimisation.
 - Advance equality of opportunity between people who share a protected characteristic and those who do not.
 - Foster good relations between people who share a protected characteristic and those who do not.
- 3.3** As recognized within the HSCP Strategic Plan 2015/16, Integration Joint Boards (IJB) have been added to the listed bodies under the Equality Act 2010 (Specification of Public Authorities) (Scotland) Order 2015 and became

subject to the general duties on 1 April 2015; and Amendment Regulations making them subject to three specific duties came into force on 11 June 2015. For the breadth of responsibilities which each IJB is accountable for, the specific duties are to:

- Report on mainstreaming the equality duty every two years.
- Assess and review policies and practices.
- Publish equality outcomes every four years and report progress every two years.

3.4 Consequently, by 30th April 2016 (and within every subsequent four years) each IJB must publish a set of outcomes (minimum of two) that address one or more of the three public sector duties (and are not outcomes of the Health Board or Local Authority). Similarly, by 30th April 2016 (and within every subsequent two years) each IJB must publish a report on the progress it has made to make the three general public sector duties integral to its functions and the progress it has made to achieve with regards to its specific outcomes.

4. Main Issues

4.1 The HSCP Strategic Plan already affirms the Partnership Board's commitment to integrate – i.e. mainstream – its obligations in respect of the equality duties into its approach to strategic planning and performance management; and into the day-to-day operational activities of WDHSCP. The intent of the Equality Act to protect groups from discrimination, harassment or victimisation readily fits with the overarching priorities and commitments set out within the Strategic Plan to the delivery of quality person centred supports and services. This reflects local recognition of the fact that the requirements of the Equality Act dovetail with – and so should sensibly be addressed through - the national Integration Planning Principles, and the need to take account of the particular needs, characteristics and circumstances of different service-users. The appended mainstreaming report – prepared in response to the specific equality duty - builds and elaborates on that approach (Appendix 1).

4.2 That mainstreaming report confirms that as part of establishing the Partnership Board, streamlined equality impact assessment processes are a routine element of all reports considered by and any decisions recommended to the Partnership Board and its Audit Committee.

4.3 That mainstreaming report also confirms a two-stage process for establishing equality outcomes:

- Firstly identifying an initial set of two equality outcomes (the minimum statutory requirement) for two protected characteristic groups that can reliably measured and reported from 1st April 2017.
- Secondly continuing work to identify further equality outcomes for the other relevant protected characteristics groups, including improving the necessary data collection systems where that is within the direction of the HSCP.

- 4.4** To meet the legislative obligation to have the attached report published in the public domain by 30th April (i.e. before the next Partnership Board meeting) it is being presented to the Audit Committee for comment and recommended endorsement. Thereafter it will be made available on the HSCP's website; and explicitly incorporated into the first annual performance report for the HSCP that will be presented to the May meeting of the Partnership Board) for scrutiny and discussion.

5. People Implications

- 5.1** In relation to specific equalities duties concerning the employment of staff, these remain the responsibility of the Health Board and the Council; and so this requirement does not apply to the Partnership Board. The HSCP will continue to meet its obligations around these areas by implementing the relevant organisational policies and procedures as appropriate as confirmed within its approved Workforce & Organisational Development Strategy.

6. Financial Implications

- 6.1** There are no financial implications associated with this report.

7. Professional Implications

- 7.1** The HSCP's local arrangements for clinical and care governance have been developed with an appreciation of the requirements of the Equalities Act in assuring and improving the care and support provided to all service users – but particularly those who are particularly vulnerable or “at risk”.

8. Locality Implications

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

9. Risk Analysis

- 9.1** The attached mainstreaming report has been prepared and is presented to this Audit Committee in order that the Partnership Board is able to appropriately meet specified milestones in relation to the Equalities Act.

10. Impact Assessments

- 10.1** The attached mainstreaming report confirms that as part of establishing the Partnership Board, streamlined equality impact assessment processes are a routine element of all reports considered by and any decisions recommended to the Partnership Board and its Audit Committee.

11. Consultation

- 11.1** This approach to equalities mainstreaming has benefitted from engagement with local protected characteristics groups independently undertaken through

the local West Dunbartonshire Community and Volunteer Service (WD CVS). The approach articulated here - and the initial equality outcomes specified within the mainstreaming report – reflects the feedback and strong support provided.

12. Strategic Assessment

- 12.1** The Strategic Plan already affirms the Partnership Board's commitment to integrate – i.e. mainstream – its obligations in respect of the equality duties into its approach to strategic planning and performance management; and into the day-to-day operational activities of WDHSCP.

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

Date: 7th March 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: WDHSCP Board: Equality Act 2010 Mainstreaming Report – March 2016

Background Papers: EHRC - Integration Joint Board FAQs:
<http://www.equalityhumanrights.com/about-us/devolved-authorities/commission-scotland/public-sector-equality-duty-scotland/integration-joint-boards-faqs>

Wards Affected: All

**West Dunbartonshire
Health & Social Care Partnership**

West Dunbartonshire Health & Social Care Partnership Board
The Equality Act 2010
Mainstreaming Report
March 2016

Document Title:	WDHSCP Board Equality Act (Scotland) Mainstreaming Report	Owner:	Head of Strategy, Planning & Health Improvement
Version No.	v1	Superseded Version:	N/A
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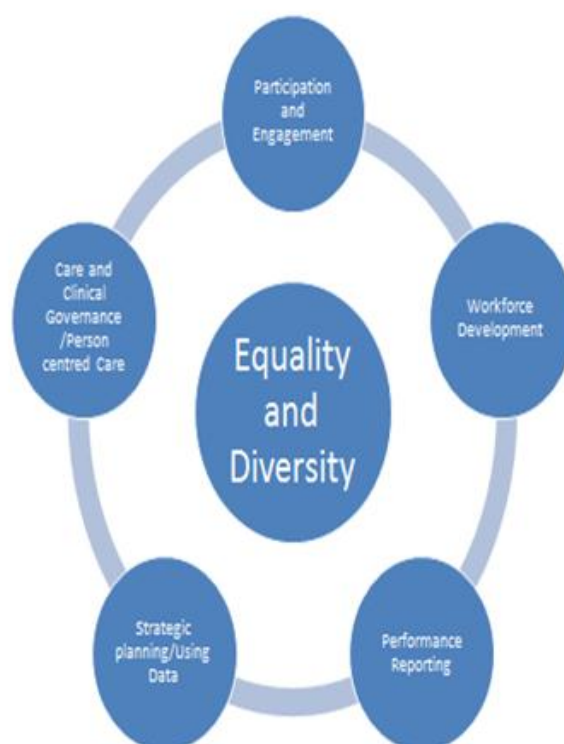
1. BACKGROUND

- 1.1 West Dunbartonshire Health & Social Care Partnership Board is responsible for the strategic planning and reporting of a range of health and social care services delegated it by NHS Greater Glasgow & Clyde Health Board and West Dunbartonshire Council (described in full within its approved Integration Scheme). The Council and the Health Board discharge the operational delivery of those delegated services (except those related to the Health Board's Acute Division services most commonly associated with the emergency care pathway) through the partnership arrangement referred to as West Dunbartonshire Health & Social Care Partnership. The Health & Social Care Partnership Board is responsible for the operational oversight of West Dunbartonshire Health & Social Care Partnership (WDHSCP).
- 1.2 The West Dunbartonshire Health & Social Care Partnership Board's:
 - Mission is to improve the health and wellbeing of West Dunbartonshire.
 - Purpose is to plan for and ensure the delivery of high quality health and social care services to and with the communities of West Dunbartonshire.
 - Core values are protection; improvement; efficiency; transparency; fairness; collaboration; respect; and compassion.
- 1.3 The Partnership Board is a legal entity in its own right created by Parliamentary Order, following ministerial approval of the Integration Scheme. It is accountable for the stewardship of public funds and is expected to operate under public sector best practice governance arrangements, proportionate to its transactions and responsibilities.
- 1.4 The Equality Act 2010 strengthens, harmonises and streamlines 40 years of equalities law in relation to the nine "protected characteristics" of age; disability; gender; race; religion and belief; sexual orientation; gender reassignment; pregnancy and maternity; and marriage and civil partnership (noting that the latter refers only to the need to eliminate discrimination in the area of employment). The Equalities and Human Rights Commission (EHRC) in its role as regulator, scrutinises and enforces the implementation of equalities duties.
- 1.5 Given its legal status, the Partnership Board – in the same way as the Council and the Health Board – is obliged to play its part in addressing the general public sector duties outlined in the Equality Act 2010, i.e. to have due regard to:
 - Eliminate discrimination, harassment and victimisation.
 - Advance equality of opportunity between people who share a protected characteristic and those who do not.
 - Foster good relations between people who share a protected characteristic and those who do not.
- 1.6 As recognized within the WDHSCP Strategic Plan 2015/16, Integration Joint Boards (IJBs) have been added to the listed bodies under the Equality Act 2010 (Specification of Public Authorities) (Scotland) Order 2015 and became subject to the general duties on 1 April 2015; and Amendment Regulations making them subject to three specific duties came into force on 11 June 2015. For the breadth of responsibilities which each IJB is accountable for, the specific duties are to:
 - Report on mainstreaming the equality duty every two years.
 - Assess and review policies and practices.
 - Publish equality outcomes every four years and report progress every two years.

- 1.7 In relation to specific equalities duties concerning the employment of staff, these remain the responsibility of the Health Board and the Council; and so this requirement does not apply to the Partnership Board. WDHSCP will continue to meet its obligations around these areas by implementing the relevant organisational policies and procedures as appropriate as confirmed within its approved Workforce & Organisational Development Strategy.
- 1.8 In relation to specific equalities duties concerning procurement, WDHSCP will continue to meet its obligations around these areas by implementing the organisational relevant policies and procedures of the Council and Health Board as per the Financial Regulations agreed for the Partnership Board.
- 1.9 Consequently, by 30th April 2016 (and within every subsequent four years) each IJB must publish a set of outcomes (minimum of two) that address one or more of the three public sector duties (and are not outcomes of the Health Board or Local Authority). Similarly, by 30th April 2016 (and within every subsequent two years) each IJB must publish a report on the progress it has made to make the three general public sector duties integral to its functions and the progress it has made to achieve with regards to its specific outcomes.

2. MAINSTREAMING: PROGRESS TO DATE

- 2.1 The Partnership Board is committed to continuing to integrate – i.e. mainstream – its obligations in respect of the equality duties into its approach to strategic planning and performance management; and into the day-to-day operational activities of WDHSCP. The intent of the Equality Act to protect groups from discrimination, harassment or victimisation readily fits with the over-arching priorities and commitments set out within the WDHSCP Strategic Plan to the delivery of quality person centred supports and services. This reflects local recognition of the fact that the requirements of the Equality Act dovetail with – and so should sensibly be addressed through - the national Integration Planning Principles, and the need to take account of the particular needs, characteristics and circumstances of different service-users.
- 2.2 Since its formation in July 2015 and adoption of the mission, purpose and values (which themselves fit well with the inclusive nature of equalities responsibilities), the Partnership Board has sought to further integrate its approach to the equalities duties – and promoting diversity - into its core business in line with the intentions and expectations of the EHRC. The WDHSCP Strategic Plan committed to an on-going approach to mainstreaming across five core inter-related and inter-overlapping dimensions of organisational activity - illustrated as follows.



2.3 Progress during 2015/16 has included:

2.3.1 Strategic Planning

The WDHSCP's inaugural Strategic Plan was developed with regards to the strategic commissioning process advocated by Audit Scotland; and benefitted from on-going engagement with a full range of local stakeholders (including the third sectors and community groups). It was subject to an equality impact assessment prior to its being approved by the Partnership Board at its first meeting on the 1st July 2015. That Strategic Plan included a dedicated Equalities Section, in expectation of this first equalities mainstreaming report.

As part of establishing the Partnership Board, streamlined *equality impact assessment* processes are a routine element of all reports considered by and any decisions recommended to the Partnership Board and its Audit Committee. This enables the Partnership Board to evidence compliance with the specific equality duty to "assess and review policies and practices" as appropriate.

The Strategic Plan also addresses a range of policies and legislation which have sought to improve person centred care and the specific impact on protected characteristic groups, including Getting It Right for Every Child; the Children and Young People (Scotland) Act 2014; and the Self-Directed Support Act.

2.3.2 Participation and Engagement

This approach to equalities mainstreaming has benefitted from engagement with local protected characteristics groups independently undertaken through the local West Dunbartonshire Community and Volunteer Service (WD CVS). The approach articulated here - and the initial equality outcomes specified later on in this report – reflects the feedback and strong support provided.

The on-going development of revised public engagement structures for the HSCP within its two defined localities (Alexandria & Dumbarton; and Clydebank) has worked with West Dunbartonshire Community and Volunteer Service (the local Third Sector Interface) to adopt a networked approach based on extensive consultation locally and a renewed emphasis on increasing representation and diversity. Work has been on-going to (co)produce a local Participation and Engagement Strategy for the HSCP that applies the National Standards for Community Engagement and which will reflect the requirements of the Equalities Act. Prior to its being finalised in Spring 2016, that Participation and Engagement Strategy will be subject to an equality impact assessment.

2.3.3 Workforce Development

Although the employer-related public sector duties for equalities are retained by the Health Board and Council, the Partnership Board is committed to a comprehensive and integrated approach to workforce development. The Partnership Board endorsed the HSCP's first Workforce and Organisational Development Strategy having been assured that it had been subject to an equality impact assessment. A key element of that Strategy is a commitment to integrated staff and practice governance – and an explicit component of which is that all staff are treated fairly and consistently. The Strategy commits to the use of an integrated Staff Governance and Practice Governance Framework that the HSCP updates annually in partnership with local trade unions (NHS and Council) through its local Staff Partnership Forum.

2.3.4 Clinical and Care Governance

Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured, supporting staff in continuously improving the quality and safety of care and ensuring that wherever possible poor performance is identified and addressed. The HSCP's local arrangements for clinical and care governance have been developed with an appreciation of the requirements of the Equalities Act in assuring and improving the care and support provided to all service users – but particularly those who are particularly vulnerable or “at risk”. Public Protection provides a range of measures which can be used together to take steps to decide whether someone is an adult at risk of harm, balancing the need to intervene with an adult's right to live as independently as possible; or where a child needs protection from harm. It also encompasses the effective and robust management of High Risk Offenders (including those subject to Multi-Agency Public Protection Arrangements – MAPPA – and Serious Violent Offenders). Public protection is an integral part of all delivery of adults and children's services within the HSCP. This includes contributing to the implementation of Equally Safe - Scotland's Strategy on Violence Against Women and Girls; appropriately utilising the disclosure scheme for domestic abuse; and raising awareness of third party reporting of hate crime. Training programmes are in place as part of the work of the local Child Protection Committee, Adult Support and Protection Committee and MAPPA.

2.3.5 Performance Reporting

Work has been on-going to identify an initial set of equality outcomes as per the requirements of the specific duties. The EHRC defines an equality outcome as a result which a public body aims to achieve in order to further one or more of the three needs of the general equality duty: to eliminate discrimination, advance equality of opportunity and foster good relations. By focusing on outcomes rather than objectives, this specific duty aims to achieve practical improvements for those who experience discrimination and disadvantage. In practice therefore, it is helpful to think of equality outcomes as results intended to achieve specific and identifiable improvements in people's life chances.

The EHRC's *Measuring Up?* series of reports has emphasised the importance of identifying and utilising robust equality outcomes that are clear and measurable. The most recent Measuring Up Report was highly critical of the high proportion (majority) of equality outcomes, which - while laudable in their intent - were not robust, clear or measurable. In addition, the nature of mainstreaming equalities suggests that equality outcomes for IJBs should at least be aligned with the national outcome measures for integration as well as the corresponding national outcomes for children and young people as well as criminal justice as defined by the Scottish Government.

Consequently a two-stage process for establishing equality outcomes will be taken forward: firstly identifying an initial set of two equality outcomes (the minimum statutory requirement) for two protected characteristic groups that can reliably be measured and reported from 1st April 2017; and secondly, then continuing work to identify further equality outcomes for the other relevant protected characteristics groups, including improving the necessary data collection systems where that is within the direction of the HSCP.

The EHRC self-assessment toolkit has proven helpful in informing the first of these stages, underpinned by recognition that equality outcomes are results intended to achieve specific and identifiable improvements in people's life chances – so the emphasis has been on identifying measures that are meaningful in practice.

The key steps in undertaking stage one - following those set out within the EHRC self-assessment toolkit - are summarised as follows:

- Identifying equality issues – involvement

The HSCP has already consulted with a variety of stakeholders - including equality groups - about the key performance indicators included within its strategic planning process. These have been adopted by the Partnership Board and have been well received as priority areas for the HSCP in its first year of operation. This approach to equalities mainstreaming has benefitted from further specific engagement with local protected characteristics groups independently undertaken through the local West Dunbartonshire Community and Volunteer Service (WD CVS). That engagement supported to the decision to initially focus on two robust equality outcome measures; and the choice of what those initial equality outcome measures should be. That engagement has also identified local protected characteristic groups who are willing to engage with the HSCP in the development of further equality outcomes.

- Identifying equality issues – gathering evidence

A range of evidence was reviewed, including: Census data (2011); National Records of Scotland data; West Dunbartonshire Social and Economic Profile; Social Care Services Scotland (2015) resource; NHSGGC Equalities in Health resources; WDHSCP service monitoring and performance management data; West Dunbartonshire Community Planning Partnership resources, including Citizen's Panel reports; Scottish Government's Equality Evidence resources; and EHRC resources.

- Using evidence and involvement information

The population of West Dunbartonshire is ageing due to a combination of factors: that the number of births within the area is dropping; the number of people migrating to other council areas within the 15 – 44 age group is increasing; and the number of deaths registered annually is falling. A key local priority then - in line with the national Reshaping Care for Older People programme - is to appropriately develop services and supports that respond to the changing needs of the increasing number and proportion of older people within the West Dunbartonshire population – and this is strongly supported by engagement with local community groups. A key element of this - as recognised by Audit Scotland and the Local Government Benchmarking Framework – is the need to continue to provide a range of supports and services to enable individual needs to be met by care at home services to enable independently life at home or in a homely setting in their community is highlighted. The review of evidence and involvement information identified that it would be helpful – and possible – to monitor provision of reablement packages with regard to the protected characteristic of sex.

There are protected characteristic groups who make up a small proportion of the West Dunbartonshire population – but who are just as entitled to the same commitment for quality services and support. The West Dunbartonshire census data from 2011 illustrates this, with 97.4% of the West Dunbartonshire population being white Scottish, white other British or white Irish. While Black and Minority Ethnic (BME) communities constitute a relatively small proportion of the West Dunbartonshire population that does not mean that they should be invisible when monitoring outcomes, especially in relation to specific risks and vulnerabilities – for example in relation to looked after children as recognised within the Getting It Right For Looked After Children And Young People Strategy (2015). The review of evidence and involvement information identified that it would be helpful – and possible – to monitor the proportion of looked after children being supported in the local community with regard to the protected characteristic of race.

- Setting clearly defined outcomes

Equality Outcome	Question To Be Answered	Performance Measure	Information Source	Protected Characteristic	Link to HSCP and National Outcomes	Link to Wider Theme	Link to General Equality Duty
All older people are supported to live as independently as is possible in their community as far as is practical given their individual needs.	Is there a difference between the percentage of men and women who have assessed care at home needs and a reablement package who have reached their agreed personal outcomes	Percentage of adults with assessed care at home needs and a reablement package who have reached their agreed personal outcomes	CareFirst (local system)	Sex	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	Getting Right for Every Child	Advance equality of opportunity
All Looked After Children are cared for and supported in the most appropriate setting to their individual needs.	Is there a difference between the percentage of BME Looked after children who are looked after in the community and the wider looked after children population?	Percentage of children being looked after in the community	CareFirst (local system)	Race	We have improved the life chances for children, young people and families at risk.	Reshaping Care for Older People	Advance equality of opportunity

The findings of the EHRC's most recent *Measuring Up?* report has informed the decision to start this process with the discipline of focusing on a limited number of equality outcome measures which are robust, clear, measurable and directly derived from national outcome measures that the HSCP will be scrutinised on by the HSCP Board as part of its core (mainstream) performance reporting. The rationales for not specifying equality outcomes for the other protected characteristics at this stage are summarised as follows:

- Age

Many HSCP services specifically concern specific age groups; and in a number of cases, tailor services to specific age groups (e.g. adult learning disability service and children with disability services). Both of the initial equality outcomes identified also have an "age" dimension. The intention is that a specific "age" related outcome measure will be identified for equality monitoring prior to the 2018 update to this mainstreaming report.

- Disability

The HSCP provides a variety of co-ordinated health and care services for individuals with disabilities (adults and children); and provides supports to enable people with a range of disabilities to live as independently as possible. Pending the publication of the Scottish Government's Delivery Plan 2016-2020 of the United Nations Convention on the Rights of Persons with Disabilities, the intention is that a specific "disability" related outcome measure will be identified for equality monitoring prior to the 2018 update to this mainstreaming report.

- Religion and belief

A specific equality outcome concerning religion and belief has not been included at this stage due to sparseness of the data collected in relation to this protected characteristic. The intention is that a specific "religion and belief" related outcome measure will be identified for equality monitoring prior to the 2020 update of these equality outcomes, alongside strengthening the necessary local data collection.

- Sexual orientation

A specific equality outcome concerning sexual orientation has not been included at this stage due to sparseness of the data collected in relation to this protected characteristic. The intention is that a specific "sexual orientation" related outcome measure will be identified for equality monitoring prior to the 2020 update of these equality outcomes, alongside strengthening the necessary local data collection.

- Gender reassignment

Currently, there is no robust and recommended question with which to collect information on gender identity in surveys or other data sources. As part of mainstreaming activity the HSCP will continue to promote and implement the NHSGGC Transgender Policy; and raise awareness of third party reporting for hate crime.

- Maternity and pregnancy

Supporting pregnant employees working within the HSCP remain the responsibility of the Health Board and the Council. WDHSCP will continue to support local staff by implementing the relevant organisational policies and procedures as appropriate. As part of mainstreaming activity the HSCP has a leading role in implementation the national Pregnancy and Parenthood in Young People Strategy.

- Presenting equality outcomes

The most recent data related to each of the identified equality outcomes at the time of finalising this report is as set out below.

Protected Characteristic - Sex	Q4 2015/16	Note
	Value	
Percentage of adults with assessed Care at Home needs and a reablement package who have reached their agreed personal outcomes	58.2%	Provisional - figures relate to 1st January to mid-February 2016.
Number of men with assessed Care at Home needs and a reablement package who have reached their agreed personal outcomes	23	
Number of women with assessed Care at Home needs and a reablement package who have reached their agreed personal outcomes	32	
Percentage of men with assessed Care at Home needs and a reablement package who have reached their agreed personal outcomes	78%	
Percentage of women with assessed Care at Home needs and a reablement package who have reached their agreed personal outcomes	44%	

Protected Characteristic - Race	Q3 2015/16	Note
	Value	
Number of looked after children	376	The small numbers involved mean that any changes will have a more significant impact on the percentage.
Number of looked after children who are from BME communities	5	
Balance of Care for looked after children: % of children being looked after in the Community	90.4%	
Percentage of children being looked after in the community who are from BME communities	80%	

The initial equality outcome measures identified here will be included in the core HSCP performance reporting internally and to the HSCP Board as part of its mainstream governance processes. This will begin by their being included in the HSCP's first annual performance report for 2015/16 (thus providing baseline data for that year as required by the EHRC); and subsequent annual performance reports thereafter.

The equality outcome measure will also be included in the public performance reporting section of the HSCP website (www.wdhscp.org.uk) to provide transparency and ease of accessibility.

An ongoing process has also been established where additional equality outcomes will be identified and included in the suite of measures over the coming reporting cycles. This approach will thus further reinforce the commitment to mainstreaming equalities by the West Dunbartonshire HSCP Board and within the HSCP.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP**Audit Committee: 23rd March 2016**

Subject: Local Government Benchmarking Framework 2014/15**1. Purpose**

- 1.1** To draw to the Audit Committee's attention the recently published Local Government Benchmarking Overview report for 2014/15 and the social care indicators within it.

2. Recommendation

- 2.1** The Audit Committee is asked to note the publication of the national overview report, and specifically the indicators concerned with social care services.

