Agenda

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health & Social Care Partnership Board Audit Committee

Date: Wednesday, 7 December 2016

Time: 14:00

Venue: Committee Room 3,
Council Offices, Garshake Road, Dumbarton

Contact: Nuala Borthwick, Committee Officer
Tel: 01389 737594 Email: nuala.borthwick@west-dunbarton.gov.uk

Dear Member

Please attend a meeting of the **West Dunbartonshire Health & Social Care Partnership Board Audit Committee** as detailed above.

The business is shown on the attached agenda.

Yours faithfully

JULIE SLAVIN

Chief Financial Officer of the
Health & Social Care Partnership

Distribution:-

Voting Members
Allan Macleod (Chair)
Gail Casey (Vice Chair)
Heather Cameron
Jonathan McColl
Martin Rooney
Rona Sweeney

Senior Management Team – Health & Social Care Partnership
Mr C. McDougall
Ms K. Cotterell

Date of issue: 28 November 2016

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD
AUDIT COMMITTEE

WEDNESDAY, 7 DECEMBER 2016

AGENDA

1 APOLOGIES

2 DECLARATIONS OF INTEREST

Members are invited to declare if they have an interest in any of the undernoted items of business on this agenda and, if so, state the reasons for such declarations.

3 MINUTES OF PREVIOUS MEETING **7 - 12**

Submit for approval as a correct record, the Minutes of Meeting of the Health & Social Care Partnership Audit Committee held on 14 September 2016.

4 COMMITTEE ACTION LIST **13 - 17**

Submit a note of the Audit Committee's Action List for information.

5 AUDIT SCOTLAND REPORT ON NHS IN SCOTLAND 2016 **19 - 74**

Submit report by the Head of Strategy, Planning & Health Improvement providing information on the recently published Audit Scotland report on the NHS in Scotland.

6 AUDIT SCOTLAND REPORT ON SOCIAL WORK IN SCOTLAND **75 – 125**

Submit report by the Head of Strategy, Planning & Health Improvement providing information on the recently published Audit Scotland report on Social Work in Scotland.

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7 THE NATIONAL HEALTH AND SOCIAL CARE STANDARDS CONSULTATION **127 - 166**

Submit report by the Head of Strategy, Planning & Health Improvement seeking endorsement of the recently launched consultation on the new National Health and Social Care Standards and the response prepared on behalf of the Health & Social Care Partnership Board.

8 CARE INSPECTORATE REPORTS FOR SUPPORT SERVICES OPERATED BY THE INDEPENDENT SECTOR IN WEST DUNBARTONSHIRE **167 – 171**

Submit report by the Head of Strategy, Planning & Health Improvement providing a routine update on the most recent Care Inspectorate assessments for three independent sector support services operating within the West Dunbartonshire area.

9 CARE INSPECTORATE REPORTS FOR OLDER PEOPLE'S CARE HOMES OPERATED BY INDEPENDENT SECTOR IN WEST DUNBARTONSHIRE **173 – 178**

Submit report by the Head of Strategy, Planning & Health Improvement providing a routine update on the most recent Care Inspectorate assessments for four independent sector residential older people's Care Homes located within West Dunbartonshire.

10 CARE INSPECTORATE REPORT FOR CARE AT HOME SERVICES OPERATED BY WEST DUNBARTONSHIRE COUNCIL **179 - 183**

Submit report by the Head of Community Health & Care providing information on the most recent inspection reports for the Council's Care at Home Services.