3. Background

- 3.1** All Scottish local authorities participate in comprehensive performance scrutiny through the Local Government Benchmarking Framework (LGBF). This Framework brings together performance indicators covering information about a wide range of key services including education, housing, social work, and leisure, as well as service costs and customer satisfaction results.
- 3.2** The intention is that by using the same indicators across all local authorities over a period of time allows comparison of performance, identification of best practice, learning from each other, and facilitation of continuous improvement.
- 3.3** To support this comparative work the Improvement Service produce an annual overview report. This report contains highlights of performance information for each Council against each indicator in the framework. The publication of the 2014/15 overview report on 29 January represents the fifth year of comparative benchmarking data.
- 3.4** The overview report concerns a period prior to the establishment of the West Dunbartonshire HSCP Board on the 1st July 2015, with the delegation of functions from the Council and Health Board on that same date.
- 3.5** The LGBF and the Improvement Services overview report includes eight indicators that were primarily concerned the former West Dunbartonshire Community Health and Care Partnership (CHCP); and would now lie within the responsibilities of the HSCP, i.e.:
- Percentage of Adults satisfied with social care or social work services.
 - Percentage of people 65+ with intensive needs receiving care at home.
 - Older Persons (Over 65) Home Care Costs per Hour.

- Average weekly cost per resident.
- Self Directed Support (SDS) spend on adults 18+ as a percentage of total social work spend on adults 18+.
- Balance of Care for looked after children: percentage of children being looked after in the Community.
- The Gross Cost of "Children Looked After" in Residential Based Services per Child per Week.
- The Gross Cost of "Children Looked After" in a Community Setting per Child per Week.

3.6 Appendix 1 details the performance of within West Dunbartonshire relative to other local authority areas across all those LGBF indicators.

4. Main Issues

4.1 It is recognised that the late publication of the Overview Report by the Improvement Service - with data almost one year old - means that the indicators in LGBF have limited value in isolation but add depth and trend information to a wider performance discussion. As such it is important to recognise the distinct purpose of benchmarking indicators as compared to performance targets – and as such, it is frequently difficult to judge and state whether a relative ranking of performance in relation to most of these indicators is good, poor, or indifferent.

4.2 West Dunbartonshire has the 3rd highest level of satisfaction with social care services in Scotland at 74%; and levels of satisfaction have increased year on year from 67% in 2012/13. The Scotland figure has followed the reverse trend decreasing from 57% in 2012/13 to 51% in 2014/15. This is particularly noteworthy within the context of health and social care integration.

4.3 The then CHCP provided care at home to 39.3% of people with intensive needs, allowing them to remain within their own homes and communities. While this figure is slightly lower than 40.7% in 2013/14, it is higher than the Scotland figure of 35.56%. At the same time, home care costs per hour (£20.91) rose above the Scotland figure (£20.01) for the first time since 2010/11. The HSCP is continuing to target services towards those with high level needs in order to maintain or even improve levels of independence – and this may provide some explanation for what is a very small cost per hour compared to the Scottish average. During 2014/15, the then CHCP established a Home Care Reablement team, which has ensured that the focus of Care at Home services is on better outcomes, maximising clients' long term independence and quality of life and appropriately minimises structured supports. The increased use of additional Telecare sensors as an integral component of care packages to sustain people at home contributes towards a reduction in the number of homecare hours and increased support to carers.

- 4.4** The cost per week for residential care for older people increased from £415.97 in 2013/14 to £460.43 in 2014/15. This is significantly higher than the Scotland figure of £372.07. However, as referenced in the Overview Report itself, “variation in net costs between councils will be largely influenced by the balance of LA funded/self-funded residents within each area, and the scale of LA care home provision and associated running costs”. East Dunbartonshire and Dumfries and Galloway have no local authority care home provision and are ranked 1st and 2nd for this measure in contrast to West Dunbartonshire's relatively high proportion of directly managed provision (all of Council employees within which are already on at least the National Living Wage).
- 4.5** Expenditure on the direct payments component of Self-Directed Support (SDS) has increased by 30% since 2013/14 and also increased as a proportion of overall adult social care spend from 1.39% to 1.77%. However, the ranking moved from 27th to 28th. The high level of satisfaction with social care services directly provided by the then CHCP may provide some explanation for this. A rolling training programme is in place for workers across the HSCP to ensure the offer of SDS options is embedded in the assessment process. A dedicated SDS support team and SDS website have also been created to raise public awareness and provide help and support. An Integrated Resource Framework has been developed to provide an indicative personal budget to meet the individual's eligible needs. This framework will be applied to all four SDS options ensuring fairness and equality across all individuals eligible for local authority funded support.

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** As in previous years, each HSCP service area will review the indicators which fall within their remit, scrutinising performance and trend information on each indicator. This complements the performance information already available and in turn will inform the actions incorporated within the next WD HSCP Strategic Plan.

10. Impact Assessments

10.1 None.

11. Consultation

11.1 None.

12. Strategic Assessment

12.1 The information provided from the LGBF will inform the next WD HSCP Strategic Plan.

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

Date: 7th March 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: LGBF 2014/15 – Analysis for West Dunbartonshire

Background Papers: National Benchmarking Overview Report 2014/15:
http://www.improvementservice.org.uk/benchmarking/documents/2016_Overview_Report.pdf

Wards Affected: All

Summary of LGBF 2014/15		Performance Against Previous Year		Performance Against Scotland Figure*		Rank				Change in Rank			
Area	No. of Pls	Better	Worse	Better	Worse	1-8	9-16	17-24	25-32	Better	Worse	No Change	
Children's Services	7	2	5	2	5	2	1	0	4	2	5	0	
Corporate Services	9	4	5	4	5	3	1	4	1	2	5	2	
Adult Social Care	5	2	3	2	3	1	2	0	2	1	4	0	
Culture & Leisure Services	8	7	1	5	3	1	4	1	2	6	2	0	
Environmental Services	14	8	6	8	6	2	4	5	3	7	6	1	
Housing Services	5	3	2	3	2	1	2	2	0	2	2	1	
Corporate Asset	2	2	0	1	1	0	1	0	1	2	0	0	
Economic Development	1	0	1	1	0	1	0	0	0	0	1	0	
TOTALS	51	28	23	26	25	11	15	12	13	22	25	4	

*Scotland
figure

The Scotland figure is calculated by dividing the sum of the numerators of all Local Authorities by the sum of the denominators of all Local Authorities and is the national figure. The exceptions to this are indicators CORP5b2 – “Average time (hours) between time of complaint and attendance on site, for those requiring attendance on site” and ENV 3c "Street Cleanliness Score" where the Scotland figure is the average of all 32 Local Authorities.

Children's Services

LGBF Code	Description	Ranking where 1 = best	2013/14	Rank	2014/15	Rank	Scotland	% Value Change 2013/14 - 2014/15	Change in rank 2013/14- 2014/15
CHN1	Cost Per Primary School Pupil	1= lowest value	5473.47	27	5377.23	28	4653.31	1.76 Better	1 Worse
CHN2	Cost per Secondary School Pupil	1= lowest value	6586.57	18	6662.61	16	6593.46	1.15 Worse	2 Better
CHN3	Cost per Pre-School Education Registration	1= lowest value	3644.24	25	4306.04	28	3306.44	18.16 Worse	3 Worse
CHN 8a	The Gross Cost of "Children Looked After" in Residential Based Services per Child per Week	1= lowest value	2946.15	15	These indicators rely on National Statistics on Looked After Children which are not published until Feb/March 2015. The benchmarking data will be refreshed to include these indicators at that time.				
CHN 8b	The Gross Cost of "Children Looked After" in a Community Setting per Child per Week	1= lowest value	176.21	5					
CHN5	% of Pupils Gaining 5+ Awards at Level 6	1=highest value	24.49	26	24.20	28	29.26	0.29 Worse	2 Worse

LGBF Code	Description	Ranking where 1 = best	2013/14	Rank	2014/15	Rank	Scotland	% Value Change 2013/14 - 2014/15	Change in rank 2013/14- 2014/15
CHN7	% Pupils from Deprived Areas Gaining 5+ Awards at Level 6 (SIMD)	1=highest value	17.83	3	13.66	8	12.75	4.17 Worse	5 Worse
CHN 10	% of Adults Satisfied with Local Schools	1=highest value	86	10	89	6	79	3 Better	4 Better
CHN 11	Proportion of Pupils Entering Positive Destinations	1=highest value	90.10	31	89.4	32	92.9	0.7 Worse	1 Worse
CHN 9	Balance of Care for looked after children: % of children being looked after in the Community	1=highest value	89	16	These indicators rely on National Statistics on Looked After Children which are not published until Feb/March 2015. The benchmarking data will be refreshed to include these indicators at that time.				
CHN 4	% of Pupils Gaining 5+ Awards at Level 5	1=highest value	We are not able at this time to include level 5 attainment data as this has not been provided by Scottish Government due to concerns over comparability of this data given changes introduced through Curriculum for Excellence. The board is exploring this with them to identify a solution and hope to include an appropriate measure in publication in January.						
CHN 6	% of Pupils from Deprived Areas Gaining 5+ Awards at Level 5 (SIMD)	1=highest value							

Corporate Services									
LGBF Indicator Code	Description	Ranking where 1 = best	2013/14	Rank	2014/15	Rank	Scotland	Change 2013/14-2014/15	Change in rank 2013/14-2014/15
CORP 1	Support services as a % of Total Gross expenditure	1= lowest value	3.36	3	3.68	3	5.07	0.33 Worse	No Change
CORP 3b	The percentage of the highest paid 5% of employees who are women	1=highest value	55.32	3	56.36	5	51.66	1.04 Better	2 Worse
CORP 7	Percentage of income due from Council Tax received by the end of the year	1=highest value	94.52	24	95.00	20	95.46	0.48 Better	4 Better
CORP 8	Percentage of invoices sampled that were paid within 30 days	1=highest value	86.61	28	90.28	23	92.52	3.67 Better	5 Better
CORP 2	Cost of Democratic Core per 1,000 population	1= lowest value	36,655.16	19	38437.53	21	30687.79	4.86 Worse	2 Worse

LGBF Code	Description	Ranking where 1 = best	2013/14	Rank	2014/15	Rank	Scotland	% Value Change 2013/14 - 2014/15	Change in rank 2013/14- 2014/15
CORP 4	The cost per dwelling of collecting Council Tax	1= lowest value	13.31	21	11.79	23	10.94	11.4 Better	2 Worse
CORP 5b2	(Domestic Noise) Average time (hours) between time of complaint and attendance on site, for those requiring attendance on site	1= lowest value	0.35	1	0.40	1	58.90	14.29 Worse	
CORP 6a	Sickness Absence Days per Teacher	1= lowest value	5.28	6	6.11	13	6.28	15.69 Worse	7 Worse
CORP 6b	Sickness Absence Days per Employee (non teacher)		12.90	31	14.46	32	10.80	12.09 Worse	1 Worse

Adult Social Care									
LGBF Indicator Code	Description	Ranking where 1 = best	2013/14	Rank	2014/15	Rank	Scotland	Change 2013/14-2014/15	Change in rank 2013/14-2014/15
SW2	SDS spend on adults 18+ as a % of total social work spend on adults 18+	1=highest value	1.39	27	1.77	28	6.86	0.38 Better	1 Worse
SW3	% of people 65+ with intensive needs receiving care at home	1=highest value	40.71	8	39.32	15	35.56	1.39 Worse	7 Worse
SW4	% of Adults satisfied with social care or social work services	1=highest value	68	9	74	3	51	6 Better	6 Better
SW1	Older Persons (Over65) Home Care Costs per Hour	1= lowest value	18.47	9	20.91	16	20.01	13.24 Worse	7 Worse
SW5	Average weekly cost per resident	1= lowest value	415.97	27	460.43	29	372.07	10.69 Worse	2 Worse

Culture & Leisure Services

LGBF Indicator Code	Description	Ranking where 1 = best	2013/14	Rank	2014/15	Rank	Scotland	% Value Change 2013/14-2014/15	Change in rank 2013/14-2014/15
C&L1	Cost per attendance at Sports facilities	1= lowest value	6.30	25	6.03	26	3.68	4.3 Better	1 Worse
C&L2	Cost Per Library Visit	1= lowest value	2.87	12	2.53	11	2.57	11.7 Better	1 Better
C&L3	Cost of Museums per Visit	1= lowest value	2.10	6	2.02	8	3.53	3.75 Better	2 Worse
C&L4	Cost of Parks& Open Spaces per 1,000 Population	1= lowest value	50695.91	31	37456.81	25	31303.95	26.11 Better	6 Better
C&L5a	% of adults satisfied with libraries	1=highest value	85	13	84	9	77	1 Worse	4 Better
C&L5b	% of adults satisfied with parks and open spaces	1=highest value	88	15	88	13	86	0 No Change	2 Better
C&L5c	% of adults satisfied with museums and galleries	1=highest value	71	18	80	11	75	9 Better	7 Better
C&L5d	% of adults satisfied with leisure facilities	1=highest value	69	27	74	21	76	5 Better	6 Better

Environmental Services

LGBF Indicator Code	Description	Ranking where 1 = best	2013/14	Rank	2014/15	Rank	Scotland	% Value Change 2013/14-2014/15	Change in rank 2013/14-2014/15
ENV1a	Net cost per Waste collection per premises	1= lowest value	35.62	1	40.73	3	65.17	14.35 Worse	2 Worse
ENV2a	Net cost per Waste disposal per premises	1= lowest value	109.66	25	112.25	27	91.46	2.37 Worse	2 Worse
ENV3a	Net cost of street cleaning per 1,000 population	1= lowest value	28638.24	32	19614.40	28	15818.12	31.51 Better	4 Better
ENV4a	Cost of maintenance per kilometre of roads	1= lowest value	21,090.72	31	10037.54	26	5618.04	52.41 Better	5 Better
ENV5a	Cost of trading standards per 1,000 population	1= lowest value	3,741.23	7	3621.98	4	5735.84	3.19 Better	3 Better
ENV5b	Cost of environmental health per 1,000 population	1= lowest value	17,559.29	18	16237.60	18	17697.66	7.53 Better	No Change
ENV3c	Cleanliness Score (%age Acceptable)	1=highest value	97.8	10	93.51	20	93.90	4.29 Worse	10 Worse
ENV6	The % of total waste arising that is recycled	1=highest value	44.01	16	44.30	19	42.80	0.29 Better	3 Worse

LGBF Code	Description	Ranking where 1 = best	2013/14	Rank	2014/15	Rank	Scotland	% Value Change 2013/14 - 2014/15	Change in rank 2013/14- 2014/15
ENV7a	% of adults satisfied with refuse collection	1=highest value	82	22	83	21	84	1 Better	1 Better
ENV7b	% of adults satisfied with street cleaning	1=highest value	81	7	79	12	74	2 Worse	5 Worse
ENV4b	Percentage of A class roads that should be considered for maintenance treatment	1= lowest value	24.75	13	25.51	15	29.03	0.76 Worse	2 Worse
ENV4c	Percentage of B class roads that should be considered for maintenance treatment	1= lowest value	29.43	16	27.61	10	36.10	1.82 Better	6 Better
ENV4d	Percentage of C class roads that should be considered for maintenance treatment	1= lowest value	42.39	24	42.49	23	37.35	0.1 Worse	1 Better
ENV4e	Percentage of unclassified roads that should be considered for maintenance treatment	1= lowest value	37.37	17	35.95	14	39.31	1.42 Better	3 Better

Housing Services

LGBF Indicator Code	Description		2013/14	Rank	2014/15	Rank	Scotland	Change 2013/14-2014/15	Change in rank 2013/14-2014/15
HSN2	Percentage of rent due in the year that was lost due to voids	1= lowest value	1.45	16	1.02	14	1.16	0.43 Better	2 Better
HSN3	Percentage of dwellings meeting SHQS	1=highest value	83.49	14	87.88	18	90.38	4.39 Better	4 Worse
HSN5	Percentage of council dwellings that are energy efficient	1=highest value	95.48	12	100.00	1	96.55	4.52 Better	11 Better
HSN1b	Gross rent arrears (all tenants) as at 31 March each year as a percentage of rent due for the reporting year	1= lowest value	8.60	24	9.55	24	5.95	0.95 Worse	No Change
HSN4b	Average time taken to complete non-emergency repairs	1= lowest value	8.67	10	9.55	15	9.88	0.88 Worse	5 Worse

Corporate Asset									
LGBF Indicator Code	Description		2013/14	Rank	2014/15	Rank	Scotland	Change 2013/14-2014/15	Change in rank 2013/14-2014/15
CORP-ASSET1	Proportion of operational buildings that are suitable for their current use	1=highest value	87.06	13	88.61	10	79.01	1.55 Better	3 Better
CORP-ASSET2	Proportion of internal floor area of operational buildings in satisfactory condition	1=highest value	55.24	31	61.71	30	82.92	6.47 Better	1 Better

Economic Development									
LGBF Indicator Code	Description		2013/14	Rank	2014/15	Rank	Scotland	Change 2013/14-2014/15	Change in rank 2013/14-2014/15
ECON1	% Unemployed People Assisted into work from Council operated / funded Employability Programmes	1=highest value	22.49	2	19.19	5	14.19	3.3 Worse	3 Worse

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 23 March 2016

Subject: National Care Standards – Overarching Principles

1. Purpose

- 1.1 To bring to the Audit Committee's the recently published overarching principles for new national care standards.

2. Recommendation

- 2.1 The Audit Committee Partnership Board is asked to note:

- The overarching principles for the anticipated new national care standards.
- The timetable for completion of the new national care standards by the Care Inspectorate and Healthcare Improvement Scotland.

3. Background

- 3.1 Scotland's National Care Standards have not been reviewed since they were first introduced in 2002. In 2015 the Scottish Government announced a review of the National Care Standards and undertook a public consultation to gather views of how best to do this. Subsequently the Care Inspectorate and Healthcare Improvement Scotland were tasked to lead a development group - National Care Standards Review Development Group - to co-produce these new standards working alongside people using services, providers and other agencies.
- 3.2 In February 2016, the final the overarching principles for new national care standards were signed off by the Cabinet Secretary for Health, Wellbeing and Sport (attached).

4. Main Issues

- 4.1 These overarching principles apply to all health and social care services in Scotland. Scottish Government has published them now in the expectation that they will help services, commissioners, and scrutiny bodies, in planning and designing services. The Care Inspectorate and Healthcare Improvement Scotland will also now use them to inform current reviews of inspection methodology.
- 4.2 The next phase of the National Care Standards Review Development Group's work is to develop a set of general and specialist standards linked to the principles. The draft standards will be published in Autumn 2016 followed by a 12 week period of consultation and engagement. The final standards will then

be rolled out from April 2017, ahead of implementation and their use in inspections thereafter.

4.3 Audit Committee members will recognise these overarching principles reinforce the existing core values of the Partnership Board and the HSCP as expressed in the Integration Scheme and Strategic Plan, i.e.:

- Protection.
- Improvement.
- Efficiency.
- Transparency.
- Fairness.
- Collaboration.
- Respect.
- Compassion.

4.4 The Partnership Board has affirmed its strong commitment to robust quality assurance within the Strategic Plan, and the important contribution that external inspection has to that process – not least to provide reassurance to the public and other stakeholders in terms of the care provided on a day and daily basis. However, in order to be deliverable and effective – and indeed to enjoy the confidence of the staff actually delivering and managing services – such inspection standards and frameworks need to be clear; proportionate; and joined-up across inspection bodies. So while these overarching principles are laudable, of greater interest is how they will be translated into meaningful standards that:

- Can fairly and objectively be assessed against.
- Avoid the development of an overly complex – and labyrinthine – inspection industry.
- Contributes to streamlining the already crowded “support and improvement” environment in which HSCPs are having to operate.
- Allow the outcome of inspection processes – whether joint or single agency - to be subjected to proper scrutiny.

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 Once confirmed, the new national care standards will be used by all services regulated by the Care Inspectorate and Healthcare Improvement Scotland.

10. Impact Assessments

10.1 The National Care Standards Review Development Group have confirmed the new standards will be developed using a human rights and wellbeing approach which recognises that people are entitled to the same high standards of care and support in a way which reflects their needs and circumstances.

11. Consultation

11.1 The National Care Standards Review Development Group developed these overarching principles following significant engagement over the past two years with people who use, provide and work in health and social care services. Consultation on the draft principles took place between October and December 2015, with a consultation report publicly available.

12. Strategic Assessment

12.1 These national overarching principles are already reflected in – and so reinforce - the core values of the Partnership Board and the HSCP, and the commitment to clinical and care governance within the Strategic Plan.

Author: Soumen Sengupta – Head of Strategy, Planning & Health Improvement

Date: 11th March 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: National Care Standards - Overarching Principles

Background Papers: National Care Standards Review Overarching Principles Consultation Report
<http://www.newcarestandards.scot/wp-content/uploads/2015/09/NCS-Consultation-Report.pdf>

Wards Affected: All



PRINCIPLES

Dignity and respect

- My human rights are respected and promoted.
- I am respected and treated with dignity as an individual.
- I am treated fairly and do not experience discrimination.
- My privacy is respected.

Compassion

- I experience warm, compassionate and nurturing care and support.
- My care is provided by people who understand and are sensitive to my needs and my wishes.

Be included

- I receive the right information, at the right time and in a way that I can understand.
- I am supported to make informed choices, so that I can control my care and support.
- I am included in wider decisions about the way the service is provided, and my suggestions, feedback and concerns are considered.
- I am supported to participate fully and actively in my community.

Responsive care and support

- My health and social care needs are assessed and reviewed to ensure I receive the right support and care at the right time.
- My care and support adapts when my needs, choices and decisions change.
- I experience consistency in who provides my care and support and in how it is provided.
- If I make a complaint it is acted on.

Wellbeing

- I am asked about my lifestyle preferences and aspirations, and I am supported to achieve these.
- I am encouraged and helped to achieve my full potential.
- I am supported to make informed choices, even if this means I might be taking personal risks.
- I feel safe and I am protected from neglect, abuse, or avoidable harm.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP**Audit Committee: 23 March 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 located within West Dunbartonshire.

2. Recommendations

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

3. Background

- 3.1** The Care Inspectorate assesses registered providers of care services in relation to four quality themes: quality of care and support; environment; staffing; and management & leadership.
- 3.2** As of April 2015, any residential care home which has been awarded Grade 2 (i.e. weak) or less and/ or has requirements placed upon them following a full inspection will usually receive a follow-up visit within twelve weeks. These follow-up visits allow the Care Inspectorate to track improvement and gain assurance that services are making the right changes. The Care Inspectorate do not intend make further requirements or revise grades or on these follow up visits (although Inspectors have some discretion to do so if they consider that sufficient evidence is evident).
- 3.3** The HSCP 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 HSCP works with independent sector providers to maintain their awareness of new developments and provide opportunities to share good practice/learning.
- 3.4** The independent sector Care Homes reported within this report are:
- Hill View Care Home
 - Balquhiddar House
 - Clyde Court Care Home

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

4. Main Issues

Hill View Care Home

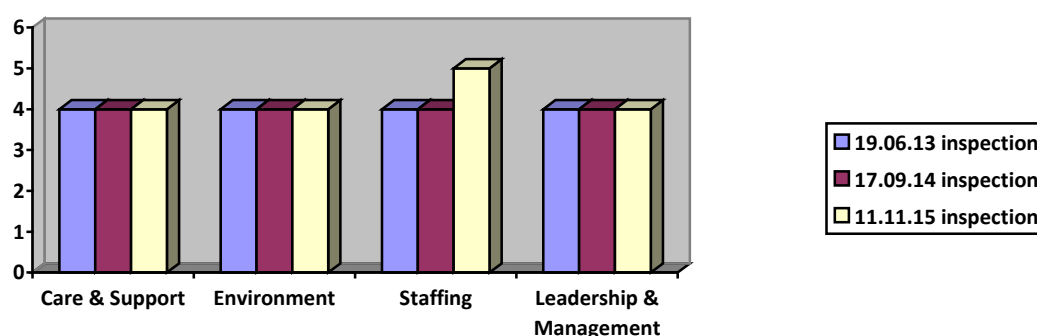
4.1 Hill View Care Home is owned and managed by BUPA Healthcare Limited. The home is registered with the Care Inspectorate for a maximum of 150 residents. As of 19th February 2016 there were 107 West Dunbartonshire residents supported within the care home.

4.2 The care home was inspected on 11th November 2015 and the report published on 5th January 2016, with grades awarded as follows:

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

4.3 There were no requirements detailed in the inspection report.

4.4 The chart below summarises the movement in grades awarded to Hill View Care Home from inspections over the last 3 years.



4.5 In December 2015, a complaints were raised concerning the quality of care being delivered. Following due process, staff from the HSCP Quality Assurance Section and two senior health care professionals visited the care home to investigate. The Management Team of the care home were then supported to devise an action plan. HSCP staff continued to visit the care home until these actions were completed.

Balquhiddier House

4.6 Balquhiddier House is owned and managed by Balquhiddier Care Ltd. The home is registered with the Care Inspectorate for a maximum of 65 residents. Balquhiddier House is a new purpose built care home that opened in July 2015 with the owners instigating an incremental admissions process to allow both resident and staff to settle into the new home. As of 19th February 2016 there were 34 West Dunbartonshire residents supported within the care home.

4.7 The care home was inspected on 9th January 2016 (its first) and the report is published on the 11th March 2016, grades awarded as follows:

- 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.

4.8 There were no requirements detailed in the inspection report.

Clyde Court Care Home

4.9 Clyde Court Care Home is owned and managed by Four Seasons Healthcare (Scotland) Limited. The home is registered with the Care Inspectorate for a maximum of 70 residents. As of 19th February 2016 there were 54 West Dunbartonshire residents supported within the care home.

4.10 The care home was inspected on 12th January 2016 and the report published on 11th February 2016. As this was their first inspection under the new Care Inspectorate inspection procedures, the Inspectorate had decided that the grades awarded at the previous inspection of 27 April 2015 would not be revisited at that occasion, i.e.:

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

4.11 This follow-up visit that focused on the requirements from the April 2015 inspection, with the progress made in addressing them as follows:

- The provider must ensure that measures are put in place to ensure that high levels of cleanliness are maintained and best practice regarding the control of infection adhered to.

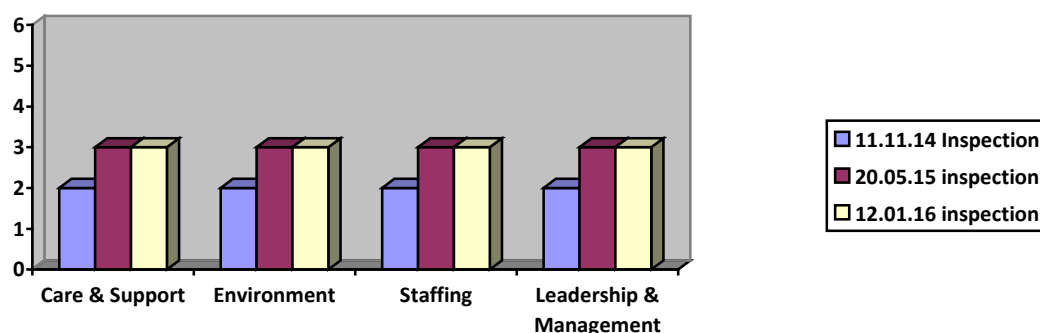
While no timescales had been given for the completion of this requirement, the Inspector was noted there had been changes to work practices and the cleaning schedules of the housekeeping team. They also acknowledged the hard work to keep the home clean and tidy, particularly as the home is in the middle of a programme of redecoration and replacement of some carpets. This made it more difficult, at times, to maintain the higher levels of cleanliness of the building. Despite this staff were to be extra vigilant in ensuring that it did not impact on the residents.

This requirement will remain in place until the Inspectors view consistent evidence to support fridges and microwaves used for residents being kept clean and best practice regarding control of infection and food safety.

- The provider must ensure that measures to protect residents and minimise the risk of falls are fully implemented.

The Inspector noted that falls risks assessment were being carried out regularly and recorded in personal plans, with equipment identified and recorded appropriately. There was evidence that the care home received support and advice from NHS Falls Team and those requirements had been carried out resulting in an improvement in this area.

- 4.12** The chart below summarises the movement in grades awarded to Clyde Court Care Home from inspections over the last 3 years.



- 4.13** Nationally there have been concerns expressed in the media over the financial stability of Terra Firma, the company who own Four Seasons Healthcare Ltd. (which is the biggest care home operator in Britain). In addition to placement in Clyde Court, the HSCP has clients placed in other Four Seasons care homes across Scotland. HSCP staff visited Clyde Court in November 2015 during which the the question of financial stability was raised with the Care Home Manager. The Care Home manager advised that all care home managers in the Four Seasons Group had received communication from the CEO of Four Seasons reassuring them of the sustainability of Four Seasons Healthcare Ltd. and that the company had sufficient financial funding to meet the needs of continued service delivery.

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 Report for Balquhiddar House has financial implications for the HSCP. 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 be entitled to the enhanced weekly rate for every resident the HSCP has placed in the home.
- 6.4** As detailed at point 6.3 above, Balquhiddar House will now receive the enhanced weekly rate £3.00 per resident per week from the date of their inspection. This means the HSCP will pay an additional £936.00 from 9/01/16 to 31/03/16, if all residents at 19/02/16 remain in care until the end of the financial year. This increase does not apply to residents who are only received the Free Personal and/or Nursing payment from the HSCP.
- 6.5** This additional payment will remain in place until either the National Care Home Contract terms are renegotiated or the Care Inspectorate reduces the grades awarded to Balquhiddar House following 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 placement of older people in such establishments.

10. Impact Assessments

- 10.1** None required.

11. Consultation

- 11.1** None required.

12. Strategic Assessment

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

Author: Soumen Sengupta – Head of Strategy, Planning & Health Improvement

Date: 11th March 2016

Person to Contact: Mrs Sharon Elliott
Quality Assurance Manager
West Dunbartonshire HSCP
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: 23 March 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 The Care Inspectorate assesses registered providers of care services in relation to four quality themes: quality of care and support; environment; staffing; and management & leadership.
- 3.2 The independent sector support service inspections reported here are for:
- Quarriers Homelife Project - service is provided throughout West Dunbartonshire Council area.
 - M and J Care & Support at Home - service is provided throughout West Dunbartonshire Council area.
 - Barnardo's Scotland Fostering (Glasgow) – service is provided in family homes to children and young people from throughout West Dunbartonshire Council area.
 - Alltogether Care Services - service is provided throughout West Dunbartonshire Council area.
- 3.3 Copies of the inspection reports can be accessed on the Care Inspectorate website: www.scswis.com.

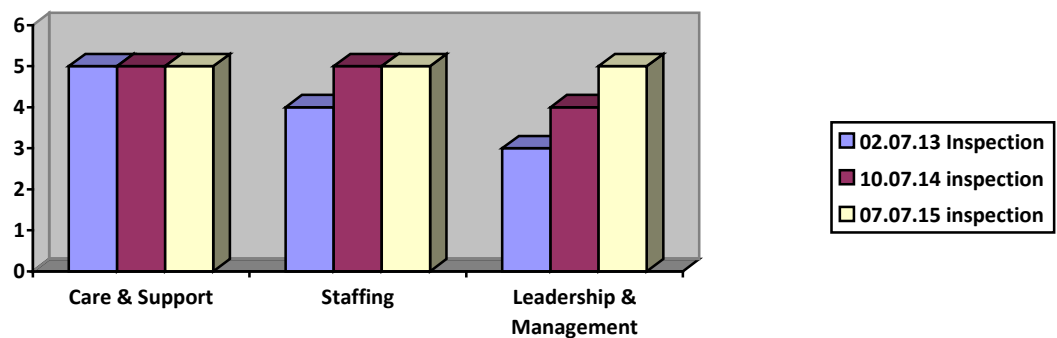
4. Main Issues

Quarriers Homelife Project

- 4.1 Quarriers Homelife Project provides housing support and care at home services to adults with learning disabilities who live in their own homes or shared tenancies. The service was inspected on 7th July 2015 and the report published on 9th December 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.

4.3 The chart below summarises the movement in grades awarded to Quarriers Homelife Project from inspections over the last 3 years.



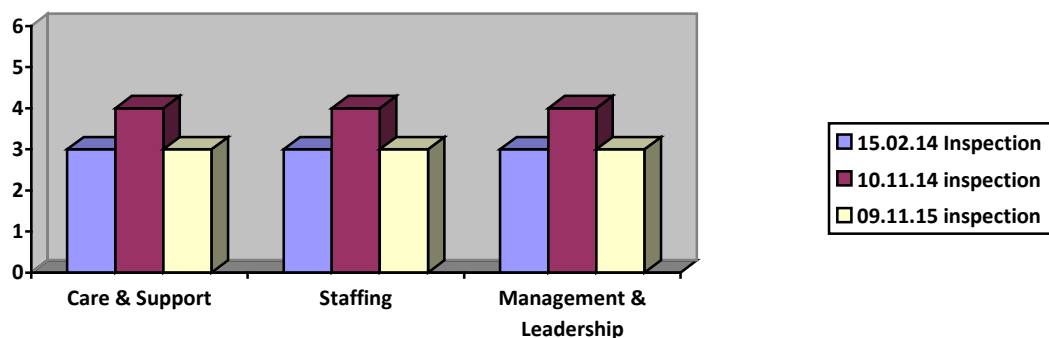
M and J Care & Support at Home

4.4 M and J Care & Support at Home provide a combined Housing Support and Care at Home service. The service is offered to a wide range of people with varying needs who live in their own homes. The service was inspected on 9th November 2015 and the report published on 29th December 2015. The following grades were awarded:

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

4.5 There were no requirements detailed in the inspection report.

4.6 The chart below summarises the movement in grades awarded to M and J Care & Support from inspections over the last 3 years.



4.7 In 2015, concerns had been raised concerning the quality of care being delivered by this Provider. These concerns were formally brought to the attention of the Provider by HSCP staff. Following an investigation by the Provider, the concerns were addressed and a member of their staff was disciplined. The HSCP continues to purchase services from this provider as there are currently no concerns regarding service delivery (as the complaint which had previously been raised has been resolved), with HSCP staff continuing to engage with them routinely.

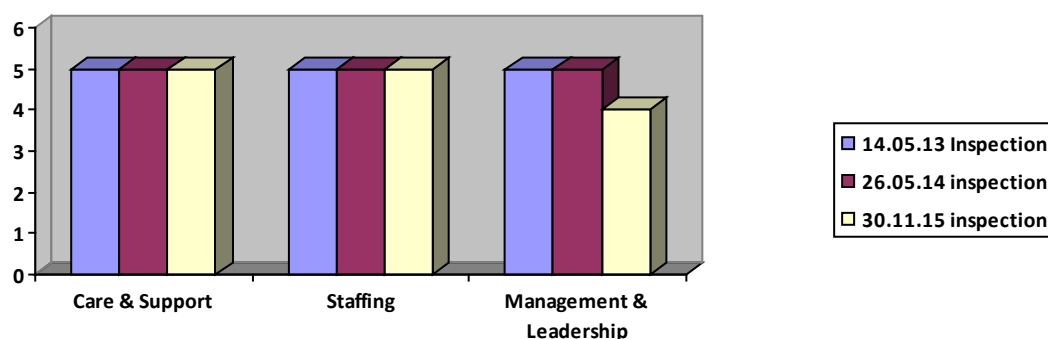
Barnardo's Scotland Fostering (Glasgow)

4.8 Barnardo's Scotland Fostering (Glasgow) provides a Fostering Service. The service offers a fostering and family placement service for children and young people from birth to 18 years. The service was inspected on 30th November 2015 and the report published on 12th February 2016. 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 4/Good.

4.9 There were no requirements detailed in the inspection report.

4.10 The chart below summarises the movement in grades awarded to Barnardo's Scotland Fostering (Glasgow) from inspections over the last 3 years.



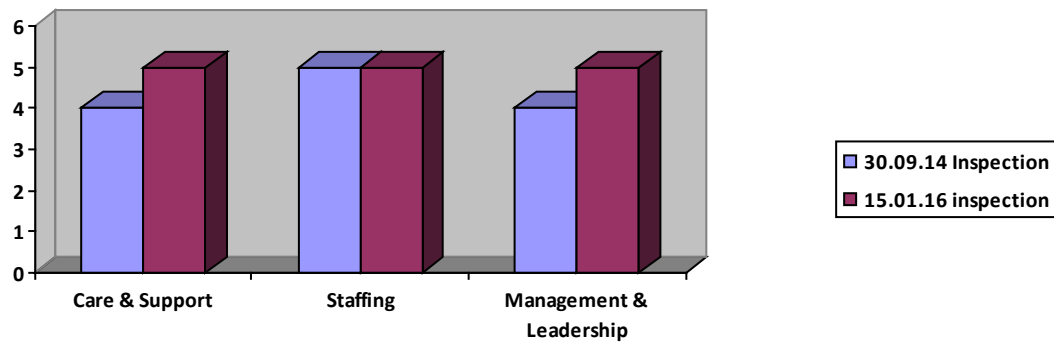
Alltogether Care Services

4.11 Alltogether Care Services provides a combined Housing Support and Care at Home service. The service is offered to a wide range of people with varying needs who live in their own homes. The service was inspected on 15th January 2016 and the report published on 16th February 2016. This is a relatively new organisation, with this being only their second inspection. 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.

4.12 There were no requirements detailed in the inspection report.

- 4.13** The chart below summarises the movement in grades awarded to Alltogether Care Services for the only inspections they have had.



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 the HSCP.

10. Impact Assessments

- 10.1** None required.

11. Consultation

- 11.1** None required.

12. Strategic Assessment

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

Author: Soumen Sengupta – Head of Strategy, Planning & Health Improvement

Date: 11th March 2016

Person to Contact: Mrs Sharon Elliott
Quality Assurance Manager
West Dunbartonshire HSCP
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: 23rd March 2016

Subject: Care Inspectorate Reports for support services managed by West Dunbartonshire Health and Social Care Partnership.

1 Purpose

- 1.1** To provide Members with information regarding the most recent inspection report for the HSCP's Learning Disability Service.

2 Recommendations

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

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 CHCP Support Service covered in this Committee report is:
- Learning Disability Service (Dumbarton Day Centre)
 - Housing Support Services, (including Locality Services)
- 3.3** Copies of inspection reports for all services can be accessed on the Care Inspectorate web-site; www.scswis.com

4 Main Issues

- 4.1** The Dumbarton Centre was inspected on 30th October 2015 and the report published on 7th December 2015.
- 4.2** Housing Support Services were inspected on 18th November 2015 and 5th February 2016
- 4.3** Table 1 below illustrates the grades for Dumbarton Centre. Table 2 illustrates the grades for Housing Support Services.

Table 1 – Dumbarton Centre

Quality Statement	Grade
We ensure that service users and carers participate in assessing and improving the quality of the care and support provided by the service	5 Very Good

Quality Statement	Grade
We respond to service users' care and support needs using person centred values	5 Very Good
We ensure that service users and carers participate in assessing and improving the quality of the environment within the service	5 Very Good
The environment allows service users to have as positive a quality of life as possible	5 Very Good
We ensure that service users and carers participate in assessing and improving the quality of staffing in the service	4 Good
We ensure that everyone working in the service has an ethos of respect towards service users and each other	4 Good
We ensure that service users and carers participate in assessing and improving the quality of the management and leadership of the service	5 Very Good
To encourage good quality care, we promote leadership values throughout the workforce	4 Good

The following overall grades were awarded to Dumbarton Centre:

For the theme of *Care and Support* – Grade 5/Very Good.

For the theme of *Quality of Environment* – Grade 5/Very Good

For the theme of *Quality of Staffing* - Grade 4/Good.

For the theme of *Quality of Management and Leadership* - Grade 4/Good.

Table 2 – Housing Support Services

Quality Statement	Grade
We ensure that service users and carers participate in assessing and improving the quality of the care and support provided by the service	5 Very Good
We respond to service users' care and support needs using person centred values.	4 Good
We ensure that service users and carers participate in assessing and improving the quality of staffing in the service.	4 Good
We ensure that everyone working in the service has an ethos of respect towards service users and each other.	5 Very Good

Quality Statement	Grade
We ensure that service users and carers participate in assessing and improving the quality of the management and leadership of the service	4 Good
To encourage good quality care, we promote leadership values throughout the workforce	5 Very Good

The following overall grades were awarded to Housing Support Services:

For the theme of *Care and Support* – Grade 4 Good.

For *Staffing* – Grade 4 Good

For *Management and Leadership* - Grade 4 Good

- 4.4** The inspection reports did not contain any requirements
- 4.5** The Inspection Reports were reviewed by the Learning Disability Service Management Team
- 4.6** The grades indicate an improvement at Dumbarton Centre in terms of the Quality of Environment. This is largely a reflection on the major refurbishment of the premises last year. The grades also indicate a slight drop in the grades for Quality of Staffing and Quality of Management. We believe this to be a reflection of the long term absence of the service manager last year, which caused some disruption to the continuity of management within the service.
- 4.7** Housing Support Services have maintained their grades from their previous inspection.
- 4.8** The table below sets out the movement in grades for the services over the last two inspections:

Dumbarton Centre	Previous Grades						Current Grades					
	1	2	3	4	5	6	1	2	3	4	5	6
	17 th August 2012						October 30 th 2015					
WDC Learning Disability Service												
• Care & support					√						√	
• Environment				√							√	
• Staff					√					√		
• Management & Leadership					√					√		

Housing Support Services	Previous Grades						Current Grades					
	1	2	3	4	5	6	1	2	3	4	5	6
	21 Oct 2014						18 Nov 2015					
<ul style="list-style-type: none"> Care & Support Environment (not assessed) Staffing Management & Leadership 				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.

5 Consultation

5.1 Not required for this report.

6 Strategic Assessment

6.1 The Council's Strategic Plan 2012-17 identifies "improve the wellbeing of communities and protect the welfare of vulnerable people" as one of the authority's five strategic priorities.

Author: John Russell - Head of Mental Health, Learning Disability & Addictions

Date: 26th February 2016

Person to Contact: Adrian McBride
Operations Manager
Learning Disability Services
118 Dumbarton Road
Clydebank
E-mail: Adrian.McBride@west-dunbarton.gov.uk
Telephone: 0141 562 2333

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: 23 March 2016

Subject: Audit Action Plans 2015/16

1. Purpose

- 1.1** The purpose of this report is to advise the Committee of action plans issued by West Dunbartonshire Council's Internal Audit Service during 2015/16 in relation to social care activities and of any relevant reports issued by NHS Greater Glasgow and Clyde's Internal Auditors.

2. Recommendations

- 2.1** It is recommended that the Audit Committee consider and note the contents of this report.

3. Background

- 3.1** When audit reports are issued by Internal Audit, management agree an action plan in relation to issues highlighted by the audit report. For a number of years, progress on implementing the actions is monitored and reported to the WDC Audit and Performance Review Committee. Going forward, it is proposed that a similar report is submitted to the IJB Audit Committee in respect of:
- Audit reports issued as a result of work carried out by the WDC Internal Audit service that is relevant to the IJB;
 - Audit reports issued as a result of work carried out by PriceWaterhouseCoopers in their role as Internal Auditors of NHS Greater Glasgow and Clyde that is relevant to the IJB; and
 - Audit reports issued by the IJB's external auditors.

4. Main Issues

- 4.1** Within the WDC Internal Audit Plan for 2015/16, two social care audits were scheduled as noted below:

Audit	Planned Days	Objectives / key tasks
Self-Directed Support	19	<ul style="list-style-type: none"> • Review assessment / eligibility • Review payment process • Review monitoring of expenditure
Child Protection	25	<ul style="list-style-type: none"> • Review system in place for recognising / identifying vulnerable children issues • Access controls to sensitive data • Security of data • Review of reports from external inspectorate agencies

- 4.2** The Self-Directed Support audit has been completed and the agreed action plan for this assignment is attached at Appendix A. The Child Protection audit is currently in progress. As can be seen from Appendix A, all action have been implemented by management.
- 4.3** The key areas of work performed by both Internal Audit and External Audit are carried out according to a risk based approach that determines the nature, extent and timing of the required audit assignments.
- 4.4** Recommendations contained within the WDC Internal Audit Service's action plans have timescales for completion in line with the following categories:

Category	Expected implementation timescale
<u>High Risk:</u> Material observations requiring immediate action. These require to be added to the department's risk register	Generally, implementation of recommendations should start immediately and be fully completed within three months of action plan being agreed
<u>Medium risk:</u> Significant observations requiring reasonably urgent action.	Generally, complete implementation of recommendations within six months of action plan being agreed
<u>Low risk:</u> Minor observations which require action to improve the efficiency, effectiveness and economy of operations or which otherwise require to be brought to the attention of senior management.	Generally, complete implementation of recommendations within twelve months of action plan being agreed

- 4.5** A report entitled "NHS Greater Glasgow & Clyde Health Board's 2015/16 Opening Budget report" was submitted to the Audit Committee meeting on 13th January 2016. This included the West Dunbartonshire Health & Social Care Partnership health budget. There are no other reports produced by PWC which are relevant to the IJB.

5. People Implications

- 5.1** There are no personnel issues with this report.

6. Financial Implications

- 6.1** There are no financial implications with this report.

7. Professional Implications

7.1 None.

8. Locality Implications

8.1 None.

9. Risk Analysis

9.1 There is a risk that failure to implement actions within the agreed timescale may result in weaknesses in internal control arrangements remaining unresolved longer than is desirable.

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 The implementation of agreed action plans will assist in ensuring proper governance and control arrangements.

Jeanne Middleton – Chief Financial Officer

Date: 8 March 2016

Person to Contact: Colin McDougall, Audit and Risk Manager
West Dunbartonshire Council
Telephone 01389 737436
E-mail – colin.mcdougall@west-dunbarton.gov.uk

Appendices: A - WDC Internal Audit Reports






Background Papers: None

Wards Affected: All Wards



Appendix A





Internal Audit Reports


Generated on: 25 February 2016

Action Status	
	Cancelled
	Overdue; Neglected
	Unassigned; Check Progress
	Not Started; In Progress; Assigned
	Completed

Project 84. Self-Directed Support (Report Issued September 2015)

Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
<u>1. Financial Assessments</u> The Charging Policy which directly affects whether an individual is required to make a contribution towards the total cost of support is open to interpretation, therefore, financial assessments are not always being completed. The Charging Policy therefore requires to be reviewed and be a more informative document. Thereafter, all staff who makes reference to the policy should be provided with guidance	The Charging Policy is currently under review. The Need to bring together a number of charging structures is acknowledged. The implementation of the I.R.F. will address the issue of financial assessments being completed.			30-Nov-2015	30-Nov-2015	David Elliott	IRF training is complete.

Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
ensuring consistency of application in relation to the completion of financial assessments. (Medium Risk)							
<u>2. Procedures</u> It is recommended that: a) Process's undertaken by the Self Directed Support Team and the Finance Team relating to Direct Payments be reviewed and streamlined to ensure that the whole process is more efficient. b) Documentation be reviewed to ensure they are fit for purpose. c) Documentation should be standardised to ensure that the same versions are being used and issued consistently (Low Risk)	The I.R.F. is now live and is an electronic format hereby providing care of use, standardisation and a paperlite model. Further paperlite agenda's will all information held electronically reducing duplication and providing a centralized sights file. Documents are currently being reviewed to ensure they are fit for purpose.		 100%	30-Nov-2015	30-Nov-2015	David Elliott	IRF is complete and live thereby streamlining the process.
<u>3. Direct Payments Documentation</u> In relation to direct payments documentation, staff should be reminded that: a) Documentation should be signed by the WDC representative/client or client representative where appropriate b) Copies of agreements should be held on file for every client (Low Risk)	Staff will be reminded that documentation should be signed by WDC representatives and clients where appropriate. Following the implementation of the I.R.F, current paperwork will be reduced as electronic approval becomes the way. Copies of agreements will be held electronically.		 100%	30-Nov-2015	30-Nov-2015	David Elliott	Completed.

<u>4. Reconciliations</u> The Direct Payments reconciliations should be more formalised and show all of the detail of the reconciliation. (Low Risk)	Agreed that a more formal recording of the reconciliation will now be carried out.		<div> <div></div> 100% </div>	30-Sep-2015	30-Sep-2015	Janice Rainey	Completed.
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WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 23 March 2016

Subject: Internal Audit Plan 2016/17 – Progress Report

1. Purpose

- 1.1** The purpose of this report is to advise members of progress in developing the planned programme of audit work for the year 2016/17.