11 FINAL AUDIT PLAN 2016/17 AND PROGRESS REPORT **185 - 201**

Submit report by the Chief Internal Auditor:-

(a) seeking approval of the final Audit Plan for 2016/17;

(b) providing an update to Members on the planned programme of audit work for the year 2016/17 in terms of the internal audit work undertaken at West Dunbartonshire Council and NHS Greater Glasgow & Clyde that may have an impact upon West Dunbartonshire Health & Social Care Partnership Board;

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(c) providing confirmation of the cost implications of the provision of audit services to the Health & Social Care Partnership; and

(d) providing information on the recommendations of the Audit Scotland report entitled 'Health and Social Care Integration (December 2015)'

12 MODEL PUBLICATION SCHEME AND GUIDE TO INFORMATION **203 - 243**

Submit report by the Head of Strategy, Planning & Health Improvement presenting the Scottish Information Commissioner's Model Publication Scheme and the draft Guide to Information for the Health and Social Care Partnership.

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, 14 September 2016 at 10.00 a.m.

Present: Allan MacLeod (Chair), Heather Cameron, Jonathan McColl and Martin Rooney.

Attending: Keith Redpath, Chief Officer; Jeanne Middleton, Chief Financial Officer; Soumen Sengupta, Head of Strategy, Planning and Health Improvement; John Russell, Head of Mental Health, Learning Disability & Addictions; Colin McDougall, Chief Internal Auditor; Allan White, Senior Social Worker, Children's Services; Yvonne Lappin, Senior Principal Officer, Fostering & Adoption; Janice Miller, MSK Physiotherapy Manager; David McConnell, Assistant Director; Peter Lindsay, Senior Audit Manager; Laurence Slavin, Senior Auditor, Audit Scotland; and Nuala Borthwick, Committee Officer (West Dunbartonshire Council).

Apologies: Apologies for absence were intimated on behalf of Gail Casey and Rona Sweeney.

Allan MacLeod in the Chair

DECLARATIONS OF INTEREST

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

MINUTES OF PREVIOUS MEETING

The Minutes of Meeting of the West Dunbartonshire Health and Social Care Partnership Board Audit Committee held on 15 June 2016 were submitted and approved as a correct record.

COMMITTEE ACTION LIST

A note of the Audit Committee's Action List was submitted for consideration and comment.

Having heard relevant officers in answer to questions from Members, it was agreed:-

(1) that in relation to Action 1, it was anticipated that the Chief Financial Officer and the Chief Internal Auditor would be in a position to report on any additional cost implications associated with the system of internal financial control within a 3 month period;

(2) that Action 3 in relation to action plans submitted to the Care Inspectorate appeared to be in operation and was now a completed action;

(3) that Action 4 relating to Members expenses was now a completed action;

(4) that in relation to Action 9, the Head of Strategy, Planning & Health Improvement would provide a report to a future meeting of the Audit Committee with suggestions on responding to the consultation;

(5) that Actions 8 and 10 would be merged into one action and a report on health inequalities amongst different socio-economic groups would be submitted to the 7 December 2016 meeting of the Audit Committee; and

(6) that Action 12 relating to Audit Accounts was now a completed action.

AUDIT SCOTLAND - 2015/16 DRAFT ANNUAL AUDIT REPORT

A report was submitted by the Chief Financial Officer presenting the Annual Report and Auditor's letter for the financial period ended 31 March 2016 prepared by the Health & Social Care Partnership Board's external auditors, Audit Scotland on the above.

After discussion and having heard the Assistant Director and the Senior Audit Manager, Audit Scotland in further explanation of the report and in answer to Members' questions, the Committee agreed:-

(1) to note the contents of the Draft 2015/16 Annual Audit Report for members of West Dunbartonshire Health & Social Care Partnership Board and the Controller of Audit for the Financial Year ending 31 March 2016;

(2) to welcome the achievement of a qualification free first set of Health & Social Care Partnership Board accounts;

(3) to note the issues raised in the appendices to the report relating to the 2015/16 Audited Annual Accounts;

(4) to authorise the Chair, Chief Officer and Chief Financial Officer to accept and sign the final 2015/16 Accounts on behalf of the Health & Social Care Partnership Board; and

(5) to pass on its congratulations and appreciation to the Chief Financial Officer for the deliverance of a positive and high quality accounts closure process.

AUDITED ANNUAL ACCOUNTS 2015/16

A report was submitted by the Chief Financial Officer presenting the audited Annual Accounts for the year ended 31 March 2016 and highlighting matters of interest as delegated by the Health & Social Care Partnership Board on 15 June 2016.

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 Audited Annual Accounts for 2015/16;

(2) to note that some minor presentational amendments would be made to the report prior to signing of the annual accounts;

(3) to acknowledge the assistance provided by Audit Scotland in finalising the Partnership Board's Audited Annual Accounts; and

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

DRAFT STRATEGIC RISK REGISTER

A report was submitted by the Head of Strategy, Planning & Health Improvement presenting the updated Strategic Risk Register in draft for the Health & Social Care Partnership.

After discussion and having heard the Chief 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 suggested revisions in relation to the efficiency and effectiveness of action movements in the updated draft Strategic Risk Register; and

(2) subject to consultation with the Chair of the Audit Committee on revisions, the updated draft Strategic Risk Register be submitted for onward recommendation to the West Dunbartonshire Health & Social Care Partnership Board at its meeting on 16 November 2016.

CARE INSPECTORATE REPORTS FOR CHILDREN & YOUNG PEOPLE'S SERVICES OPERATED BY WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

A report was submitted by the Head of Children's Health, Care and Criminal Justice providing the most recent inspection reports for the Council's Throughcare, Fostering and Adoption Services for Children and Young People.

After discussion and having heard the Senior Social Worker, Children's Services and the Assistant Principal Officer, Fostering and Adoption Services 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 reflect the quality levels expected by the Council; and

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

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

A report was submitted by the Head of Strategy, Planning & Health Improvement providing a routine update on the most recent Care Inspectorate assessment for one independent sector residential older peoples' Care Home located in West Dunbartonshire.

The Committee agreed to note the content of the report.

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

A report was submitted by the Head of Strategy, Planning & Health Improvement providing a routine update on the most recent Care Inspectorate assessment for ten independent sector support services operating within the West Dunbartonshire area.

After discussion and having heard the Chief Officer in further explanation of the report and in answer to Members' questions, the Committee agreed to note the content of the report.

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 & Care providing information on the most recent inspection reports for one of the Council's Older People's Residential Care Home Services.

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

(1) that the Chair, on behalf of the Committee, would write to the staff at Boquhanran House to recognise their achievement in sustaining grade 4 for 'environment'; and

(2) to note the content of the report.

INTERNAL AUDIT UPDATE

The Chief Internal Auditor provided a verbal update on internal audit for the Partnership Board.

Having heard the Chief Internal Auditor, it was noted:-

(1) that all actions for 2015/16 had been implemented by management;

(2) that there were currently four systems audits planned for the Partnership; one on homecare with the other three to commence in due course; and

(3) that the areas of governance, performance and financial management will be reviewed over the remainder of the year; and

(4) that in the future, the Chief Internal Auditor will provide the Audit Committee with written reports as part of the meeting's papers.

LOCAL GOVERNMENT AUDITS - INTRODUCTION TO AUDIT SCOTLAND: WEST DUNBARTONSHIRE INTEGRATION JOINT BOARD

A report was submitted by Audit Scotland providing information on the senior audit team appointed to West Dunbartonshire Health & Social Care Partnership.

After discussion and having heard both the Senior Audit Manager and Senior Auditor, Audit Scotland in further explanation of the report and in answer to Members' questions, the Committee agreed to note the appointments to the new senior audit team for West Dunbartonshire Health & Social Care Partnership for the five year audit appointment term, with the local audit team led by Carol Hislop, Senior Audit Manager.

EXCLUSION OF PRESS AND PUBLIC

The Committee was asked to approve the undernoted Resolution:-

"In terms of Section 50 (A) of the Local Government (Scotland) Act, 1973 that the press and public be excluded from the remainder of the meeting as the following item of business involves the likely disclosure of exempt information as defined in Paragraph 11 of Part 1 of Schedule 7A to the Act."