2. Recommendations

- 2.1** It is recommended that the Audit Committee note progress in developing the Audit Plan for 2016/17.

3. Background

- 3.1** The Chartered Institute of Public Finance and Accountancy (CIPFA) / Institute of Internal Auditors (IIA) Public Sector Internal Audit Standards (PSIAS) require the preparation of a risk-based audit plan.
- 3.2** The PSIAS also requires that the plan should be based on a clear understanding of the organisation's functions and the scale of potential audit areas. The plan should be partly informed by consultation with key stakeholders, including the Audit Committee and senior management. The Audit Committee should approve the Internal Audit plan.
- 3.3** The provision of Internal Audit services within West Dunbartonshire Council is delivered by an in-house team. NHS Greater Glasgow and Clyde has contracted out the delivery of Internal Audit services to PriceWaterhouseCoopers (PWC).
- 3.4** At its meeting on 19th August 2015, the Health & Social Care Partnership Board agreed that the internal audit service for the Partnership Board would be provided by West Dunbartonshire Council's (WDC) Internal Audit Section, with Colin McDougall appointed as Chief Internal Auditor for the Partnership Board. This role includes the responsibility for preparing an audit plan for the Integrated Joint Board (IJB) as well as reporting to the Audit Committee on the outcome of relevant audit work.
- 3.5** The Audit Plan was compiled using a risk based approach through a review of the Audit Universe which includes all significant activities and systems that contribute to the achievement of the IJB's strategic priorities and objectives.

4. Main Issues

4.1 The audit planning process has taken into account the following factors:

- A risk based audit needs assessment identifying all potential audit areas;
- Consultations with senior management;
- The plans of External Audit and other inspection agencies;
- The IJB's strategic priorities and risks;
- Current issues and changes in computer systems; and
- Resources available.

4.2 Internal Audit monitors delivery of the plan continuously during the year using a number of performance indicators. Progress is reported to members on a regular basis.

4.3 WDC's audit plan includes a number of audit reviews which cover Social Care service areas, namely:

<u>Audit</u>	<u>Days Allocated</u>
Scottish Social Services Council Registration	20
Employment Support (Social Work initiative for vulnerable people)	15
Home Care	20
Fostering and adoption payments / allowances	25
Total	80

It is recognised that the West Dunbartonshire Health and Social Care Partnership is at the early implementation stage and the audit reviews shown above may be repositioned within the IJB Audit Plan for 2016/17.

These audits, together with other Council wide system reviews, will help to inform an opinion on the control environment within the IJB.

4.4 Similarly, much of the audit work which is carried out within NHS Greater Glasgow and Clyde by PWC will cover services which are delegated to the IJB and the findings of these reviews will also contribute to an opinion of the control environment.

4.5 In addition to the reviews referred to at paragraphs 4.3 and 4.4 above, the IJB has a draft audit plan which includes 35 days drawn from the Internal Audit service of West Dunbartonshire Council (see further paragraph 4.6 below).

For the overall draft internal audit plan for NHS Greater Glasgow and Clyde, a total of 665 indicative audit days has been allocated. Further discussion have still to take place with NHS Greater Glasgow and Clyde in order to understand which elements of this overall plan are relevant to the IJB.

- 4.6** The planned audit activity for 2016/17 to be carried out within the IJB by WDC's Internal Audit team is as follows:

<u>Audit</u>	<u>Days Allocated</u>
Post implementation review <i>Assessing how the health and social care integration process has progressed since the IJB came into being, including consideration of the level of achievement of key strategic objectives</i>	15
Governance and Assurance <i>Considering how the IJB links to the Council's governance arrangements and the flow of information between the IJB and the Council.</i>	10
Committee <i>Support to the IJB and the Audit Committee through preparing reports attending meetings and providing training and support to members of the IJB Audit Committee.</i>	10
Total	35

5. People Implications

- 5.1** There are no personnel issues with this report.

6. Financial Implications

- 6.1** There are no financial implications with this report.

7. Professional Implications

- 7.1** None.

8. Locality Implications

8.1 None.

9. Risk Analysis

9.1 The Plan has been constructed taking cognisance of the risks associated with major systems. Consultation with Senior Managers was carried out to ensure that risks associated with delivering strategic objectives have been considered.

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 The establishment of a robust audit plan will assist in assessing whether the Partnership Board and Officers have established proper governance and control arrangements which contribute to the achievement of the strategic priorities of the HSCP Strategic Plan.

Author: Jeanne Middleton – Chief Financial Officer

Date: 8 March 2016

Person to Contact: Colin McDougall, Audit and Risk Manager
West Dunbartonshire Council
Telephone 01389 737436
E-mail – colin.mcdougall@west-dunbarton.gov.uk

Appendices: None

Background Papers: None

Wards Affected: All Wards

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP**Audit Committee: 23 March 2016**

**Subject: Audit Scotland: West Dunbartonshire Health & Social Care
Partnership Board Annual Audit Plan 2015/16**

1. Purpose

- 1.1** To present the 2015/16 Audit Scotland Annual Audit Plan drafted for the Audit Committee.

2. Recommendation

- The Audit Committee is recommended to consider the draft Audit Scotland report prepared and offer feedback prior to its being finalised.

3. Background

- 3.1** In October 2015 the Accounts Commission approved the appointment of Audit Scotland's Audit Services Group as external auditors of the West Dunbartonshire Health & Social Care Partnership Board. The audit appointment is for one year, covering the 2015/16 financial year, the first accounting period for which the partnership is required to prepare financial statements. A fresh appointment of external auditors will be made later this year as part of the Accounts Commission's cycle of auditor rotation.
- 3.2** The 2015/16 annual audit plan is focused on the identification and assessment of the risks of material misstatement in West Dunbartonshire Health & Social Care Partnership Board's financial statements.

4. Main Issues

- 4.1** This report summarises the key challenges and risks facing the partnership and sets out the audit work that Audit Scotland propose to undertake in 2015/16. The plan reflects:
- this being the first year of the board's activities;
 - the risks and priorities facing the partnership;
 - current national risks that are relevant to local circumstances;
 - the impact of changing international auditing and accounting standards; and
 - the responsibilities under the Code of Audit Practice as approved by the Auditor General for Scotland.

4.2 The planned work in 2015/16 includes:

- an audit of the financial statements and provision of an opinion on whether:
 - they give a true and fair view of the state of affairs the partnership as at 31 March 2016 and its income and expenditure for the year then ended
 - the accounts have been properly prepared in accordance with the Local Government (Scotland) Act 1973 and the 2015/16 Code of Practice on Local Authority Accounting in the United Kingdom (the Code)
- a review and assessment of the partnership's governance and performance arrangements in a number of key areas including budgetary control and performance reporting; and
- collection of relevant financial and performance information to inform Audit Scotland's national reports.

5. People Implications

5.1 None associated with this report.

6. Financial Implications

6.1 The proposed audit fee for the 2015/16 audit of the partnership is £17,100. Audit Scotland's fee covers the cost of planning, delivery, and reporting the annual audit including auditor's attendance at committees.

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 The audit of the financial statements does not relieve Partnership Board's Audit Committee (as the body charged with overseeing and scrutinising governance) or the Chief Financial Officer of their responsibilities.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

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.

Author: Jeanne Middleton – Chief Financial Officer,

Date: 23 March 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 - Annual Audit Plan 2015/16

Background Papers: None

Wards Affected: All



[DRAFT] West Dunbartonshire Health & Social Care Partnership

**Annual Audit Plan
2015/16**

**Prepared for Members of West Dunbartonshire
Health & Social Care Partnership Integration Joint
Board**

March 2016

Key contacts

David McConnell, Assistant Director
dmcconnell@audit-scotland.gov.uk

Peter Lindsay, Senior Audit Manager
plindsay@audit-scotland.gov.uk

Karen Cotterell, Senior Auditor
kcotterell@audit-scotland.gov.uk

4th Floor, South Suite
The Athenaeum Building
8 Nelson Mandela Place
Glasgow
G2 1BT
Telephone: 0131 625 1500
Website: www.audit-scotland.gov.uk

The Accounts Commission is a statutory body which appoints external auditors to Scottish public bodies (www.audit-scotland.gov.uk/about/ac/). Audit Scotland is a statutory body which provides audit services to the Accounts Commission and the Auditor General (www.audit-scotland.gov.uk/about/).

The Accounts Commission has appointed David McConnell as the external auditor of West Dunbartonshire Health & Social Care Partnership for 2015/16.

This report has been prepared for the use of [DRAFT] West Dunbartonshire Health & Social Care Partnership and no responsibility to any member or officer in their individual capacity or any third party is accepted.

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Summary

Introduction

1. In October 2015 the Accounts Commission approved the appointment of Audit Scotland's Audit Services Group as external auditors of the West Dunbartonshire Health & Social Care Partnership (the partnership). Our audit appointment is for one year, covering the 2015/16 financial year, the first accounting period for which the partnership is required to prepare financial statements. A fresh appointment of external auditors will be made later this year as part of the Accounts Commission's cycle of auditor rotation.
2. Our audit is focused on the identification and assessment of the risks of material misstatement in West Dunbartonshire Health & Social Care Partnership's (the partnership) financial statements.
3. This report summarises the key challenges and risks facing the partnership and sets out the audit work that we propose to undertake in 2015/16. Our plan reflects
 - this being the first year of the board's activities
 - the risks and priorities facing the partnership
 - current national risks that are relevant to local circumstances
 - the impact of changing international auditing and accounting standards
 - our responsibilities under the Code of Audit Practice as approved by the Auditor General for Scotland.

Summary of planned audit activity

4. Our planned work in 2015/16 includes:
 - an audit of the financial statements and provision of an opinion on whether:
 - they give a true and fair view of the state of affairs the partnership as at 31 March 2016 and its income and expenditure for the year then ended
 - the accounts have been properly prepared in accordance with the Local Government (Scotland) Act 1973 and the 2015/16 Code of Practice on Local Authority Accounting in the United Kingdom (the Code)
 - a review and assessment of the partnership's governance and performance arrangements in a number of key areas including budgetary control and performance reporting.
 - collection of relevant financial and performance information to inform Audit Scotland's national reports

Responsibilities

5. The audit of the financial statements does not relieve management or the partnership's Audit Committee, as the body charged with governance, of their responsibilities.

Responsibility of the appointed auditor

6. Our responsibilities, as independent auditor, are established by The Public Bodies (Joint Working) (Scotland) Act 2014, The Local Government (Scotland) Act 1973 and the Code of Audit Practice, and guided by the auditing profession's ethical guidance.
7. Under the Local Government (Scotland) Act 1973, the Accounts Commission is responsible for appointing the external auditors of local government bodies including councils, joint boards and bodies falling within section 106 of the Act. The Public Bodies (Joint Working) (Scotland) Act 2014 specifies that Integration Joint Boards (IJBs) should be treated as if they were bodies falling within section 106 of the 1973 Act.
8. Auditors in the public sector give an independent opinion on the financial statements. We also review and report on the arrangements set in place by the audited body to ensure the proper conduct of its financial affairs and to manage its performance and use of resources. In doing this, we aim to support improvement and accountability.

Responsibility of the Chief Financial Officer

9. It is the responsibility of the Chief Financial Officer, as the appointed "proper officer", to prepare the financial statements in accordance with relevant legislation and the Code of Practice on Local Authority Accounting in the United Kingdom (the Code). This means:
 - Ensuring that adequate arrangements are in place to gain assurances on the accuracy, completeness and integrity of the information provided by the council and the health board
 - maintaining proper accounting records
 - preparing financial statements which give a true and fair view of the state of affairs of the partnership as at 31 March 2016 and its expenditure and income for the year then ended.

Format of the accounts

10. The financial statements should be prepared in accordance with the Code, which constitutes proper accounting practice.

Audit Approach

Our approach

11. Our audit approach is based on an understanding of the characteristics, responsibilities, principal activities, risks and governance arrangements of the partnership. This approach includes:
 - understanding the business of the partnership and the risk exposure which could impact on the financial statements
 - obtaining assurances from auditors of the stakeholder bodies as to the effectiveness of their respective key systems of internal control, and considering how any risks identified in these systems could impact on the financial statements
 - identifying major transaction streams, balances and areas of estimation and understanding how the partnership will include these in the financial statements
 - assessing and addressing the risk of material misstatement in the financial statements
 - determining the nature, timing and extent of the audit procedures necessary to provide us with sufficient audit evidence as to whether the financial statements give a true and fair view.
12. We have also considered and documented the sources of assurance which will make best use of our resources and allow us to focus audit testing on higher risk areas during the audit of the financial statements. The main areas of assurance for the audit come from planned management action and reliance on systems of internal control. Planned management action being relied on for 2015/16 includes:
 - comprehensive closedown procedures for the financial statements accompanied by a timetable issued to all relevant staff
 - clear responsibilities for preparation of financial statements and the provision of supporting working papers
 - delivery of unaudited financial statements to agreed timescales with a comprehensive working papers package
 - completion of the internal audit programme for 2015/16.
13. Auditing standards require internal and external auditors to work closely together to make best use of available audit resources. Internal audit services are provided by the Internal Audit section of West Dunbartonshire Council (the council) and NHS Greater Glasgow and Clyde (the health board). We seek to rely on the work of internal audit wherever possible and as part of our planning process we carry out an early assessment of the internal audit function to determine whether it has sound documentation standards and reporting procedures in place and complies with the main requirements of the Public Sector Internal Audit Standards (PSIAS). For 2015/16 we have been able to refer to the assessments of internal audit carried out by the external auditors for the council and the health board.

14. Due to the nature of the work being carried out by internal audit we do not plan to place formal reliance on the work of internal audit to support our audit opinion on the financial statements.
15. In respect of our wider governance and performance audit work we also plan to review the findings and consider other areas of internal audit work including:
 - Budgetary control and monitoring review
 - Information security
 - Governance and assurance arrangements.
18. Based on our knowledge and understanding of the partnership we have set our planning materiality at £1.36 million (1% of budgeted gross expenditure).
19. We set a lower level, known as performance materiality, when defining our audit procedures. This is to ensure that uncorrected and undetected audit differences do not exceed our planning materiality. This level depends on professional judgement and is informed by a number of factors including:
 - extent of estimation and judgement within the financial statements
 - extent of audit testing coverage.

Materiality

16. Materiality can be defined as the maximum amount by which auditors believe the financial statements could be misstated and still not be expected to affect the decisions of users of financial statements. A misstatement or omission, which would not normally be regarded as material by amount, may be important for other reasons (for example, the failure to achieve a statutory requirement or, an item contrary to law). In the event of such an item arising, its materiality has to be viewed in a narrower context; such matters would normally fall to be covered in an explanatory paragraph in the independent auditor's report.
17. We consider materiality and its relationship with audit risk when planning the nature, timing and extent of our audit and conducting our audit programme. Specifically with regard to the financial statements, we assess the materiality of uncorrected misstatements both individually and collectively.
20. For 2015/16 performance materiality has been set at £0.816 million. We will report, to those charged with governance, all misstatements identified which are greater than £0.02 million.
21. The audit approach will be amended to take account of the limited amount of transactions and balances contained within the financial statements.

Reporting arrangements

22. The partnership is subject to the audit and accounts provisions of a body under Section 106 of the Local Government (Scotland) Act 1973. The Local Authority Accounts (Scotland) Regulations 2014 require that the unaudited annual accounts are submitted to the appointed external auditor no later than 30 June each year. The

partnership's board is required to consider the unaudited annual accounts at a meeting by 31 August.

23. The health board is required to submit, to the Scottish Government Health and Social Care Directorate (SGHSCD), audited accounts by 30 June each year. Following submission to SGHSCD, health boards' annual financial statements are laid before the Scottish Parliament at the earliest possible date but by 31 December following the financial year end.
24. Financial and non-financial information will be required by a mutually agreed date that allows health boards to meet their statutory obligations. The partnership will need to ensure that arrangements are made to provide and agree this information by the specified date. This information should, as a minimum, include details of balances held at the year-end, the transactions in the year and a schedule of other information including assurances needed for the governance statement. Guidance issued by the Scottish Government proposes agreement of in-year transactions and year-end balances with the council and health board by April 30.
25. Partnerships must publish the unaudited accounts on their websites and give public notice of the inspection period.
26. The partnership's board must meet by 30 September to consider whether to approve the audited annual accounts. Immediately after approval, the annual accounts require to be signed and dated by specified members and officers, and then provided to the auditor. The Controller of Audit requires audit completion and issue of an independent auditor's report by 30 September each year.

27. The partnership is required to publish on its website its signed audited annual accounts, and the audit certificate, by 31 October. The annual audit report is required to be published on the website by 31 December.

28. A proposed timetable for the audit of the 2015/16 financial statements is included at Exhibit 1 below.

Exhibit 1: Financial statements audit timetable

Key stage	Date
Meetings with officers to clarify expectations of working papers and financial system reports	By 31 March 2016
Agreement of transactions and balances with relevant local authority and health board	By 30 April 2016
Latest submission date of unaudited financial statements with complete working papers package	By 3 June 2016
Consideration of unaudited financial statements by those charged with governance	By 31 August 2016
Progress meetings with lead officers on emerging issues	As required
Latest date for final clearance meeting with Chief Financial Officer	TBC
Agreement of audited unsigned financial statements, and issue of Annual Audit Report which includes the ISA 260 report to those charged with governance	By 30 September 2016

Key stage	Date
Independent auditor's report signed	By 30 September 2016

29. Matters arising from our audit will be reported on a timely basis and will include agreed action plans. Draft management reports will be issued to relevant officers to confirm factual accuracy. Responses to draft reports are expected within three weeks of submission. A copy of all final agreed reports will be sent to the Chief Officer, Chief Financial Officer and Chief Internal Auditor.
30. We will provide an independent auditor's report to the partnership and the Accounts Commission that the audit of the financial statements has been completed in accordance with applicable statutory requirements. The Annual Audit Report will be issued by 30 September.
31. All annual audit reports produced are published on Audit Scotland's website: www.audit-scotland.gov.uk.
32. Planned outputs for 2015/16 are summarised at [Appendix 1](#).

Quality control

33. International Standard on Quality Control (UK and Ireland) 1 (ISQC1) requires that a system of quality control is established as part of financial audit procedures. This is to provide reasonable assurance that those professional standards and regulatory and legal requirements are being complied with and that the

independent auditor's report or opinion is appropriate in the circumstances.

34. The foundation of our quality framework is our Audit Guide, which incorporates the application of professional auditing, quality and ethical standards and the Code of Audit Practice issued by Audit Scotland and approved by the Accounts Commission. To ensure that we achieve the required quality standards, Audit Scotland conducts peer reviews and internal quality reviews and has been subject to a programme of external reviews by the Institute of Chartered Accountants of Scotland (ICAS).
35. As part of our commitment to quality and continuous improvement, Audit Scotland will periodically seek your views on the quality of our service provision. We do, however, welcome feedback at any time and this may be directed to the engagement lead, David McConnell.

Independence and objectivity

36. Auditors appointed by the Accounts Commission must comply with the Code of Audit Practice. When auditing the financial statements, auditors must also comply with professional standards issued by the Financial Reporting Council (FRC) and those of the professional accountancy bodies. These standards impose stringent rules to ensure the independence and objectivity of auditors. Audit Scotland has in place robust arrangements to ensure compliance with these standards including an annual "fit and proper" declaration for all members of staff. The arrangements are overseen by the Assistant Auditor General, who serves as Audit Scotland's Ethics Partner.

37. Auditing and ethical standards require the appointed auditor to communicate any relationships that may affect the independence and objectivity of audit staff. We are not aware of any such relationships pertaining to the audit of the partnership.

Audit issues and risks

Audit issues and risks

38. Based on our discussions with staff, attendance at committee meetings and a review of supporting information we have identified the following main risk areas for the partnership. We have categorised these risks into financial risks and wider dimension risks. The financial statements issues and risks, which require specific audit testing, are summarised below and detail contained in [Appendix 2](#).

Financial statement issues and risks

39. **Financial statements:** NHS Greater Glasgow and Clyde will require to have the financial statements of the partnership available to it in sufficient time to allow incorporation into its group financial statements. There is a risk that the partnership is unable to provide the necessary information within the timescales required by NHS Greater Glasgow and Clyde to meet its statutory sign-off deadline of 30 June 2016.
40. We will continue to engage with officers on a regular basis throughout the duration of the accounts preparation.
41. **Management assurances:** Transactions of the partnership are processed through the respective ledgers of the partner bodies, NHS Greater Glasgow and Clyde and West Dunbartonshire Council. Preparation of the partnership's financial statements relies on the

provision of financial information from the systems of the two partner bodies. The Chief Finance Officer of the partnership must obtain assurance; that the costs transferred to the accounts of the partnership are complete and accurate and were incurred on behalf of the partnership for services prescribed in the integration scheme. There is a risk that the Chief Finance Officer does not have adequate assurance that information received from each partner is accurate and complete. We will review the assurances received by the partnership from the council and health board as part of the audit of the financial statements.

Wider dimension issues and risks

42. **Financial sustainability:** The partnership is operating in an environment with a number of challenges and risks to future finances. These include increases in demand, demographic changes, welfare reform and potential changes in central funding. The partnership will need strong financial management and budgetary control to address these challenges.
43. **Annual Performance Report:** The Public Bodies (Joint Working) (Scotland) Act 2014 requires that an annual performance report is completed within four months of the financial year end. The partnership may not be able to comply with this requirement and deadline, given that this is the first year of operation and external guidance regarding how this should be presented is not yet available.

National performance audit studies

44. Audit Scotland's Performance Audit and Best Value Group undertake a programme of studies on behalf of the Auditor General and Accounts Commission. In line with Audit Scotland's strategy to support improvement through the audit process, we will carry out work to collect relevant financial and performance information to inform Audit Scotland's national reports.

Fees and resources

skills of our team are provided in Exhibit 2. The core team will call on other specialist and support staff as necessary.

Audit fee

- 45. In determining the audit fee we have taken account of the risk exposure of the partnership, the planned management assurances in place, and the level of reliance we plan to take from the work of internal audit. We have assumed receipt of a complete set of unaudited financial statements and comprehensive working papers package by 3 June 2016.
- 46. The proposed audit fee for the 2015/16 audit of the partnership is £17,100. Our fee covers the costs of planning, delivering and reporting the annual audit including auditor's attendance at committees.
- 47. Where our audit cannot proceed as planned through, for example, late receipt of unaudited financial statements or being unable to take planned reliance from the work of internal audit, a supplementary fee may be levied. An additional fee may also be required in relation to any work or other significant exercises outwith our planned audit activity.