2016/17 HEALTH CARE SAVINGS OPTIONS

A report was submitted by the Chief Financial Officer providing an update on the 2016/17 Health Care Savings options.

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

(1) to note the terms of the discussion in relation to initial savings options to restore financial budget balance to the Health budget in 2016/17;

(2) to note the Health Board has identified that an element of non-recurring relief is potentially available to offset the in year shortfall against savings targets and that discussions are underway to determine how non-recurring funding will be allocated to Partnerships within this financial year;

(3) to note that the NHS Board will consider the savings options from all parts of the NHS system during October 2016; and

(4) that a further update report would be presented to the Health & Social Care Partnership Board at its next meeting on 16 November 2016.

VALEDICTORIES

Jeanne Middleton, Chief Financial Officer

The Chair, Mr MacLeod advised that that this would be the last meeting of the Audit Committee that Jeanne Middleton would attend as she was retiring from service with the Health & Social Care Partnership in October 2016.

On behalf of the Committee, Mr MacLeod thanked Mrs Middleton for her professional support and for the sterling work undertaken to set up the financial systems required of the Partnership Board.

John Russell, Head of Mental Health, Learning Disability & Addictions

Mr Redpath informed the Committee that Mr John Russell would also be retiring from service with the Health & Social Care Partnership at the beginning of October 2016 and thereafter the Committee noted their appreciation of Mr Russell's 8 years of service in West Dunbartonshire and wished him well in his retirement.

The Meeting closed at 12.15 p.m.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
AUDIT COMMITTEE
COMMITTEE ACTION LIST- updated 29.09.16

No.	Action required	Date to be completed	Responsible Officer	Comments	Completed
Meeting Date - 30 September 2015					
1.	A review to be submitted to a meeting of the Audit Committee in 6 months to enable Members to consider any additional cost implications associated with the system of internal financial control to the Audit Committee.	31 March 2016	Chief Financial Officer	To be submitted to the meeting of the Audit Committee on **15 June 2016** given committee deadline dates for March would not allow for 6 month period. Chief Internal auditor to provide verbal update. If position not satisfactory a report will be required. Update from 14.09.16 Audit Committee:- It is anticipated that the CFO and Chief Internal Auditor would be in a position to report on any additional cost implications associated with the system of internal financial control within a 3 month period.	
2.	Individual risk assessment reports to be submitted to future meetings of the Partnership Board, with particular reference having been made to Risk 3 – Failure to deliver efficiency savings and targets and operate within allocated budgets and Risk 4 – Failure to plan and adopt a balanced approach to manage additional unscheduled care pressures and business continuity challenges that are faced in winter.	Future meetings of Partnership Board when requested by Audit Committee	Chief Financial Officer/ Head of Strategy, Planning and Health Improvement	Work ongoing to review 2016/17 savings options for Health Care and 2016/17 Social Care savings options in place and delivering. Work well underway for 2017/18.	
3.	See completed action 4 below				**14 Sept 16**

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
AUDIT COMMITTEE
COMMITTEE ACTION LIST- updated 29.09.16

No.	Action required	Date to be completed	Responsible Officer	Comments	Completed
Meeting Date - 13 January 2016					
4.	See completed action 5 below				**14 Sept 16**
5.	Forthcoming Audit Scotland Report – Social Work in Scotland	Once final report on the national audit is published.	Head of Strategy, Planning and Health Improvement	Update will be provided once report is published	
6.	Audit Scotland Report on Health & Social Care Integration 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.	Future meeting	Head of Strategy, Planning and Health Improvement	Given the planned internal audit of integration arrangements that has already been confirmed, this would be best covered once that work has been completed and can be reported by the Chief Internal Auditor. This would enable the Audit Committee to have a more objective and rounded discussion.	
7.	Audit Scotland Report on Health & Social Care Integration That the Chief Internal Auditor use the relevant recommendations made by Audit Scotland within the 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.	Following first year of the H&SCP Board's establishment.	Chief Internal Auditor	Update to be provided at 14 September meeting.	