Audit team

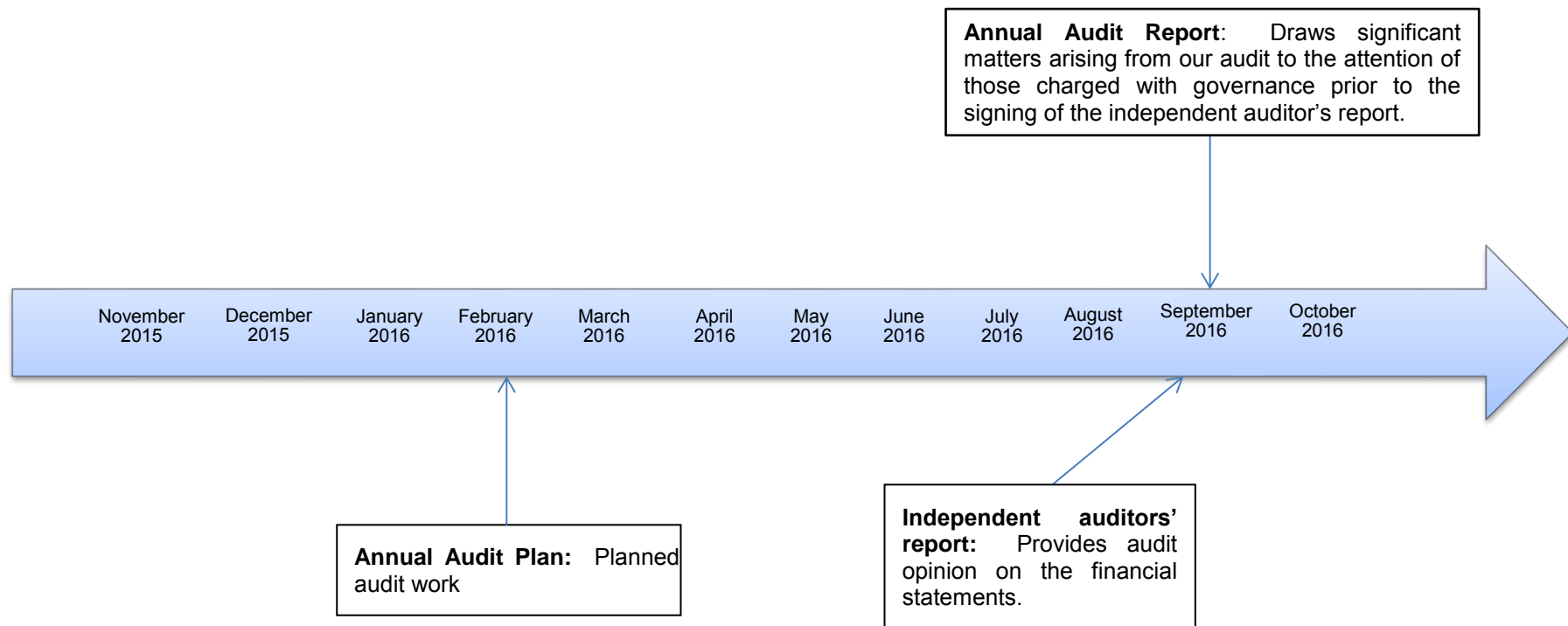
- 48. Dave McConnell, Assistant Director, Audit Services is your appointed auditor. The local audit team will be led by Peter Lindsay who will be responsible for day to day management of the audit and who will be your primary contact. Details of the experience and

Exhibit 2: Audit team

Name	Experience
David McConnell CPFA Assistant Director (Certifying auditor)	David has worked in public sector audit since 1981, firstly with the National Audit Office and since 1985, with the Accounts Commission/Audit Scotland. He therefore has extensive experience of audit in Central Government, Local Government and the NHS.
Peter Lindsay CPFA Senior Audit Manager	Peter has over nineteen years' experience of public sector internal and external audit with both Audit Scotland and PricewaterhouseCoopers, covering local government, education and the NHS. Peter's previous experience has also involved secondments to Scottish Enterprise and the Social Work Inspection Agency.
Karen Cotterell (FCCA) Senior Auditor	Karen has six years experience within audit, covering both public and private sector. Prior to this Karen spent four years working in Industry gaining overall financial oversight as Financial Controller and Account Manager.

Appendix 1: Planned audit outputs

The diagram below shows the key outputs planned for the partnership in 2015/16.



Appendix 2: Significant audit risks

The table below sets out the key audit risks, the related sources of assurance received and the audit work we propose to undertake to address the risks during our audit work.

#	Audit Risk	Source of assurance	Audit assurance procedure
Financial statement issues and risks			
1	Financial statements There is a risk that the partnership has not fully embedded processes to submit draft financial statements on time, and in line with statutory guidance.	<ul style="list-style-type: none"> • A sound system of budgetary control, including regular budget monitoring. • Strong working relationships between the council and health board • Officers have cognisance of all issued guidelines from IRAG and LASAAC • Adequate accounting policies have been prepared and agreed. • Timescales will be determined in line with the council timescale to ensure delivery of the financial statements. • Processes and procedures are in place at the council and the health board (e.g. early closing procedures and regular agreements of balances throughout the year) to allow accurate information to be provided in a timely manner. • These are suggested assurances – up to Partnership to provide them 	<ul style="list-style-type: none"> • Continue to engage with officers prior to the accounts being prepared to help ensure the relevant information is disclosed and timetable met. • Confirm that the governance statement is in accordance with Code requirements, • Review technical guidance from IRAG and LASAAC. • Ensure accounting policies are appropriate and complete. • Gaining assurances from the auditors of West Dunbartonshire Council and HHS Greater Glasgow and Clyde over the accuracy, completeness and appropriate allocation of the partnership ledger entries.

#	Audit Risk	Source of assurance	Audit assurance procedure
2	Management assurances Transactions of the partnership are processed through the existing systems of both the council and health board, and maintained on their respective financial ledgers. Therefore, the Chief Finance Officer must have adequate assurance that information received from each organisation is accurate and complete.	<ul style="list-style-type: none"> Monthly monitoring of financial information. Regular reporting to the partnership board. Strong working relationships between the council and health board. These are suggested assurances – up to Partnership to provide them 	<ul style="list-style-type: none"> Ensure governance statement adequately reflects the position of the partnership. Review financial reporting throughout the year to ensure it accurately reflects the financial position of the partnership Confirm that appropriate action is taken on issues raised in Internal Audit reports. Carry out audit testing to confirm the accuracy and correct allocation of IJB transactions, and that they are recorded in the correct financial year. Seek audit assurances from the external auditors of the council and health board.
Wider dimension issues and risks			
3	Financial sustainability The partnership will need strong financial management and budgetary control to address the challenges and risks to future finances.	<ul style="list-style-type: none"> Strong working relationships between the council and the health board. Due diligence completed on the three year budget setting process. The partnership strategic plan is based on an evidence based affordable budget. Regular financial monitoring which is reported to the partnership. These are suggested assurances – up to Partnership to provide them 	<ul style="list-style-type: none"> Review ongoing budget monitoring reports to ensure they accurately reflects the position of the partnership. Obtain evidence of remedial action being taken on areas of overspend.

#	Audit Risk	Source of assurance	Audit assurance procedure
4	Annual performance report The partnership may not be able to comply with this requirement and deadline, given that this is the first year of operation and external guidance regarding how this should be presented is not yet available.	<ul style="list-style-type: none"> Regular performance reporting to the IJB and PAC. Development of performance indicators relating to the strategic plan, HEAT targets and local outcome agreement These are suggested assurances – up to Partnership to provide them 	<ul style="list-style-type: none"> Review ongoing performance reports presented to the Partnership Board and/or Audit Committee. Review the annual performance report to ensure that it accurately reflects the work of the partnership during the year and covers the information required by the Act.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 23 March 2016

Subject: Audit Scotland Report on Changing Models of Health and Social Care

1. Purpose

- 1.1** To bring to the Audit Committee's attention the recently published Audit Scotland report on Changing Models of Health and Social Care.

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** At its September 2015 meeting, the Audit Committee were informed that Audit Scotland had been undertaking national work looking at changing models of health and social care, with the aims of providing a better understanding of the pressures NHS boards and councils are facing. The intent was to show how resources could be used to provide different models of care and support in the future to better match needs using modelling, taking into account service users' views and highlighting good practice
- 3.3** That national report on Changing Models of Health and Social Care was subsequently published on the 10th March 2016 (Appendix 1).

4. Main Issues

- 4.1** Audit Scotland gathered evidence for the audit by:
- Analysing national and local information, for hospitals, councils and community-based services to identify pressures in the system, including performance, activity and financial data carrying out projection analysis to estimate the potential effect of increasing pressures in health and social care.
 - Conducting desk-based research to identify examples of new care models outside Scotland.
 - Working closely with one partnership area to illustrate the types of changes required and how this affects different parts of the health and social care system.

- Interviewing staff from NHS boards, councils, the Convention of Scottish Local Authorities (COSLA), the Scottish Government and other relevant organisations, such as professional and scrutiny bodies.
- 4.2** It is important to note that the Report does accept that Audit Scotland did not review all new models in all areas of Scotland; and that not all of the models and approaches that they have highlighted will be directly transferable in their entirety to other areas.
- 4.3** The Report asserts that the shift to new models of care is not happening fast enough to meet the growing need; and the new models of care that are in place are generally small-scale and are not widespread.
- 4.4** The Report emphasises that integration authorities – with NHS boards and councils - need to adopt innovative models of care and ways of working that are quite different from traditional services to provide opportunities for better care; and that services cannot continue as they are, with a significant cultural shift in the behaviour of the public required about how they access, use and receive services.
- 4.5** The Report also acknowledges (albeit it very briefly) that delivering that the changes that such innovations represent involves making difficult decisions about changing, reducing or cutting some services; and that local communities have strong ties to existing services which can make discussions about changes difficult. It is surprising – and possibly quite telling – then that the Report chose not to elaborate further on those (not insignificant) challenges to delivering change; and chose not to include any explicit reference to them within either the Summary section or its key messages.
- 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** At a headline level, the recommendations for integration authorities are already reflected through both the HSCP's developing approach to strategic

planning; and its local approach to the development of operational services (as expressed within the approved Strategic Plan). The Integrated Care Fund Mid Year Report presented to the Partnership Board at its February 2016 meeting detailed key developments that have been led by the HSCP across its services and with other stakeholders.

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: 11th March 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: Changing Models of Health and Social Care (March 2016)

Background Papers: Audit Committee Report: Forthcoming Audit Scotland Reports (September 2015)

Wards Affected: All

Changing models of health and social care



ACCOUNTS COMMISSION 

AUDITOR GENERAL 

Prepared by Audit Scotland
March 2016


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.

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- 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

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- examine how public bodies spend public money
- help them to manage their finances to the highest standards
- check whether they achieve value for money.

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- NHS bodies
- further education colleges
- Scottish Water
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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.

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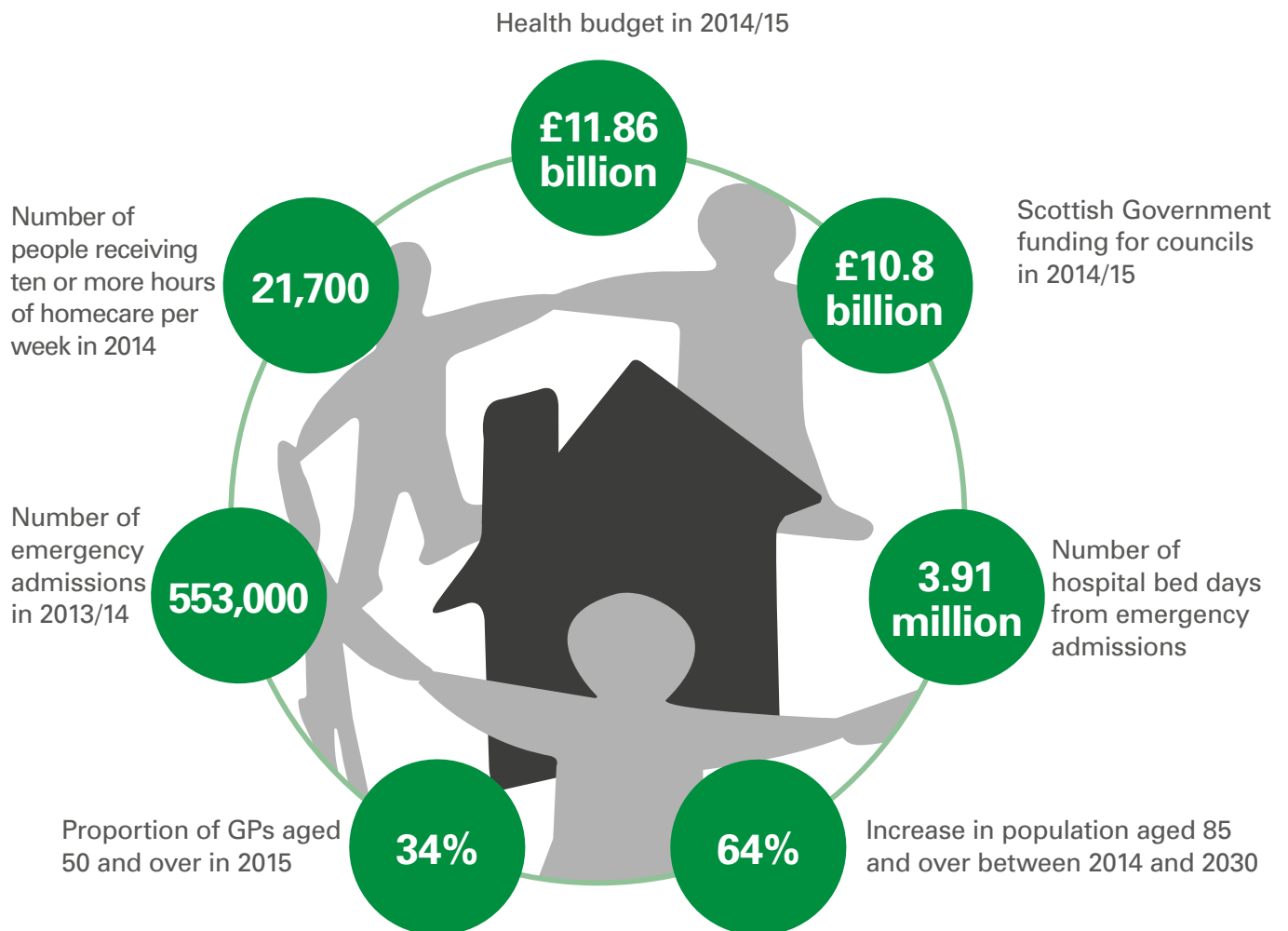
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Exhibit data

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



Summary



Key messages

- 1** The growing number of people with complex health and social care needs, particularly frail older people, together with continuing tight finances, means that current models of care are unsustainable. New models of care are needed. With the right services many people could avoid unnecessary admissions to hospital, or be discharged more quickly when admission is needed. This would improve the quality of care and make better use of the resources available.
- 2** The Scottish Government has set out an ambitious vision for health and social care to respond to these challenges. There is widespread support for the 2020 Vision, which aims to enable everyone to live longer, healthier lives at home or in a homely setting. There is evidence that new approaches to health and care are being developed in parts of Scotland.
- 3** The shift to new models of care is not happening fast enough to meet the growing need, and the new models of care that are in place are generally small-scale and are not widespread. The Scottish Government needs to provide stronger leadership by developing a clear framework to guide local development and consolidating evidence of what works. It needs to set measures of success by which progress can be monitored. It also needs to model how much investment is needed in new services and new ways of working, and whether this can be achieved within existing and planned resources.
- 4** NHS boards and councils, working with integration authorities, can do more to facilitate change. This includes focusing funding on community-based models and workforce planning to support new models. They also need to have a better understanding of the needs of their local populations, and evaluate new models and share learning.

the shift to new models of care is not happening fast enough to meet the growing need

Recommendations

The Scottish Government should:

- provide a clear framework by the end of 2016 of how it expects NHS boards, councils and integration authorities to achieve the 2020 Vision, outlining priorities and plans to reach its longer-term strategy up to 2030. This should include the longer-term changes required to skills, job roles and responsibilities within the health and social care

workforce. It also needs to align predictions of demand and supply with recruitment and training plans

- estimate the investment required to implement the 2020 Vision and the National Clinical Strategy
- ensure that long-term planning identifies and addresses the risks to implementing the 2020 Vision and the National Clinical Strategy, including:
 - barriers to shifting resources into the community, particularly in light of reducing health and social care budgets and the difficulties councils and NHS boards are experiencing in agreeing integrated budgets
 - new integration authorities making the transition from focusing on structures and governance to what needs to be done on the ground to make the necessary changes to services
 - building pressures in general practice, including problems with recruiting and retaining appropriate numbers of GPs. The role of GPs in moving towards the 2020 Vision should be a major focus of discussions with the profession as the new GP contract terms are developed for 2017
- ensure that learning from new care models across Scotland, and from other countries, is shared effectively with local bodies, to help increase the pace of change. This should include:
 - timescales, costs and resources required to implement new models, including staff training and development
 - evaluation of the impact and outcomes
 - how funding was secured
 - key success factors, including how models have been scaled up and made sustainable
- work to reduce the barriers that prevent local bodies from implementing longer-term plans, including:
 - identifying longer-term funding to allow local bodies to develop new care models they can sustain in the future
 - identifying a mechanism for shifting resources, including money and staff, from hospital to community settings
 - being clearer about the appropriate balance of care between acute and community-based care and what this will look like in practice to support local areas to implement the 2020 Vision
 - taking a lead on increasing public awareness about why services need to change
 - addressing the gap in robust cost information and evidence of impact for new models.

NHS boards and councils should work with integration authorities during their first year of integration to:

- carry out a shared analysis of local needs, and use this as a basis to inform their plans to redesign local services, drawing on learning from established good practice
- ensure new ways of working, based on good practice from elsewhere, are implemented in their own areas to overcome some of the barriers to introducing new care models
- move away from short-term, small-scale approaches towards a longer-term approach to implementing new care models. They should do this by making the necessary changes to funding and the workforce, making best use of local data and intelligence, and ensuring that they properly implement and evaluate the new models
- ensure, when they are implementing new models of care, that they identify appropriate performance measures from the outset and track costs, savings and outcomes
- ensure clear principles are followed for implementing new care models, as set out in [Exhibit 9 \(page 30\)](#).

Information Services Division (ISD) should:



- ensure it shares and facilitates learning across Scotland about approaches to analysing data and intelligence, such as using data to better understand the needs of local populations.

Background

1. We have reported previously that NHS boards and councils are finding it increasingly difficult to cope with pressures facing health and care services. Our recent progress report on health and social care integration found that significant risks need to be addressed if integration is to fundamentally change the way health and care services are delivered. Evidence suggests that the new partnerships with statutory responsibilities to coordinate integrated health and social care services, integration authorities, will not be in a position to make a major impact during 2016/17. Many integration authorities 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.

2. We have produced this report, building on our previous work on health and social care, to identify new local models of care and to help increase the pace of change. It aims to support new integrated authorities to implement new ways of working and address the challenges facing health and social care services.

3. We have produced two supplements to accompany this report:

- [Supplement 1 \[PDF\]](#)  is a handbook for local areas and includes:
 - case studies referenced throughout the report
 - a system diagram of the types of new care models being introduced across Scotland
 - links to useful documents and checklists.
- [Supplement 2](#)  is a model of East Lothian's whole-system approach to introducing new ways of working and the data analysis and intelligence that local partners are using to inform their work.

About the audit

4. This audit builds on key pressures identified in the demand and capacity work undertaken as part of the NHS in Scotland 2013/14 audit. It assesses how NHS boards, councils and partnerships might deliver services differently in the future to meet the needs of the population. Our report highlights examples of some of the new approaches to providing health and social care aimed at shifting the balance of care from hospitals to more homely and community-based settings. It also considers some of the main challenges to delivering the transformational change needed to deliver the Scottish Government's 2020 Vision for health and social care and actions required to address them.

5. We gathered evidence for the audit by:

- analysing national and local information, for hospitals, councils and community-based services to identify pressures in the system, including performance, activity and financial data
- carrying out projection analysis to estimate the potential effect of increasing pressures in health and social care
- conducting desk-based research to identify examples of new care models outside Scotland
- working closely with one partnership area to illustrate the types of changes required and how this affects different parts of the health and social care system
- interviewing staff from NHS boards, councils, the Convention of Scottish Local Authorities (COSLA), the Scottish Government and other relevant organisations, such as professional and scrutiny bodies.

Part 1

Health and social care in Scotland



Health and social care services are facing increasing pressures

6. In recent years, demands on health and social care services have been increasing because of demographic changes. People are living longer with multiple long-term conditions and increasingly complex needs. At the same time, NHS boards and councils are facing increasingly difficult financial challenges. There is general recognition that changes are needed and that NHS boards and councils need to support more people in the community.

The proportion of older, frail people is increasing

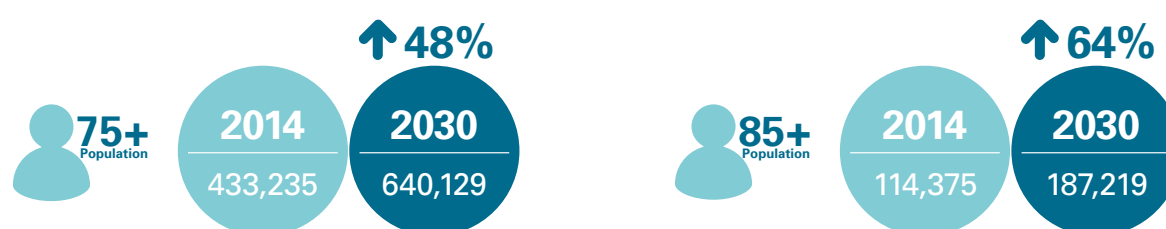
7. The proportion of older people is growing more rapidly than the rest of the population; this is a major factor contributing to the pressures on health and care services. The biggest changes are predicted in the 75 and over population ([Exhibit 1](#)). From 2002 to 2020, data shows an increase of around 6,600 people aged 75 and over each year. From 2021 up to 2039, it is estimated there will be around 16,000 more people aged 75 and over each year.¹ The 85 and over population is estimated to double by 2034.

health and social care services need to adapt to cope with the effects of the changing population

Exhibit 1

The projected population of older people in Scotland, 2014-30

The percentage of the population aged 75 and over is set to increase considerably over the next 15 years.



Source: *Projected population of Scotland (2014-based)*, National Records of Scotland, 2015

8. Although the population is ageing, overall healthy life expectancy (the number of years people might live in good health) has improved. Over time, this may help to reduce some of the pressure on health and social care services. Average healthy life expectancy increased between 2002 and 2008. It has remained at around the same level between 2009 and 2014. In 2014, average life expectancy for men was around 77 years and healthy life expectancy 60 years, and for women it was around 81 and

63 years.^{2, 3} However, healthy life expectancy for men in the most deprived areas in Scotland still remains 18 years lower than those in the least deprived areas. GPs working in deprived areas face significant challenges in tackling health inequalities. GPs working in practices serving the 100 most deprived areas in Scotland (Deep End project) reported the following:

- They treat more patients with multiple health problems than GPs working in less deprived areas.⁴
- They are constrained by a shortage of consultation time with patients that limits the opportunity to provide appropriate treatment, advice and referral to suitable services.⁵

9. As people age they are more likely to have multiple conditions and become frail. Frailty is a decreased ability to withstand illness or stress without loss of function. For frail people, a minor injury or illness can result in a significant loss of function. Common conditions, such as dementia, also contribute to frailty.⁶ In Scotland, an estimated ten per cent of people aged over 65 are frail and a further 42 per cent are at risk of becoming frail.⁷

10. Not all older people need support from health and care services, but for those that do, it is important that these services are well coordinated. They should focus on preventing ill health and where possible reduce the need for hospital-based care. Older people make more use of hospital services than the rest of the population, particularly unplanned care such as A&E services and emergency admission to hospital. Older patients are more likely to remain in hospital for longer. The majority of people who are nursed at home, and get help with daily living activities such as washing, dressing and eating, are aged 75 or older.⁸

The number of emergency admissions to hospital is increasing

11. The number of people admitted to hospital in an emergency is an important measure that can indicate problems in other parts of the health and care system, such as a lack of social care support in the local area. Of all admissions to acute hospitals, around 85 per cent are emergency admissions. Around 30 per cent of emergency admissions relate to surgical specialties, such as orthopaedic surgery or urology. The majority of these admissions are not preventable and these patients require hospital treatment. However, there is scope to reduce emergency admissions by providing more preventative and community-based services. This includes emergency admissions in medical specialties such as general medicine, geriatric medicine, psychiatry of old age, rehabilitation medicine, and GP beds. The number of people admitted to hospital in an emergency between 2005/06 and 2013/14 increased by almost 80,000 (17 per cent), to 553,000. The number of emergency admissions increased by 17 per cent for people aged 65-74, by 19 per cent for people aged 75-84 and by 39 per cent for people who were aged 85 and older (**Exhibit 2, page 11**). Older people are more likely to be admitted to hospital in an emergency than people aged under 65. In 2013/14, 71 per cent of emergency bed days were occupied by people aged 65 and over. Of these:

- 18 per cent were occupied by people aged 65-74
- 29 per cent were occupied by people aged 75-84
- 23 per cent were occupied by people aged 85 and older.

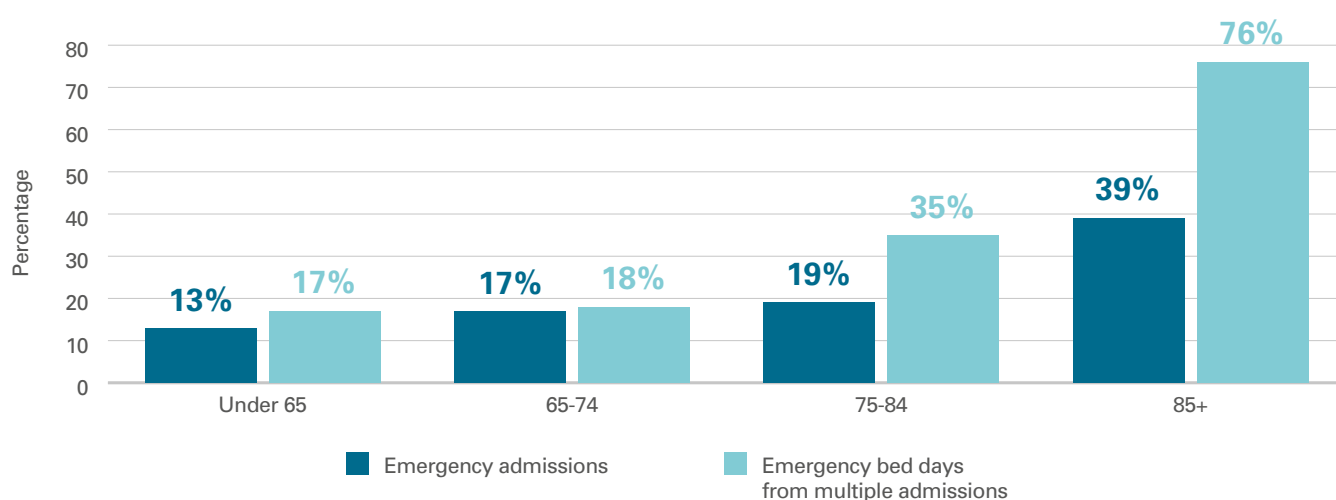
12. The number of emergency bed days for older people admitted to hospital three or more times in a year is increasing. Between 2005/06 and 2013/14, the number of bed days occupied by people aged 65 and over from multiple emergency admissions increased by 38 per cent to over 685,000 bed days. For people aged 65-74, the number of bed days increased by 18 per cent, for people aged 75-84 by 35 per cent, and for people aged 85 and older by 76 per cent ([Exhibit 2](#)).⁹

13. Although the overall number of emergency bed days has been reducing, the number of emergency admissions has been increasing along with the associated costs. Patients admitted to hospital in an emergency have a shorter length of stay, but most costs are incurred in the first few days when tests,

Exhibit 2

Increase in emergency admissions and multiple emergency admission bed days, by age group, 2005/06 to 2013/14

The number of older patients admitted to hospital in an emergency and the number of bed days for multiple emergency admissions (three or more admissions in one year) have increased considerably.



Source: SMR01 activity analysis provided to Audit Scotland by ISD, November 2015



investigations or treatments are carried out. An emergency admission to hospital is more expensive than a planned admission. This means that although the percentage increases in the number of all admissions to hospital and in the number of emergency admissions are similar, the percentage increase in costs for emergency admission is higher ([Exhibit 3, page 12](#)).

14. There is more to be done to ensure that people are receiving the best care and treatment, rather than being admitted to hospital as an emergency, and to reduce hospital costs to allow more effective use of resources. An example is putting in place models of care to support older people in the community and prevent admission to hospital where possible. We highlight examples of this happening in some areas later in the report. To address the current challenges in relation to emergency admissions, a number of partners across the health and care system need to work well together. This includes GPs, community nurses and social care staff.

Exhibit 3

Changes in admissions to hospital and associated costs and bed days, 2010/11 to 2013/14

The total number of emergency bed days has been decreasing, but the number of emergency admissions has been increasing along with the associated costs.

 Admissions to hospital				 Hospital bed days	
Number		£ Costs		Number	
All admissions	Emergency admissions	All admissions	Emergency admissions	All admissions	Emergency admissions
752,000	553,000	£3.35 billion	£2.57 billion	4.61 million	3.91 million
5% ↑	6% ↑	1% ↑	5% ↑	4% ↓	3% ↓

Source: IRF–NHS Scotland and Local Authority Social Care Expenditure–Financial Years 2010/11–2013/14, ISD Scotland, March 2015; SMR01 activity analysis provided to Audit Scotland by ISD, November 2015

Health and social care services need to adapt to cope with the effects of the changing population

15. Pressures on health and social care services are likely to continue to increase over the next 15 years. It is difficult to know the extent of this growth but NHS boards and councils are finding it challenging to cope with the present demand for health and social care services. These increasing pressures have significant implications for the cost of providing health and social care services and challenges in ensuring that people receive the right care, at the right time and in the right setting. To address this, local partnerships need to redesign services to avoid unnecessary admissions to hospital. Where hospital admissions cannot be avoided, support needs to be put in place to get people home as quickly and as safely as possible. Local areas are developing approaches involving targeting both small numbers of individuals who use high levels of resources and prevention in the broader population.

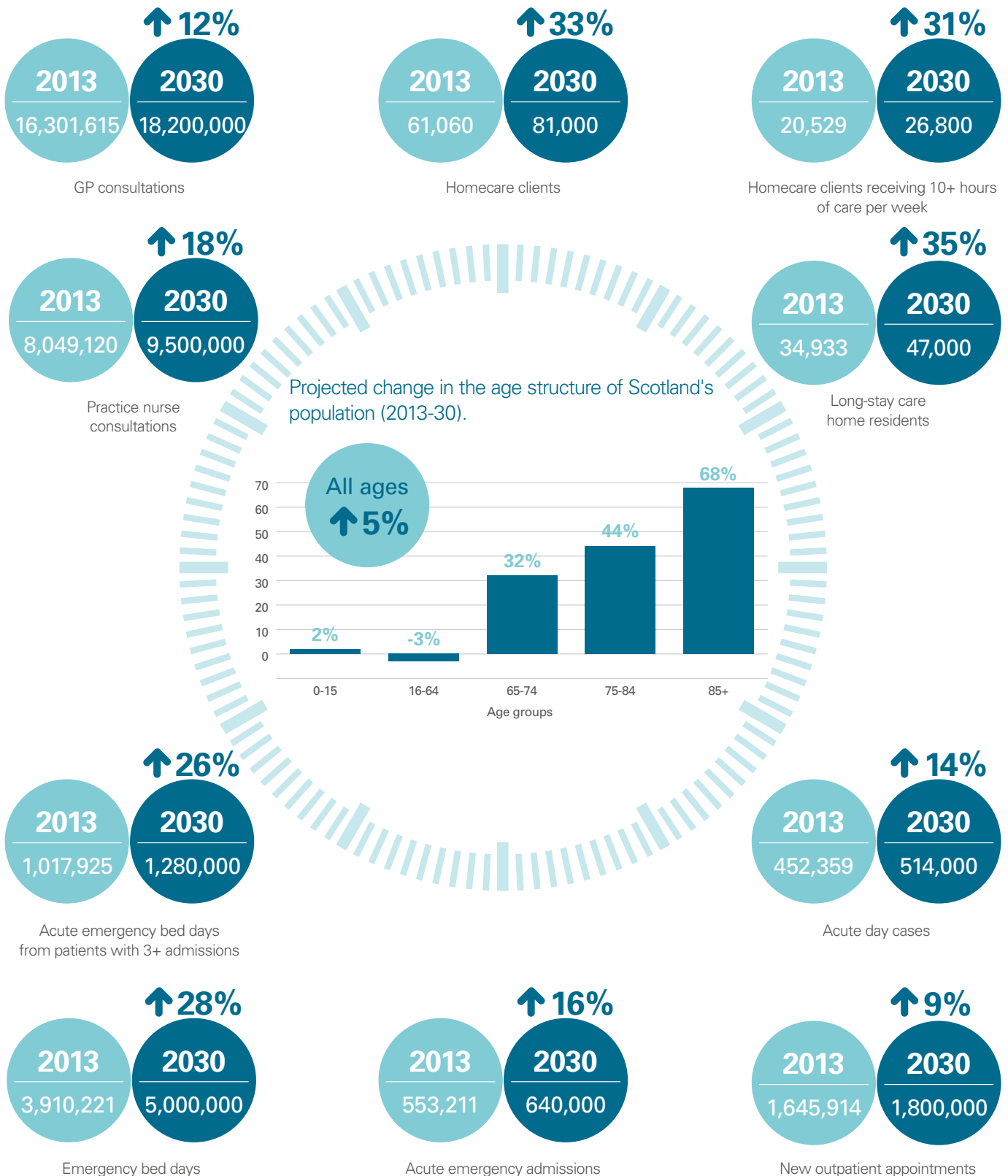
16. To help to explain the complexity of the health and social care system, and the potential impact changing demographics will have on services over the next 15 years, we have prepared [Exhibit 4 \(page 13\)](#). It shows projected rises in activity arising from a growing, ageing population. These are based on applying projected increases in the population to key measures that can indicate how well the system is working. The health and social care system is inter-related. If anything goes wrong in one part of the system, it can affect other parts of the system. The growing population will affect all parts of the health and social care system. If the population increases as predicted, and services continue to be delivered in the same way, the impact across the system is significant and highlights the need for change. Based on our projection analysis, in 2030, compared to 2013, there could be an additional:

- 1.9 million GP appointments and 1.5 million practice nurse appointments

Exhibit 4

Pressures on health and social care services, 2013-30

If current rates of activity continue, it is unlikely that health and social care services will be able to cope with the effects of the changing population unless they make major changes to the way they deliver services.



Note: Each indicator (eg, number of emergency admissions) is calculated as a rate of the population by using National Records of Scotland mid-year population estimates. The rate in 2013/14 is assumed to continue over the projection years. Over each of the projected years, the estimated rate is multiplied by the estimated projected population to find the number for that indicator.

Source: Audit Scotland analysis, 2016

- 20,000 homecare clients and 12,000 long-stay care home residents
- 87,000 emergency admissions to hospital and 1.1 million associated hospital bed days
- 62,000 hospital day cases and 154,000 outpatient appointments.

17. A number of factors will affect how much these pressures continue to increase, including: the ageing population; levels of deprivation and health inequalities; changes in healthy life expectancy; and the extent to which new ways of providing services are adopted, particularly preventative and community-based services. However, it is clear that health and social care services will need to be delivered differently to cope with the increasing pressures associated with the growing population.

NHS boards and councils are facing increasing financial pressures

18. The Scottish Government has estimated it would need an annual increase in investment of between £422 million and £625 million in health and social care services to keep pace with demand.¹⁰ Its assumption is based on current service models remaining the same and demand increasing in line with the growth in the older population and changes in healthy life expectancy. This level of investment is not sustainable in the current financial climate. Budgets for health and social care services are reducing. Over the period 2010/11 to 2014/15:

- The health budget decreased by 0.6 per cent in real terms, that is allowing for inflation, to £11.86 billion.¹¹ The draft health budget is set to increase by 3.6 per cent in real terms in 2016/17. It includes £250 million of funding in NHS boards' budgets for integration authorities aimed at improving outcomes in social care.¹²
- Scottish Government overall funding for councils decreased by 5.9 per cent in real terms to £10.8 billion. Between 2010/11 and 2013/14, spending on social care services increased slightly by two per cent to around £3 billion.^{13, 14} In 2016/17, Scottish Government funding for local government is set to decrease by 7.2 per cent.

GPs are central to developing new types of care, but pressures are building in general practice

19. GPs have a key role to play in coordinating care for patients, involving other professionals such as nurses, occupational therapists, physiotherapists and social workers as required. Owing to increasing pressures on GPs' time, new models of care will need to ensure patients are referred to the most appropriate professional based on needs, allowing GPs to focus on patients with complex needs.

20. There is currently a major gap in information about demand and activity for most community health services, including general practice services. Until 2012/13, the Information Services Division (ISD) of National Services Scotland collated practice team information (PTI). This will be replaced by a new system, Scottish Primary Care Information Resource (SPIRE). A phased roll out of SPIRE is due to start in March 2016 and complete by January 2017. It is essential to have good information on the patterns of use of general practice and demand for services to be able to design new models of care.

21. In the absence of published demand and activity data, a number of other indicators point to pressures building in general practice. These include patients' declining satisfaction with access to general practice, increasing patient visits to general practice, recruitment and retention issues, and dissatisfaction among GPs ([Exhibit 5, page 16](#)). These all have implications for the quality of care patients receive and their health outcomes. The National Audit Office has found that similar issues also exist in England.¹⁵ The Scottish Government is in the process of negotiating a new contract for 2017 with GPs, partly to address some of these concerns.

The Scottish Government has set out an ambitious vision for health and social care

22. In September 2011, in recognition of the challenges facing health and social care, the Scottish Government set out an ambitious vision to enable everyone to live longer, healthier lives at home or in a homely setting by 2020.¹⁶ This vision aims to help shape the future of healthcare in Scotland in the face of changing demographics and increasing demand for health services. Central to the vision is a healthcare system with integrated health and social care, and a focus on prevention, anticipation and supported self-management. Some of the main principles of the policy, particularly in relation to shifting more care and support into the community, are:

- focusing on prevention, anticipation, supported self-management and person-centred care
- expanding primary care, particularly general practice
- providing day case treatment as the norm when hospital treatment is required and cannot be provided in a community setting
- ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission
- improving the flow of patients through hospital, reducing the number of people attending A&E, and improving services at weekends and out-of-hours
- improving care for people with multiple and chronic conditions
- reducing health inequalities by targeting resources in the most deprived areas
- planning the workforce to ensure the right people, in the right numbers in the right jobs
- integrating adult health and social care.

Integration of health and social care is integral to delivering the 2020 Vision

23. Health and social care services in Scotland are currently undergoing reform. Under these arrangements NHS boards and councils are required, as a minimum, to combine their budgets for adult social care, adult primary healthcare and aspects of adult secondary healthcare. This accounts for more than £8 billion of funding that NHS boards and councils previously managed separately. The new integration authorities are expected to coordinate health and care services and commission 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, with a greater emphasis on preventative services and

Exhibit 5

Indicators of building pressure in general practice

There is a lack of data on general practice activity and demand for services. But available indicators show pressures on general practice continuing to build.



General practice activity

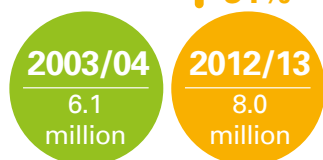


11% increase in patient contacts between 2003/04 and 2012/13 to 24.2 million

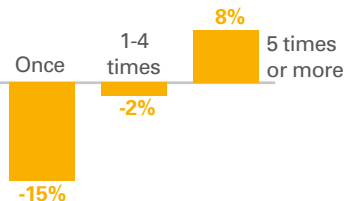
67% of contacts were with GPs in 2012/13

This increase is primarily driven by a rise in practice nurse contacts of

↑31%



Change in patients contacting their GP practice 2011/12 to 2013/14



24.2 million

GP contacts (2012/13)



1.6 million

A&E and Minor Injury Unit attendances (2012/13)



0.9 million

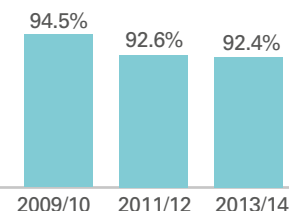
Out-of-hours contacts (2014/15)

Patient experience 2013/14



1 in 6 patients found it difficult to get through to their GP practice on the telephone

The percentage of people able to see or speak to a doctor or nurse within 48 hours has decreased



78% of patients said they were able to book appointments 3 or more days in advance

2015 BMA survey of 1,800 GPs in Scotland



25% of GPs described their workload as unmanageable



69% felt workload had a negative impact on their personal commitment to their career



a third would like to retire by 2020

17% of practices had at least one vacancy



Workforce



Around 1 in 2 community nurses were aged 50 and over, compared with 1 in 3 hospital nurses in 2015



↑37%

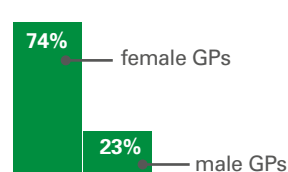
increase in female GPs over the ten-year period to 2015



↓15%

decrease in male GPs over the ten-year period to 2015

Percentage of GPs working part-time in 2013



GP partners aged 50 and over



33%

vs



42%

2005

2015

Source: Health and Care Experience Survey 2013/14, Scottish Government, May 2015; Practice Team Information (PTI), ISD Scotland, October 2013; GP Out of Hours Services in Scotland, 2014/15, ISD, August 2015; A&E and minor incidents unit (MIU) activity data provided to Audit Scotland by ISD, January 2014; Primary Care Workforce Survey 2013, ISD Scotland, September 2013; The UK nursing labour market review 2013, Royal College of Nursing, September 2013; The future of general practice - survey results, British Medical Association (BMA), February 2015; Community nursing staff in post and vacancies, ISD Scotland, June 2015; Nursing and midwifery staff in post, ISD Scotland, September 2015; BMA press release, 13 March 2015; Number of GPs in Scotland by age, designation and gender, ISD Scotland, December 2015.

allowing people to receive care and support in their home or local community, rather than being admitted to hospital. The integration authorities will be responsible for delivering new National Health and Wellbeing Outcomes.¹⁷ These focus on the experiences and quality of services for people using those services, carers and their families. Examples of the outcome indicators include the percentage of adults able to look after their health very well or quite well, and the percentage of people with a positive experience of the care provided by their GP practice.¹⁸

24. Our recent report on progress towards integration of health and social care services confirms that the new integration authorities are expected to be operational by the statutory deadline of 1 April 2016. However, there are a number of issues that the integration authorities need to address if they are to take a lead on improving local services. These include agreeing budgets, and setting out comprehensive strategic plans, clear targets and timescales to show how they will make a difference to people who use health and social care services. They will also need to deal with significant long-term workforce issues and ensure that complex governance arrangements, including the structures and processes for decision-making and accountability, work in practice.¹⁹

Part 2

New ways of providing health and social care



New approaches to delivering health and social care are emerging

25. We have identified a number of new models across Scotland that are designed to deliver more care to people in community settings in line with the 2020 Vision. We have identified different types of care models in local areas, including:

- community preventative approaches
- better access to primary care and routine hospital treatments
- enhanced community care models
- intermediate care models
- initiatives designed to reduce delayed discharges.

26. We have not reviewed all new models in all areas of Scotland. We have selected a number of examples in some areas of Scotland to illustrate the different types of models that exist and to highlight particular aspects of good practice ([Exhibit 6, pages 20-21](#)). These include ten primary and community care 'test sites' referenced in the Scottish Government's Programme for Government, published in September 2015.^{20, 21} Some of these are at an early stage of development and others are more established. They include:

- local GP surgeries working together for faster appointments
- GPs and health professionals, such as nurses, physiotherapists and pharmacists, working together in multidisciplinary teams
- providing treatment that patients currently have to travel to hospital to receive.

27. The Scottish Government intends to work closely with the ten test sites over the next two years to offer support and guidance and share learning.

28. We have produced a supplement to the report containing case studies ([Supplement 1 \[PDF\]](#)). There are hyperlinks throughout the report to the relevant case studies.

29. Most new care models are designed to relieve pressures on the acute sector but have an impact on different parts of the health and social care system. A high-level system diagram showing where the new models of care described in [Exhibit 6](#) sit within the overall health and social care system is set out in [Supplement 1 \[PDF\]](#).

new care models are emerging but there is a lack of evidence about what works

New models need to be implemented and evaluated properly

30. A common issue with many of the new care models being introduced across Scotland is a lack of evidence about the impact, implementation costs, efficiency gains or cash savings, and outcomes for service users. Some new ways of working are based on similar models from elsewhere, either another part of Scotland or other countries. But it is still important to monitor any new models to assess the impact on local systems and assess the costs, savings, outcomes and sustainability. This will help to assess the value for money of new models, whether the benefits justify the costs and if they should be rolled out more widely. For many of the new models that have been introduced in Scotland, it is too early to assess their impact. We were not able to carry out a cost benefit analysis for the care models described in [Exhibit 6](#) owing to a lack of local cost information.


31. Many organisations highlighted the lack of time, resource and skills as a barrier to carrying out major change and also to properly evaluating new models. Senior managers in local bodies need to recognise that a successful change programme requires strong leadership and experience in change management to take forward major changes to services. Also, sufficient resources need to be included in the business case for changes to be properly implemented and evaluated.

More can be learned from the innovation of others

32. Although not all the models and approaches listed in [Exhibit 6](#) will be directly transferable in their entirety to other areas, they each include aspects of innovation and improvement which can help inform how services could develop in other areas. In the following paragraphs we explore particular aspects of some of the models in more detail to provide a flavour of the new approaches being taken in some local areas.

Using a model of care focusing on the whole population to achieve a sustainable service

Population health models of care aim to improve the health of the entire population, rather than targeting specific age groups or certain conditions. Within this model the focus is on preventative measures and reducing inequalities.

[Case study 1 \[PDF\]](#)  provides details of a GP practice in Forfar developing a model of care focused on the whole population to improve access, health and wellbeing and to sustain services in the longer term in the light of the pressures we highlighted in [Part 1](#).

33. The Nuka model of care from Alaska, also described in [Case study 1 \[PDF\]](#) , has influenced the model the Forfar GP practice is developing. Native Alaskans create, manage and own the whole healthcare system. Multidisciplinary teams provide integrated health and care services in primary care centres and the community. These are coordinated with a range of other services and combined with a broader approach to improving family and community wellbeing.

Multidisciplinary teams working together to keep people at home


34. Recent work by the King's Fund suggests that collaboration through place-based systems of care offers NHS organisations the best opportunity for tackling the growing challenges facing them. This is where organisations work together to improve health and care for the local populations they serve.²² There are examples of place-based care in Scotland in Tayside ([Case study 2 \[PDF\]](#) ) and Glasgow ([Case study 3 \[PDF\]](#) )




Exhibit 6

New models of health and social care in Scotland

We have identified different types of new approaches to delivering health and social care in Scotland.

Community preventative approaches

These help people to stay in the community, in particular people with multiple conditions and complex needs. These approaches aim to help people self-care and to reduce people's demands for healthcare in the longer term. Examples of self-care include changing diet, taking more exercise or taking medicines at the right time.

- Two GP practices in Forfar are planning to merge into one of the largest practices in Scotland. Patients will be allocated to one of five multidisciplinary teams within the practice, each delivering a patient-centred model of care. Each multidisciplinary team will include GPs, nurses, healthcare assistants, an administrator and a named community nurse. The patients are encouraged to manage their conditions and self-care ([Case study 1 \[PDF\]](#) )
- The [House of Care](#) model is being tested in Lothian, Tayside and Glasgow. This approach encourages people living with multiple, long-term conditions to self-manage their care through joint planning, goal-setting and action planning.
- Patients with complex and/or multiple conditions from deprived areas in Glasgow may be eligible to be part of the [CAREplus](#) initiative. Inclusion allows patients longer consultations with a GP or nurse. This enables them to discuss their problems in more detail and make a list of priorities ([Case study 3 \[PDF\]](#) )
- The [Links Worker Programme](#) has placed community links practitioners in GP practices in deprived areas of Glasgow. They are not medically qualified, but link practices and patients with community-based services and resources such as lunch clubs and self-help groups based on individual patients' needs ([Case study 3 \[PDF\]](#) )


Improved access to primary care and routine hospital treatments

These approaches are designed to improve access to care for local people by health professionals working together, or in a different way.

- [New community health hubs in Fife and Forth Valley](#): Patients will be able to get access to a range of services that they would normally have had to travel to an acute hospital to receive. A new type of doctor will be part of the healthcare team. They will be qualified GPs with an extra year of training to give them the skills they need to work across primary and acute care. This training began in autumn 2015.
- [The new model of delivering healthcare for the Small Isles](#) (Canna, Rum, Eigg, Muck and surrounding islands) is a combination of telehealth facilities and improving local skills to deal with healthcare needs. This is alongside a visiting service provided through NHS Highland's new rural support team, initially led by two GPs based on Skye. The rural support team includes GPs, nurse practitioners and paramedics.





Enhanced community care

This is a multidisciplinary team approach aimed at keeping people at home or in a homely setting, managing crisis situations and avoiding inappropriate admission to hospital. Some models also support quicker discharge from hospital.

- The [Tayside Enhanced Community Support Service](#) enables GPs, with the support of a multidisciplinary team, to lead the assessment of older people with frailty and at risk of unplanned hospital admission, and to respond to any increased need for health and social care support ([Case study 2 \[PDF\]](#) )


Cont.