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
AUDIT COMMITTEE
COMMITTEE ACTION LIST- updated 29.09.16

No.	Action required	Date to be completed	Responsible Officer	Comments	Completed
Meeting Date - 23 March 2016					
8.	Equality Act 2010 Mainstreaming Report A report on the range of vulnerable and socio-economic groups as well as protected characteristics be provided to the next meeting of the Audit Committee to enable members to consider marginalised groups other than those required by the Equality Act 2010. Health Inequalities amongst different socio-economic groups Updated 14.09.16 – actions combined to form one report.	15 June 2016 Future meeting	Head of Strategy, Planning and Health Improvement	Since this discussion at Audit Committee, the Scottish Government has confirmed that it intends to publish a new national public health strategy, the scope of which is likely to consider such groups within the population. Officers anticipate that this Strategy will be published towards the end of 2016 - as such it would be logical to prepare a report that considers this action within the context of that Strategy when it is available. Officers will bring such a report to the earliest meeting of the Audit Committee possible. Soumen Sengupta will provide report to 7 December 2016 meeting to coincide with the publication of the new national public health strategy which is anticipated mid-autumn. See separate report on agenda.	
9.	National Care Standards – Overarching Principles That a Partnership response to the proposed consultation on the National Care Standards Review Development Group's work to develop a set of general and specialist standards linked to the	Future meeting	Head of Strategy, Planning and Health Improvement	The national consultation on the new care standards has not begun yet. As soon as it does, Officers will bring a draft response to the soonest H&SCP Board or Audit Committee meeting (depending on deadline). Updated from 14.09.16 – the Head of Strategy, Planning and Health	

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
AUDIT COMMITTEE
COMMITTEE ACTION LIST- updated 29.09.16

No.	Action required	Date to be completed	Responsible Officer	Comments	Completed
	principles would be submitted to a future meeting of the Partnership Board and or the Audit Committee depending on the timing of the 12 week consultation.			Improvement would provide a report to a future meeting with suggestions on responding to the consultation.	
Meeting Date – 15 June 2016					
10.	Merged with Item 8				
11.	Silver Swan – outcomes and recommendations relevant to IJBs from the recent national pandemic flu exercise	Future meeting	Head of Strategy, Planning and Health Improvement	No additional/specific actions from Silver Swan to report on at this point. Anything pertinent to the H&SCP Board/Audit Committee that emerges will be reported on if and when formally available.	
12.	See competed action 6				
Completed Actions					
1.	Financial costs associated with the external audit service provided by Audit Scotland to the Partnership to be confirmed and provided at a future meeting of the Audit Committee.	Future meeting	Chief Financial Officer	Included in Audit Scotland's Annual Audit Plan £17,100 This has been reported as a note in the Annual Accounts.	**15 June 2016**
2.	A presentation on the structure of business continuity planning would be provided at the next meeting of the Audit Committee on 23 March 2016 to ensure members are satisfied that there was rigorous continuity planning processes in place.	23 March 2016 (to be moved to 15 June 2016 to enable fuller report)	Head of Strategy, Planning and Health Improvement		**15 June 2016**

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
AUDIT COMMITTEE
COMMITTEE ACTION LIST- updated 29.09.16

No.	Action required	Date to be completed	Responsible Officer	Comments	Completed
3.	Minutes of Previous Meeting That the Action List would be included as a substantive item on future agendas.	14 September 2016 onwards	Committee Officer		**14 Sept 2016**
4.	All action plans submitted to the Care Inspectorate in response to inspection reports will be submitted to the Audit Committee for information following publication of Care Inspectorate reports.	Ongoing	Heads of Service responsible for inspection reporting	Council reports to be submitted as timeously as possible after being received.	**14 Sept 2016**
5.	Financial Governance update – national guidance would be sought from the Scottish Government on expense arrangements for members of the Partnership Board.	When received from Scottish Government	Chief Financial Officer	Any appropriate Board Member expenses are processed through appropriate partner	**14 Sept 2016**
6.	Audited Accounts	To be submitted to Audit Committee on 14 September 2016 and Partnership Board on 16 November 2016.	Chief Financial Officer		**14 Sept 2016**

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 7th December 2016

Subject: Audit Scotland Report on NHS in Scotland 2016

1. Purpose

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

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 Audit Scotland published its annual report on how the NHS in Scotland is performing in October 2016 and is appended here.