Enhanced community care (continued)

- [East Lothian service for the integrated care of the elderly \(ELSIE\)](#): This whole-system approach offers access to multidisciplinary and multiagency emergency care at home, or the place people call home, to older people. The service offers a single point of contact for both people who are at risk of being admitted to hospital, and to actively facilitate the discharge of people from hospital ([Supplement 2](#) .
- [Forth Valley's Advice Line For You \(ALFY\)](#) is a nurse-led telephone advice line to help older people remain well at home. Nursing advice is available 24 hours a day, seven days a week ([Case study 5 \[PDF\]](#) .
- [The Govan SHIP project](#) aims to reduce demand for acute and residential care and improve chronic disease management. Four GP practices in Govan Health Centre provide a multidisciplinary approach to patients of any age who are known to be vulnerable ([Case study 3 \[PDF\]](#) .
- [Community-based dementia care](#): In Perth and Kinross, the closure of a number of community hospital dementia beds allowed increased investment in community mental health teams that are looking after more patients in their own homes ([Case study 8 \[PDF\]](#) .

Intermediate care

This involves time-limited interventions aimed at promoting faster recovery from illness and maintaining the independence of people who might otherwise face unnecessarily prolonged hospital stays or inappropriate admission to hospital or residential care.


- [The Glasgow Reablement Service](#) provides tailored support to people in their own home for up to six weeks. It builds confidence by helping people regain their skills to do what they can and want to do for themselves at home ([Case study 8 \[PDF\]](#) .
- [Bed-based intermediate care](#) is provided across most health and social care partnerships. [Step-up beds](#) are for people admitted from home for assessment and rehabilitation as an alternative to acute hospital admission. [Step-down beds](#) are for people who are well enough to be discharged from acute hospital but need a further period of assessment and rehabilitation before they can return home.

Reducing delayed discharges

These approaches aim to increase the understanding of the reasons for delays in patients being discharged from hospital, and find ways to reduce this. A number of models combine reducing delayed discharges with providing enhanced care in the community to prevent people being admitted to hospital in the first place.



- [Tayside Enhanced Community Support Service](#) (as above)
- [East Lothian Service for the integrated care of the elderly \(ELSIE\)](#) (as above)
- [The Glasgow 72-hour discharge model](#) ensures patients who are considered fit for discharge from hospital are discharged within 72 hours. Their options for discharge are to go home, or home with support in place if needed. Another option is for people to go to a temporary care bed for a maximum of four weeks where they will be assessed and rehabilitated and a care plan will be developed and agreed for them.
- [The East Lothian 'Discharge to Assess' service](#) is delivered by physiotherapists and occupational therapists who provide early supported discharge and assess patients at home, rather than in an acute setting. This includes arranging equipment, active rehabilitation and developing packages of care. The service is an integral part of ELSIE (as mentioned in the above section: 'Enhanced community care').

Source: Audit Scotland

35. A number of areas across Scotland have recently introduced an enhanced community support model. This tends to involve multidisciplinary teams delivering an enhanced level of care, working together to keep people at home or in a homely setting, managing crisis situations and avoiding inappropriate admission to hospital. Tayside has combined this model of care with a local area-based approach that aligns consultant geriatricians to GP practices ([Case study 2 \[PDF\]](#) .

36. Most enhanced community support service models are targeted towards older people. However, in one area of Glasgow, three new linked approaches to delivering health and social care are facilitating an enhanced service for anyone in the local population who is judged to be vulnerable. This includes people with mental health problems or people who use services frequently and people with complex needs. [Case study 3 \[PDF\]](#)  provides more detail of these three approaches and includes patient stories to illustrate the difference the new approaches have made to people using the service.

Nurse-led approaches that maximise the population's resilience



37. The Buurtzorg model of care from the Netherlands is an example of an effective nurse-led approach to delivering health and social care that maximises people's resilience (their ability to withstand stress and challenge) ([Case study 4 \[PDF\]](#) ). Health and social care organisations can help to build people's resilience by: supporting them to look after themselves; providing preventative services that keep them well in the community; and by ensuring they know how to access help if things go wrong. Forth Valley has introduced some of the elements of this approach in its Advice Line For You (ALFY) model ([Case study 5 \[PDF\]](#) .

38. The ALFY model's *Your Plan* enables people to take responsibility for the challenges they face and to use their own skills and abilities, and friends, family and people who care for them, to develop resilience. This echoes the Buurtzorg service that promotes self-care, independence and the use of informal carers. The Buurtzorg model has improved the quality of patient care through round-the-clock access to a district nursing team by telephone or a home visit service. Results have shown:

- a correlated decrease in unplanned care and hospital admissions
- better patient satisfaction, when compared to other homecare providers in the Netherlands.²³

Longer-term strategic approaches

39. We have found evidence of longer-term programmes supporting the 2020 Vision, where organisations have built on previous work, identified priority areas to focus on and are working on scaling up a number of models:

- The Scottish Ambulance Service's strategic approach to patient care involves closer working with primary care teams to ensure patients are referred to the most appropriate service, and to avoid admission to hospital wherever possible ([Case study 6 \[PDF\]](#) .
- The Scottish Centre for Telehealth and Telecare's Technology Enabled Care Programme encourages more use of established technology to help improve health and wellbeing outcomes ([Case study 7 \[PDF\]](#) .

Taking a whole-system approach

40. East Lothian partnership is taking a whole-system approach to understanding its local population and planning health and social care services and has the following long-term objectives:

- to increase the percentage of over 65s living at home
- to increase the percentage of spending on community care compared with institutional care
- to increase years of healthy life.

41. East Lothian recognises a number of challenges to providing health and social care services to its local population. East Lothian is developing intelligence about various parts of the health and social care system and using it to improve the way it delivers services. An analysis of East Lothian's population and primary care data shows:

- an ageing population with increasing levels of frailty and complex health needs
- increasing hospital admissions in some local areas from younger people with increasing long-term conditions and ill-health
- the groups of people who use a disproportionately high level of health services are those who are nearing the end of their life, are in care homes or have mental health needs
- relatively low numbers of people being admitted to hospital in an emergency, but high rates of occupied bed days and delays in discharge from hospital
- variety in the quality of access to GPs in different practices across East Lothian
- a predicted shortage of GPs owing to an ageing workforce
- preliminary information on the demand levels on GPs, such as the percentage of the practice population presenting to the GP each week.

42. To meet its objectives, East Lothian is focusing on:

- understanding the pattern of service use by high resource users and working out ways of intervening earlier to improve the support people receive and reduce unnecessary demand for services
- expanding ELSIE for people who are at risk of admission to hospital or have just been discharged from hospital to 24 hours a day, seven days a week
- supporting primary care services to meet demand to improve access for patients and to promote early intervention and prevention
- conducting a comprehensive bed modelling exercise to address the problem of delayed discharges, bring patients from Edinburgh hospitals closer to home and ensure efficiency and effectiveness of services.

43. East Lothian is bringing together growing intelligence about its population, how people access services, and various strands of work which all aim to improve how it delivers services. This is allowing the partnership to build a comprehensive picture of the needs of its local population. It is also taking into account how changes to services affect different parts of the health and social care system and how these are linked. However, the partnership still has to fully evaluate the impact of new ways of working it has recently introduced. The different elements of East Lothian's whole-system approach to health and social care are summarised in [Exhibit 7 \(pages 24-25\)](#). An interactive version of this exhibit is set out in [Supplement 2 !\[\]\(23d9fc146e83b5c3013cfa32c784f8d5_img.jpg\)](#) and provides more detail on the overall approach.

Exhibit 7
East Lothian's whole-system model

In East Lothian intelligence on various parts of the health and social care system is being used to change the way that services are being delivered.

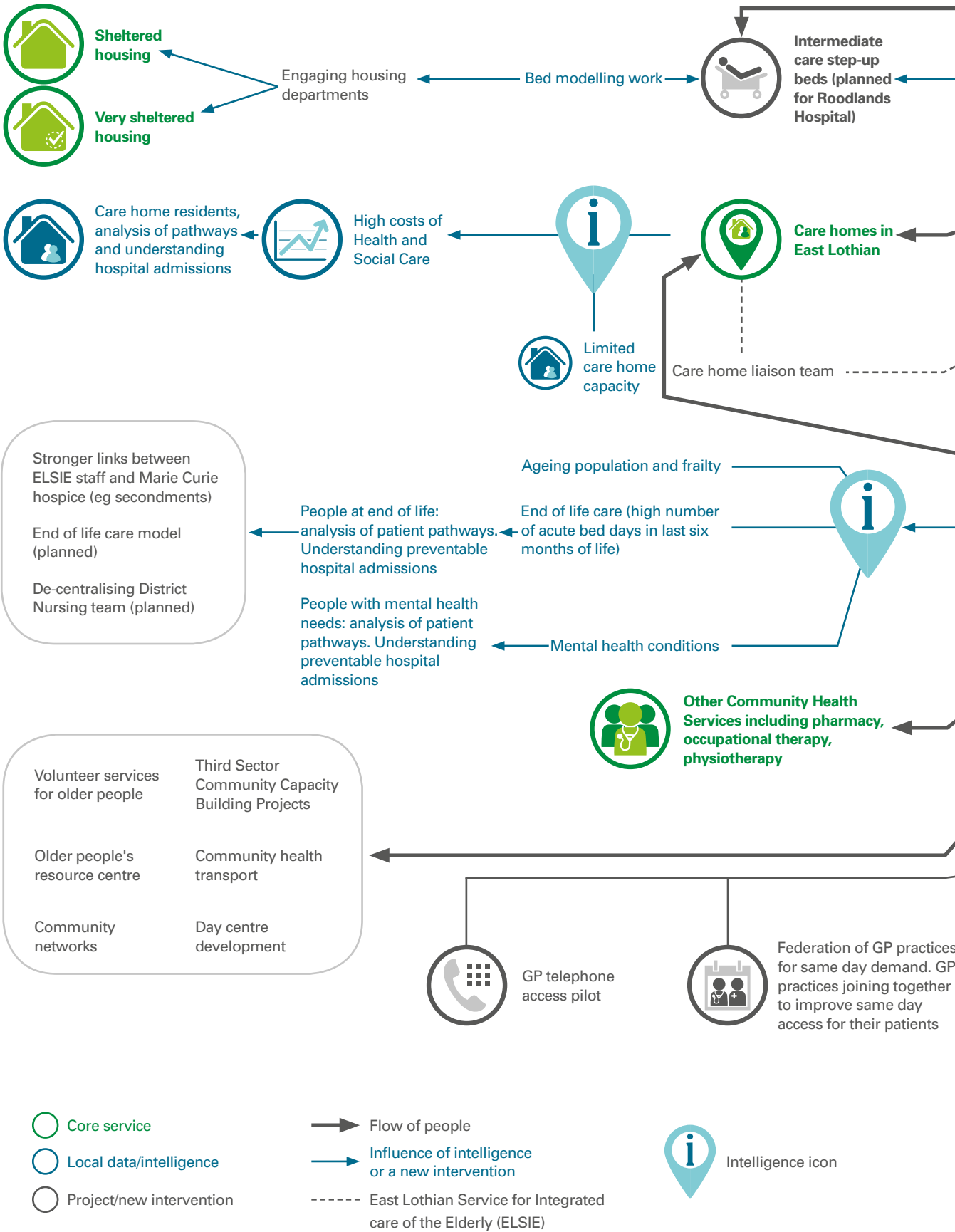
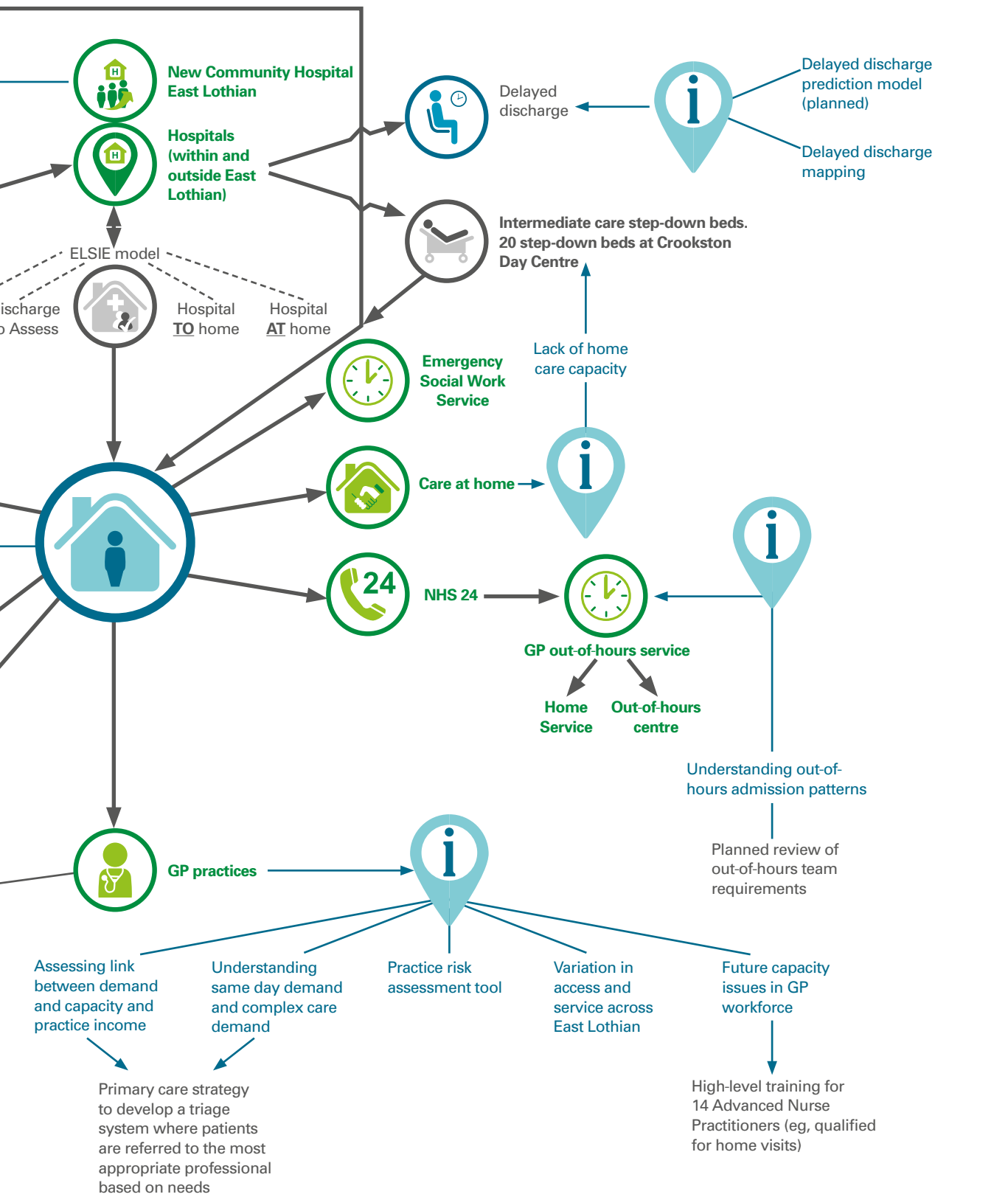


Exhibit 7 continued



Source: Audit Scotland

Part 3

Making it happen



The transformational change required to deliver the 2020 Vision is not happening

44. Public sector bodies have continued to deliver health and social care services in an increasingly challenging environment. This includes tightening budgets, changing demographics, growing demand for services, increasing complexity of cases and rising expectations from people who use these services. Alongside these pressures, NHS boards and councils are implementing major service reform to integrate adult health and social care services. It is clear that services cannot continue in the same way within the current resources available.

45. Transformational change is required to meet the Scottish Government's vision to shift the balance of care to more homely and community-based settings. NHS boards and councils need to significantly change the way they provide services and how they work with the voluntary and private sectors. Traditionally there has been an emphasis on hospital and other institutional care rather than the community-based and preventative approach outlined in the 2020 Vision. We have highlighted in previous reports that despite the Scottish Government's considerable focus and resources aimed at shifting the balance of care over a number of years, this has not changed to any great extent.²⁴ We will monitor trends in the balance of care as part of our ongoing work on health and social care integration.

46. Over the four-year period from 2010/11 to 2013/14, the balance of expenditure on institutional services, such as hospitals and care homes, and on care at home or in community settings, has remained static. The percentage of total expenditure on adult health and social care (around £11.7 billion) has remained at 56 per cent for institutional-based care and 44 per cent for community-based care ([Exhibit 8, page 27](#)).

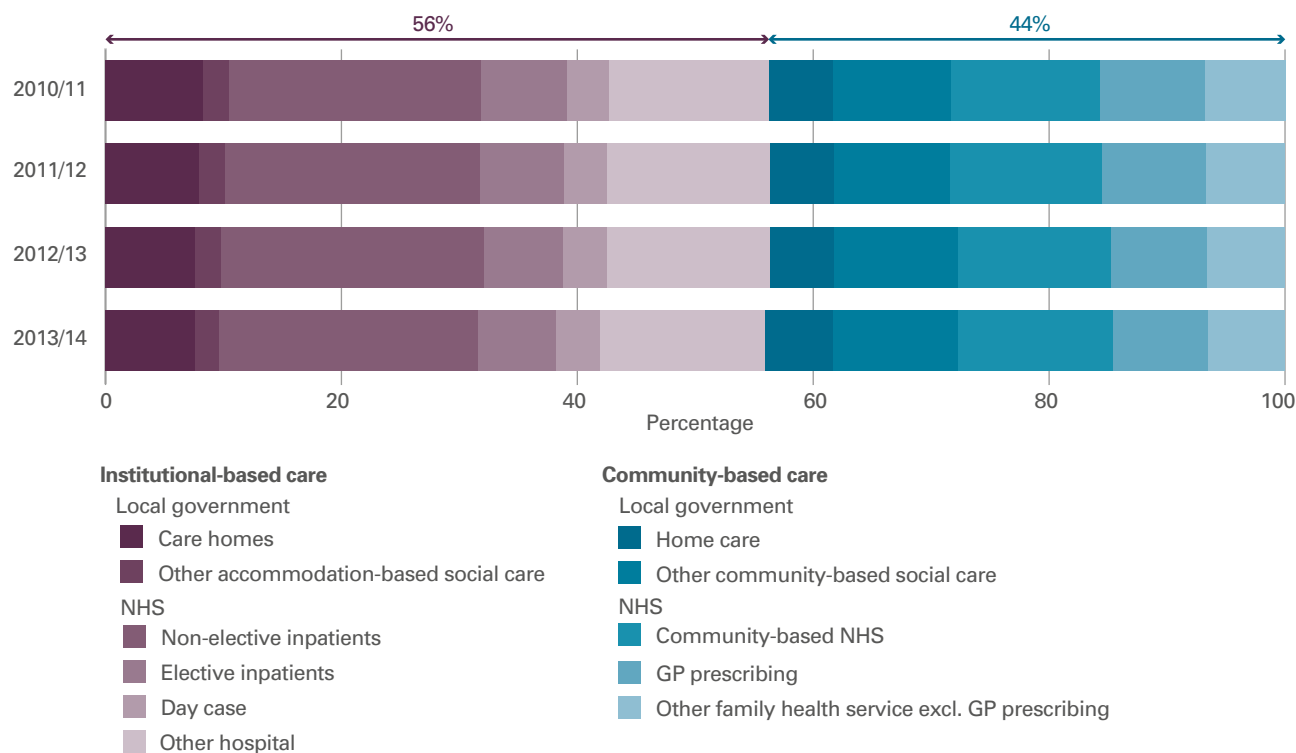
47. Our 2015 annual report on the NHS in Scotland highlighted that the Scottish Government has not made sufficient progress towards achieving its 2020 Vision of changing the balance of care to more homely and community-based settings.²⁵ In this audit looking at changing models of care, we found that there are many small-scale models and pilots across Scotland delivering new approaches to health and social care. However, there is limited evidence of transformational change happening on the scale required to meet the objectives of the 2020 Vision. Most initiatives are at a relatively early stage and have yet to be fully evaluated. This means the potential outcomes for service users and impact on resources are still to be fully established. Currently clear plans are lacking at a national and local level about what is needed to sustain new models of care. Examples include the funding, workforce and long-term planning requirements that are needed to ensure successful pilots are continued and scaled up.

the Scottish Government needs to provide stronger leadership by developing a clear framework to guide local development

Exhibit 8

Breakdown of adult health and social care expenditure, 2010/11 to 2013/14

The proportion of expenditure on institutional and community-based care has remained static.



Note: **Other accommodation-based social care** includes sheltered housing, hostels and supported accommodation. **Other community-based social care** includes meals, community service, prison social work, youth crime and youth work services. **Other hospital** includes maternity inpatients, special care baby units, outpatients and day patients. **Other family health service excl. GP prescribing** is General Medical Services expenditure.

Source: IRF–NHS Scotland and Local Authority Social Care Expenditure–Financial Years 2010/11–2013/14, ISD Scotland, March 2015



48. In June 2015, the Cabinet Secretary for Health, Wellbeing and Sport confirmed that the Scottish Government and NHS boards had not made sufficient progress 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, to make more progress and increase the pace of implementing the vision and to expand the current focus of the vision.

49. The Scottish Government has engaged with staff, service users and other interested groups about improving the health of the population and its plans for health and social care services. It published a National Clinical Strategy in February 2016 setting out its plans for health and social care in Scotland over the next 10 to 15 years. The Scottish Government has published this strategy to help partners as they implement the 2020 Vision. The strategy also comments on the direction of travel beyond 2020. The new strategy describes a number of new proposals and changes to current services. GPs will focus on care that is more complex and the wider primary care team will develop extended skills and responsibilities. A new structure is proposed for a network of hospital services with more specialities planned and provided on a regional or national basis. There is also a strong focus on the need to reduce waste, harm and variation in treatment and making more use of technology to support and improve care.

The Scottish Government needs to provide stronger leadership and a clear plan for implementing the 2020 Vision

50. The Scottish Government's overall aim of enabling everyone to live longer, healthier lives at home, or in a homely setting, by 2020 is widely accepted. In May 2013, the Scottish Government set out high-level priority areas for action during 2013/14.²⁶ This lacked a clear framework of how it expects NHS boards and councils to achieve this in practice, and there are no clear measures of success, such as milestones and indicators to measure progress. The cost implications of implementing the 2020 Vision are unknown and there is a lack of detail about the main principles of the policy (paragraph 22). There is also slow progress in developing the workforce needed for new models of care and a lack of information about capital investment to support the 2020 Vision.²⁷ The recently published National Clinical Strategy is intended to provide a clearer framework, but it does not detail how the high-level proposals will be implemented or contain any milestones or indicators or financial analysis.

51. The introduction of health and social care integration means there is now much more flexibility for partners to develop local solutions to local problems as they develop services and support systems to help people to live independently at home or in a homely setting. There is still an important role for Government to set the strategic direction and then to provide the support local partners need to ensure they are able to implement more effective models of care, if the pace of change is to increase.

52. In order for the 2020 Vision and the National Clinical Strategy to be realised, the Scottish Government needs to clarify:

- the immediate and longer-term priorities for local bodies to focus on
- a clear framework to guide local development of new care models, including the types of models to be tested, the resources required (such as funding and skills, job roles and responsibilities of the workforce), and how new models will be tested and rolled out in a coordinated way
- long-term funding plans to help implement the 2020 Vision and the National Clinical Strategy, to allow local bodies to plan and implement sustainable, large-scale changes to services
- how it will measure progress, for example by setting milestones and indicators.


The Scottish Government needs to identify priorities and risks

53. The Scottish Government needs to provide a clear plan now about what needs to be done to reach its longer-term strategy up to 2030. It should identify short, medium and long-term priorities for delivering its vision over the next 15 years. Examples include focusing on implementing high-impact changes to providing services in the short term, identifying the funding and other resources required for the medium term and achieving improved outcomes for the population in the long term. In its plans, the Scottish Government needs to identify and take into account specific risks to delivering its 2020 Vision and longer-term strategy. This should include the following:

- The risks we have highlighted in our report on health and social care integration. Up to late 2015, the focus has been on getting the structures and governance in place for health and social care integration. The Scottish Government will need to ensure that the new partnerships make the transition to focusing on what needs to be done on the ground to make the necessary changes to services.
- Health and social care budgets. Real-terms reductions in NHS and council budgets will pose risks to implementing new models and shifting more care into community-based settings. Council budgets have seen significant cuts in recent years and although new integrated health and social care budgets should allow funding to flow from NHS to social care budgets, it is not yet certain this will happen in practice. Councils and NHS boards are finding it difficult to agree budgets for the new integration authorities.
- The building pressures in general practice, including problems with recruiting and retaining the workforce. The new GP contract that will come into effect in Scotland in 2017 will be crucial in managing the role of general practice in helping to implement the changes required to meet the 2020 Vision. The role of GPs in moving towards the 2020 Vision should be a major focus of the discussions between the Scottish Government and the profession as the new contract terms are developed.

The Scottish Government should outline clear principles for implementing new care models

54. Various principles should be followed for new care models to be implemented, tested, evaluated and rolled out successfully. If local bodies are to expand and roll out new models, they must have thorough information on the costs involved for planning and ensuring the models are sustainable. The Scottish Government has not provided an estimate of the investment needed to implement its 2020 Vision and longer-term strategy, and whether it can be achieved within existing resources. It needs to model how much investment is needed in new services and new ways of working and if it can be achieved within existing and planned resources.

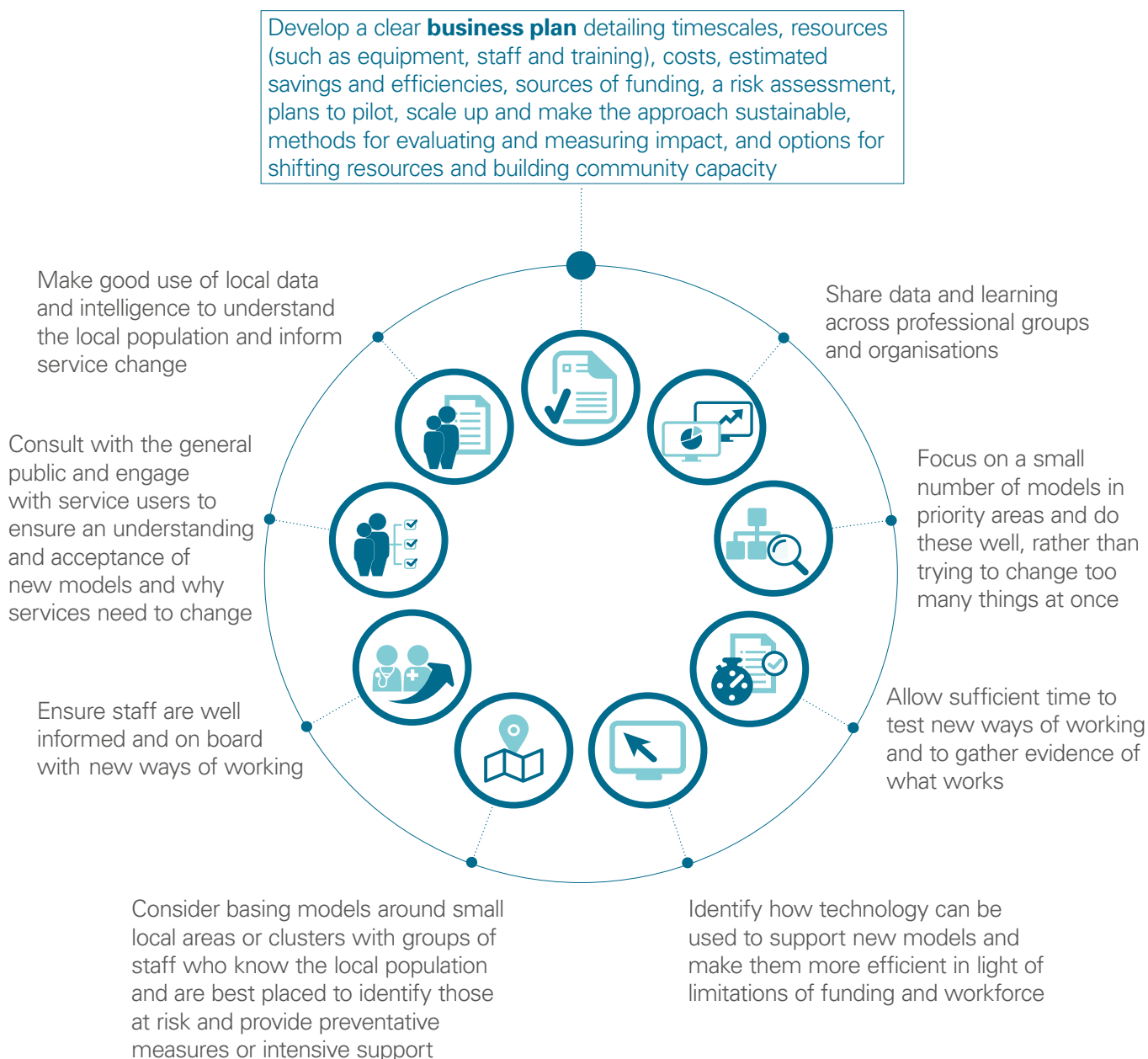
55. Staff implementing new models should have a business plan that clearly details how they will implement, monitor and review them. [Exhibit 9 \(page 30\)](#) summarises principles for implementing new care models. It draws on the information collated from our fieldwork and the learning shared by local bodies and other organisations. Links to toolkits and reports that may be useful for NHS boards, councils and integration authorities for implementing new models of care are included in [Supplement 1 \[PDF\]](#) .

56. Few of the models outlined in [Exhibit 6](#) have been fully costed or properly evaluated. In several cases, it is too early to assess the impact of new ways of working. However, sometimes this is due to the lack of good monitoring data or the lack of skills and resources to carry out an evaluation. Generally, there is a lack of evidence of community-based models having a major impact and clarity about what works. This is a common problem, not unique to Scotland, but a crucial one to address so that local areas can efficiently identify and implement the most effective models.²⁸

Exhibit 9

Principles for planning, implementing, monitoring and reviewing new care models

New care models should be properly planned, implemented, monitored and evaluated to ensure value for money and sustainability.






Source: Audit Scotland

Mechanisms to support a significant shift in resources from acute to community settings are needed

57. Moving towards more community-based care is central to the 2020 Vision, but the balance of care is not shifting ([Exhibit 8](#)). To achieve the transformational change required to meet the 2020 Vision, the Scottish Government needs to

identify mechanisms that will drive a significant shift of resources from acute to community settings. Some local partnerships have found innovative ways to overcome barriers to improvement, but more can be done to facilitate change locally. The Scottish Government has an important role to play in supporting local bodies make these changes.

58. There are tools that can facilitate the transfer of resources across a local system, demonstrated in the examples seen in Tayside, Glasgow and Highland ([Case study 8 \[PDF\]](#)  and [Case study 9 \[PDF\]](#) ). Scotland could apply learning from other countries. For example, Canterbury, New Zealand, shifted the balance of care through strong leadership, a clear vision, and a collaborative and whole-system approach. An important factor was its focus on 'one system, one budget'. It prioritised spending on those in greater need to reduce relying on residential care and to keep people in their own homes for longer. This had the effect of reducing demand and costs for hospital and other institutional care, and allowed for more investment in the community ([Case study 10 \[PDF\]](#) .

59. The Scottish Government needs to identify what balance of care it wants to achieve, what this will look like in practice and the financial implications of achieving this. The Scottish Government should challenge local partnerships to be clear about their specific ambitions in relation to the balance of acute and community care in their local areas, with clear timescales and milestones for achieving it.

60. The continued focus on targets in the acute sector is counterproductive to moving more funding into the community. NHS boards are under significant pressure to meet challenging hospital waiting time targets. This means that the acute sector continues to absorb considerable resources to meet these targets. A focus on short-term funding and increasing use of the private sector to help meet targets does not demonstrate value for money. The focus on annual targets does not help to achieve the longer-term aims and objectives of the NHS. Integration authorities are required to deliver outcome measures. This recent development with a greater focus on improving people's experiences of health and social care services is more helpful than focusing on narrow performance targets.

61. The Scottish Government needs to identify adequate and timely longer-term funding to support transformational change. It has provided multiple short-term funds to help local bodies implement change, but these do not provide the level of funding or certainty to make large-scale sustainable changes.²⁹ It has announced a £30 million transformational change fund to 'support creativity and transformation' in its draft budget for 2016-17.

62. In 2014, we reported on progress of the Scottish Government's policy of reshaping care for older people.³⁰ As part of this audit, we considered the impact of the £300 million Change Fund over four years, introduced by government in 2011/12 to support its policy. We found that the Change Fund had led to the development of a number of small-scale initiatives, but that they were not always evidence-based or monitored on an ongoing basis. It was unclear how successful projects would be sustained and expanded.³¹

63. Similar challenges in transforming services to have a greater focus on community-based care are also evident in England. There may be lessons to learn from the approach NHS England is taking to testing and rolling out new models of care, but it is too early to assess the effectiveness of its approach.

The Health Foundation and the King's Fund have recommended that existing disparate strands of funding for transforming services in NHS England should be pooled into one transformation fund. They also recommend that a single body, with strong, expert leadership, oversees the investment for transformational change and that ongoing evaluation should be a core activity of the fund. They advise that the fund must be properly resourced to support investment in the four key areas that are essential for successful transformation: staff time, programme infrastructure, physical infrastructure and double-running costs.³²

There is a lack of coordinated, clear and accessible learning



64. The current fragmented approach to implementing new ways of working means that the learning within individual organisations, and the work carried out by various national bodies, is not being consolidated. The Scottish Government needs to coordinate new ways of working and information at a national level to ensure a more efficient and effective approach. The Scottish Government should draw on successful improvement models it has implemented in other areas, such as its patient safety programme.

65. Support for service change and improvement has been available to local bodies from a number of national organisations, such as the Quality, Efficiency and Support Team (QuEST) within the Scottish Government, Healthcare Improvement Scotland (HIS), ISD, the Scottish Centre for Telehealth and Telecare, and the Joint Improvement Team (JIT). However, the activities of these various organisations are not well coordinated. They all have slightly different roles and the learning from the work they do with local bodies is not drawn together. A significant amount of information is available on the various organisations' websites, but it is not always easy to navigate or identify the key information partners should use when they are considering implementing a new model of care. This information could be used to better effect to help increase the pace of change.

66. From April 2016, QuEST, HIS and JIT will combine into one integrated improvement resource. Its overall aim is to support and facilitate NHS boards, integration authorities and their partners to deliver care and support that will improve health and wellbeing outcomes for their populations.³³ This new integrated improvement resource is a positive step and will facilitate a more coordinated national approach and will make better use of improvement resources available to support partnerships.

The public's perception of health and social care services needs to change

67. The Scottish Government first set out its vision for a different health and social care system in 2011, but the system remains largely the same, and the public has not seen major redesign of local services in many parts of Scotland. NHS boards, councils and integration authorities will need to adopt innovative models of care and ways of working that are quite different from traditional services to provide opportunities for better care. They will need to exercise much more flexibility in how they use resources, such as money; assets, including buildings and equipment; and their workforce. This involves making difficult decisions about changing, reducing or cutting some services. Services cannot continue as they are and a significant cultural shift in the behaviour of the public is required about how they access, use and receive services. The introduction of health and social care integration provides an opportunity to engage more directly with communities about services and the need for change.

68. Local communities have strong ties to existing services which can make discussions about changes difficult, for example discussions about changing how hospital services are delivered. There are recent examples in NHS Tayside where the board consulted extensively with the public about closing community hospital beds. The board explained why it needed to close beds and the benefits of providing services differently. It also engaged with patients and their families about their needs and how they could best be met in the new care model in a more homely setting. By closing care of elderly and dementia beds in a number of community hospitals, NHS Tayside has been able to shift more resources into community teams. This has allowed many more patients to be supported in the community and they are now receiving care in their homes instead of being admitted to hospital ([Case study 8 \[PDF\]](#) ). It is important that NHS boards, councils and partnerships involve staff and local people as they develop new models of care. The Nuka model of care illustrates the benefits of staff and local people being closely involved in developing their local services ([Case study 1 \[PDF\]](#) .

69. The Scottish Government cannot make the significant changes that are required on its own. Local bodies also need to work closely with staff to develop and implement new ways of working. Fifty-five per cent of staff in NHS Scotland responding to the 2015 national staff survey reported that they are kept well informed about what is happening in their NHS board. Only 28 per cent of staff reported that they are consulted about change at work.³⁴ A focus on local populations within integration authorities will have an important role in reforming how to deliver services. This should 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.

NHS boards and councils can do more to address barriers and facilitate change

70. Staff within NHS boards and councils still face many barriers to making the level of changes required. We highlighted in [Part 2](#) some examples of new care models being introduced across Scotland. Staff leading these often faced difficulties getting these in place or rolling them out. But new models have been successfully implemented where staff have taken a strategic approach with clear plans, aims and outcomes. Some of the main challenges to implementing new models include:

- overcoming structural and cultural barriers when bringing together staff from different parts of an organisation or from different organisations
- freeing up staff time to develop and implement new care models
- securing funding for new approaches owing to limited evidence of what works
- having resources for a long enough period to be able to fully test new models to demonstrate any benefits and outcomes for service users
- lack of robust evaluation of new models and being able to identify the attributable impact of a particular approach alongside other services and programmes
- temporary funding and staffing preventing the models continuing or expanding
- shifting resources from acute to community-based settings to allow new care models to develop significantly in line with national policy.

Funding needs to be focused on new community-based models


71. At the same time as dealing with increasing demand, NHS boards are facing a tightening financial position and councils are experiencing budget cuts ([Part 1](#)). The NHS is finding it difficult to release funding from the acute sector to increase investment in the community. Councils are finding it difficult to fund the level of social care services required to meet current demand, and the demands on health and social care services are likely to continue to increase. Barriers to releasing funding to invest in new care models include the following:

- Some NHS boards are overspending against their planned hospital budgets owing to pressures on hospital services. This makes it more challenging to release any funding to invest in community-based services. For example, NHS Highland has overspent on its budget for Raigmore hospital over the last five years (£9.6 million in 2013/14) and NHS Fife has overspent on its acute services division budget for the last two years (£10.6 million in 2014/15).^{35, 36} In August 2015, NHS Greater Glasgow and Clyde reported spending levels of £5.3 million over its projected acute services division budget. The board had aimed to be £1.7 million over of its budget at that point in the year to be able to achieve a breakeven position by the end of the financial year.³⁷
- Investment in NHS community-based services has not increased at the same rate as investment in hospital-based services. Between 2010/11 and 2013/14, spending on community-based services increased by 4.9 per cent in cash terms, but reduced by 0.5 per cent in real terms. Spending on hospital-based services increased by 8.4 per cent in cash terms and by 2.8 per cent in real terms.³⁸
- Making improvements in preventing hospital care can increase costs in the community. For example, new care models to prevent admission to hospital increase the costs in community-based health and social care services, such as additional homecare, but the savings in hospital care are often not realised or transferred.
- New community-based care models may place additional pressure on councils already struggling to cope with demand for social care services and are not sustainable without a shift in funding.
- Public and political resistance to closing local hospitals or wards makes it difficult to release significant amounts of funding to invest in radically changing the way services are delivered.
- Closing a small number of hospital beds, or one or two wards, releases limited cash as many of the overhead costs remain or are only slightly reduced. Examples of overhead costs include theatre costs, input from staff covering a number of wards or specialties, cleaning and porter costs, and heating and lighting costs.

72. We did find some examples of local areas overcoming these difficulties and finding innovative ways to direct more funding to community-based care models. In Tayside, closure of community hospital dementia beds has allowed increased investment in community-based teams that are looking after more patients in their own homes. In Glasgow, the reablement service is helping more people to live independently and freeing up more resources for homecare

services ([Case study 8 \[PDF\]](#) ). In Perth and Kinross and Highland, local areas are using tools to manage scarce resources and competing demands ([Case study 9 \[PDF\]](#) ). There are also lessons from other countries. In Canterbury, New Zealand, a long-term transformational programme and integrated system has increased investment in community-based care and shifted the balance of care ([Case study 10 \[PDF\]](#) ). The introduction of health and social care integration brings opportunities for partners to overcome barriers to shifting resources to more community-based and preventative services.

Changing models of care have implications for the structure and skills of the workforce

73. NHS boards and councils face major challenges in ensuring that staff with the right skills are able to provide new community-based models of care to meet the needs of the population. Recruiting and retaining staff on permanent contracts remains a significant problem for the NHS and the social care sector. In the NHS, vacancy rates, staff turnover rates and sickness absence levels all increased during 2014/15. Our [NHS in Scotland 2015 \[PDF\]](#)  report stated that a national coordinated approach is needed to help resolve current and future workforce issues. It highlighted that 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. We plan to carry out further work on the NHS workforce during 2016/17.


74. Over many years, councils have had difficulties recruiting and retaining care home and homecare 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 plan to publish a report on Social Work in Scotland in Summer 2016. This will examine issues with recruiting and retaining social work staff in more detail.

75. To shift to more community-based services and care in homely settings, the availability and development of community-based staff with the right skills is crucial. But the balance of community-based staff has not increased significantly in recent years. For example:

- Between 2009 and 2013, the estimated number of GPs in post in Scottish general practices increased by less than one per cent, from 3,700 WTE to 3,735 WTE. The Royal College of General Practitioners in Scotland has calculated that an additional 740 GPs are required in Scotland by 2020, based on predicted population growth.³⁹
- Between 2009 and 2014, there have been some changes in the number of people in the social care workforce. Adult day care services staff decreased by nine per cent. The number of adult care home staff increased slightly (one per cent). Staff providing housing support and care at home services increased overall by four per cent, however decreased by three per cent between 2009 and 2013, and only increased again between 2013 and 2014 by six per cent.⁴⁰ Between 2010 and 2014 the number of people receiving homecare fell by nearly seven per cent to 61,740, while the total number of homecare hours rose by over seven per cent to 678,900. The number of people receiving ten or more hours of homecare per week, those with more complex needs, increased by four per cent to 21,700.⁴¹

76. A number of other workforce issues were raised in our fieldwork, including the following:

- Limited capacity in general practice to cope with increasing demand.
- An increasing workload for GPs and the wider primary care team from monitoring patients on long-term medicines.
- GPs do not have protected time for service development, research and strategic meetings. This makes it difficult for GPs to get involved in developing new care models.
- Fewer junior doctors are choosing general practice as a profession.
- Problems recruiting nurses in specialty areas linked to caring for frail and elderly patients.
- A need to train more nurses who currently work in hospitals so they can work in the community.

77. Some local areas are finding solutions to the workforce issues we describe above. We found examples of different groups of staff getting involved in new community-based care models to reduce the pressure on limited GP capacity. Different professions are also working together in multidisciplinary teams to provide more efficient and better quality care, for example in Glasgow, Grampian and East Lothian ([Case study 11 \[PDF\]](#) )

78. BMA Scotland has set out a new role for GPs. It has proposed that GPs should be the senior clinical decision-makers in the community, become more involved in making improvements across the system and focus on complex care in the community. This would mean GPs being less involved in more routine tasks and other health professionals in the wider community team taking on extended roles.⁴² This is a proposal in the new National Clinical Strategy. A review of primary care out-of-hours services also recognises the importance of a multidisciplinary team approach and the contribution of the wider team. It proposes a new model for patient access to out-of-hours care.⁴³

79. In June 2015, the Scottish Government announced it was providing a primary care investment fund of £50 million over three years to help address workload and recruitment issues in primary care. It is a modest amount and represents around 3.5 per cent of the Scottish Government's primary and community services budget.⁴⁴ The Scottish Government anticipates that it will provide an initial impetus to encourage GPs to try new ways of working over the next three years. But it is not clear how its effectiveness will be monitored.

80. Key elements of the three-year fund include the following:

- Primary Care Transformation Fund allocating £20.5 million to GP practices to test new ways of working to address current demand. The Scottish Government is developing a framework for the fund and is inviting health boards and integration authorities to develop proposals to test new ways of working in primary care. Information on the application process and selection criteria was made publicly available in February 2016.

- An investment of £16.2 million for Pharmacist Independent Prescribers to recruit up to 140 new pharmacists. The aim is that they will work with GP practices to help care for patients with long-term conditions and to free up GPs' time so they can spend it with other patients.
- A GP Recruitment and Retention Programme of £2.5 million to explore the issues surrounding recruiting and retaining GPs. The programme will implement proposals to increase the number of medical students who choose to go into GP training and encourage GPs to work in rural and economically deprived areas.
- A £6 million Digital Services Development Fund to help GP practices put digital services in place more quickly. This includes developing online booking for appointments and implementing webGP, an electronic consultation and self-help web service hosted on a GP practice's website.
- The balance of just under £5 million will be used to fund:
 - equipment to enable optometrists to screen people for glaucoma
 - changes to front-line services so that Allied Health Professionals, such as physiotherapists, can better support active and independent living
 - a leadership programme to equip GPs with the necessary skills to play a leading role in developing local integration work
 - additional research and training through the Scottish School of Primary Care.⁴⁵

81. In February 2016, the Scottish Government announced a further £27 million investment over the next five years to develop the NHS workforce. This includes £3 million to train 500 advanced nurse practitioners and over £23 million to increase the number of medical school places and widen access to medical schools. A new entry-level programme will be introduced to support and encourage more people from deprived backgrounds to study medicine.

82. Many general practices are struggling to recruit and retain staff. During 2015, NHS boards had to support nine practices that were not able to continue as successful businesses and provide the services required to their local population. This may become an increasing problem in light of the building pressures we have outlined throughout this report what impact it has on. Where NHS boards have had to step in, it is not clear what impact this has had on the performance of practices and the services provided to patients. The Scottish Government should monitor these practices for any improvements or deterioration in the way services are provided, and share any learning.

A better understanding of the needs of local populations is required


83. NHS boards, councils and partnerships need to have a good understanding of their local population and how people use different services so they can provide services that effectively meet local needs. This understanding can help to identify where resources, including money and staff, are being directed and if they are using these resources in the best way. It can also help to identify changes required to the way services are delivered and how resources can be redirected to priority areas.

84. We found that NHS boards, councils and partnerships are at varying stages with this kind of analysis and taking different approaches to it. However, integration authorities will all have to carry out needs assessments of their local population, and this is an important step in improving local analysis. The organisations that are making good use of their local data are starting to think differently about how they can best deliver and redesign services. They are identifying a small number of priorities to focus on, which is much more manageable than trying to fix everything at once. It is also more effective than having too many small-scale projects that are difficult to manage and unlikely to demonstrate a significant impact.

Health and social care data is improving

85. ISD is developing an extensive database of linked data on health and social care activity and costs and demographic information. It is making this information available to NHS boards, councils and partnerships to help them gain a better understanding of the needs of their local population, current patterns of care and how resources are being used. The Health and Social Care Data Integration and Intelligence Project (HSCDIIP), now known as Source, is a long-term project that aims to support integration authorities by improving data sharing across health and social care.⁴⁶ From April 2015, the central team has begun sharing local data in the form of an interactive dashboard that contains easy-to-read information summaries. This has required local areas to sign an information governance agreement to enable NHS boards and councils to view each other's data across a local population. Some partnership areas have taken some time to get these agreements in place and therefore gain access to the analysis. As at February 2016, five partnerships had finalised these agreements and undergone training for the software that will allow them to access and analyse the linked data for their local area (Angus, Borders, Dumfries and Galloway, East Renfrewshire, and Midlothian). This is the first time this linked data has been available and this is a valuable resource for partnerships.

86. ISD is also providing data and analytical support through a Local Intelligence Support Team (LIST) initiative. This allows partnerships to have an information specialist from ISD working with them in their local area. The central team can also provide additional support and tailored analysis. This includes forecasting costs, pathway analysis to show how individuals move from one service to another, and the resource associated with the use of different services at a local population level.

87. Some areas have made good use of the support provided by the Source team to better understand their population and also the data that has been made available to them. This includes Perth and Kinross, East Lothian, and West Dunbartonshire ([Case study 12 \[PDF\]](#) ).




88. These examples demonstrate how detailed analysis of local data at a local area and individual level is crucial in understanding the needs of a population, how people are currently using services and how costs are incurred. This then provides local areas with the information they need to identify how services can be provided differently and more efficiently to provide better outcomes for people and reduce costs. Using this information to identify the individuals at most risk of their health deteriorating allows preventative measures to be put in place or for care to be provided in a more effective and efficient way. This has the potential to free up resources across the whole system. If local areas do not have this level of information, they will not be able to properly plan or transform services in the future.





89. ISD is in a good position, through the Source and LIST work, to share good practice about data analysis across all partnership areas. ISD held a conference in September 2015 to share early learning from across Scotland. ISD should continue to share good practice. This could include:

- hosting further national events
- publishing good practice examples on its website to illustrate how local areas are making good use of data
- developing toolkits to assist partnership areas to identify appropriate approaches to analysing and understanding local data.

Endnotes



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