4. Main Issues

4.1 The report details the position for the NHS across Scotland as a whole and also provides information related to individual territorial NHS Health Boards, including NHS Greater Glasgow & Clyde. Key messages within the report of particular note are:

- That NHS funding is not keeping pace with increasing demand and the needs of an ageing population, with NHS boards having to make unprecedented levels of savings in 2016/17.
- That it is increasingly difficult to balance the demand for hospital care alongside providing more care in the community, as most spending is still on hospitals and other institutional-based care.
- The imperative for an ongoing discussion with the public about the way services will be provided in the future, with a significant cultural shift required in terms of how people access, use and receive services. The Scottish Government, NHS boards and integration authorities need to work with the public about the need for and benefits of change, and develop and agree options for providing services differently.

5. People Implications

5.1 With respect to the workforce considerations highlighted within the Audit Scotland report, Audit Committee members will recall that two key themes of the Health & Social Care Partnership's Workforce & Organisational Development Strategy are a "capable workforce" and a "sustainable workforce", with an update having been presented at the November 2016 meeting of the Partnership Board.

6. Financial Implications

6.1 With respect to the financial pressures highlighted within the Audit Scotland report, Audit Committee members will appreciate that the Chief Financial Officer has articulated the financial challenges that the Health & Social Care Partnership faces (and as recognised within the Strategic Plan 2016-19) within their regular budgetary reports to the Partnership Board.

7. Professional Implications

7.1 As noted in the report, the Chief Medical Officer's most recent annual report (on realistic medicine) and the National Clinical Strategy (which was presented to the Partnership Board at its May 2016 meeting) outline the need to reduce waste, harm and variation in treatment and clinical practice given the estimate that 20 percent of mainstream clinical practice brings no benefit to the patient.

8. Locality Implications

8.1 None associated with this report.

9. Risk Analysis

9.1 With respect to the issues pertaining to governance in the report, the Audit Committee will have been reassured by the positive report on Audit Scotland's Annual Audit Report and Accounts 2015/16 for West Dunbartonshire Health & Social Care Partnership Board that was presented by Audit Scotland at the September 2016 meeting.

9.2 Alongside the report, Audit Scotland has produced a checklist ostensibly for NHS Board non-executive directors, with the aim of promoting good practice, scrutiny and challenge in decision-making with respect to financial and service performance; and service reform (appendix 2). Whilst not all of the elements are directly transferable to integration authorities, Audit Committee members may find it useful to reflect upon the questions posed in respect of the totality of the Partnership Board's resources and arrangements for health and social care.

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 on-going implementation of the current Strategic Plan.

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

Date: 7th December 2016

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

Appendices: Audit Scotland: NHS in Scotland (October 2016)

Audit Scotland: NHS in Scotland - Checklist for NHS non-executive directors (October 2016)

Background Papers: HSCP Board (May 2016): WD HSCP Clinical Care Governance Report 2015/16 (May 2016)

Audit Committee: Annual Audit Report and Accounts 2015/16 (September 2016)

HSCP Board: Workforce & Organisational Development Support Plan Update (November 2016)

Realistic Medicine - Chief Medical Officer's Annual Report 2014-15:
http://www.gov.scot/Resource/0049/00492520.pdf

Wards Affected: All

NHS in Scotland 2016

AUDITOR GENERAL

Prepared by Audit Scotland
October 2016

Auditor General for Scotland

The Auditor General's role is to:

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

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

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

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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.

Contents

Links

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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

NHS Scotland key performance targets met at March 2016

1 out of 8

£12.2 billion

Total health budget in 2015/16

Increase in drug costs between 2012/13 and 2014/15

10 per cent

£291 million

Total savings reported by NHS boards in 2015/16

Number of outpatients waiting for an appointment at March 2015 and March 2016

254,911

275, 517

£492 million

Total savings planned by NHS boards in 2016/17

Summary

Key messages

1 Over the last decade, there have been improvements in the way health services are delivered and reductions in the time that patients need to wait for hospital inpatient treatment. There have also been improvements in overall health, life expectancy, patient safety and survival rates for a number of conditions, such as heart disease. At the same time, 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.

2 NHS funding is not keeping pace with increasing demand and the needs of an ageing population. NHS boards are facing an extremely challenging financial position and many had to use short-term measures to break even. NHS boards are facing increasing costs each year, for example drug costs increased by ten per cent, allowing for inflation, between 2012/13 and 2014/15. NHS boards will need to make unprecedented levels of savings in 2016/17 and there is a risk that some will not be able to achieve financial balance.

NHS boards are facing an extremely challenging financial position

3 Despite the significant financial challenges facing NHS boards, there have been improvements in some areas, for example in reducing the overall number of bed days from delayed discharges. However, boards are struggling to meet the majority of key national standards and the balance of care, in terms of spending, is still not changing. It is difficult balancing the demand for hospital care, alongside providing more care in the community. Boards need to ensure they maintain high-quality hospitals, while investing in more community-based facilities.

4 The NHS workforce is ageing and difficulties continue in recruiting and retaining staff in some geographical and specialty areas. Workforce planning is lacking for new models of care to deliver more community-based services. There is uncertainty about what these models will look like and the numbers and skills of the workforce required. NHS boards' spending on temporary staff is increasing and this is putting pressure on budgets.

5 The NHS is going through a period of major reform. A number of wide-ranging strategies propose significant change, including the National Clinical Strategy, integration of health and social care services and a new GP contract. These need to be underpinned by a clear plan for change. Some progress is being made in developing new models of care, but this has yet to translate to widespread change in local areas and major health inequalities remain.

Recommendations

The Scottish Government should:

- provide a clear written plan for implementing the 2020 Vision and National Clinical Strategy, including:
  - immediate and longer-term priorities, including a public health strategy to help NHS boards focus on preventing ill health and tackle health inequalities
  - support for new ways of working and learning at a national level
  - long-term funding plans for implementing the policies
  - a workforce plan outlining the workforce required, and how it will be developed
  - ongoing discussion with the public about the way services will be provided in the future to manage expectations (paragraphs 88-92)
- set measures of success by which progress in delivering its national strategies can be monitored, including its overall aim to shift from hospital to more community-based care. These should link with the review of national targets and align with the outcomes and indicators for health and social care integration (paragraph 69)
- consider providing NHS boards with more financial flexibility, such as three-year rolling budgets rather than annual financial targets, to allow better longer-term planning (paragraphs 13-19).

The Scottish Government, in partnership with NHS boards and integration authorities, should:

- model the cost of implementing its National Clinical Strategy and how this will be funded, including the capital investment required (paragraph 93)
- share good practice about health and social care integration, including effective governance arrangements, budget-setting, and strategic and workforce planning (paragraphs 81-85)
- in line with the national policy on realistic medicine:
  - work to reduce over-investigation and variation in treatment
  - ensure patients are involved in making decisions and receive better information about potential treatments (paragraph 87).

NHS boards, in partnership with integration authorities, should:

- take ownership of changing and improving services in their local area, working with all relevant partner organisations (paragraph 96)

- develop long-term workforce plans (more than five years) to address problems with recruitment, retention and succession planning and to ensure high quality of care (paragraphs 94-95)

- work with the public about the need for change in how they access, use and receive services and to take more responsibility for looking after their own health and managing their long-term conditions (paragraph 33).

Background

1. The NHS in Scotland provides a range of vital services across the country to thousands of people every day, often in partnership with other bodies. Increasing costs and growing demand for services, combined with continuing pressures on public finances, mean the NHS continues to face significant challenges in delivering its services. The NHS is going through a period of major reform. The Scottish Government has an overarching policy to provide integrated health and social care, with a focus on prevention, anticipation and supported self-management. A number of wide-ranging strategies are proposing significant change, including the National Clinical Strategy, integration of health and social care services and a new GP contract. New integration authorities have been in place since April 2016. They manage more than £8 billion of resources that NHS boards and councils previously managed separately.

About this audit

2. This is our annual report on how the NHS in Scotland is performing. The overall aim of the audit was to answer the question: How well is the NHS in Scotland performing and is it equipped to deal with the challenges ahead?

The specific audit questions were:

- How well did the NHS manage its finances and performance in 2015/16?

- Is the NHS in Scotland equipped to deal with the financial challenges in 2016/17 and beyond?

- Is the NHS making good progress towards implementing public service reform?

3. The report has two parts:

- Part 1 Financial and service performance

- Part 2 Service reform.

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

- the audited annual accounts and auditors' reports on the 2015/16 audits of the 23 NHS boards

- NHS boards' Local Delivery Plans (LDPs), which set out how boards intend to deliver services to meet performance indicators and targets, as well as indicative spending plans for the next three to five years
- monthly Financial Performance Returns (FPRs) that each NHS board submits to the Scottish Government throughout the year
- activity and performance data published by Information Services Division (ISD), part of NHS National Services Scotland
- interviews with senior staff in the Scottish Government and a sample of NHS boards.

5. We reviewed service performance information at a national and board level. Our aim was to present the national picture and highlight any significant variances between boards. We focused on a sample of key targets and standards, covering some of the main activities of the NHS. Where we have used trend information, we have selected a time period where information is most comparable. Information about the financial performance of NHS boards is included in the Appendix.

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

Part 1

Financial and service performance

Key messages

1 In 2015/16, the total health budget was £12.2 billion, 40 per cent of the Scottish Government's budget. Although the budget increased by 2.7 per cent in real terms from the previous year, it is not keeping up with growing demand and the needs of an ageing population. In addition, NHS boards continue to face increasing pressures from rising staff and drug costs.

2 Many NHS boards struggled to achieve financial balance in 2015/16 and many had to use short-term measures to break even. Boards found it difficult to achieve the savings required and this will be even more challenging in 2016/17.

3 NHS boards need to look at reorganising acute services to free up more resources for investing in community-based facilities, but they are often faced with considerable public and political resistance to proposed changes to local services. Along with the Scottish Government, they need to engage with the public about the need for and benefits of changing how services are provided.

4 NHS boards continue to find it difficult to meet key national performance targets. Overall NHS Scotland failed to meet seven out of eight key targets. The only standard met nationally was the drug and alcohol treatment standard. The cancer 31 days referral to treatment standard was just missed by 0.1 per cent.

NHS spending is not keeping pace with the growing and ageing population, increasing demand and rising costs

Although health spending has increased it is not keeping up with growing demand and the needs of an ageing population

7. The Scottish Government is responsible for managing the overall health budget and allocating budgets to individual boards. Our NHS in Scotland 2014 supplement provides a summary of how health budgets are managed. In 2015/16, the total health budget for spending on core services, known as the departmental expenditure limit (DEL), was £12.2 billion. This accounts for 40 per cent of the Scottish Government's budget (£30.1 billion).[1] The Scottish Government allocated:

- £10.4 billion to the 14 territorial NHS boards that serve each area of Scotland and deliver frontline healthcare services

- £1.3 billion to Healthcare Improvement Scotland, the Mental Welfare Commission and the seven special NHS boards that provide specialist and national services (for example, the Scottish Ambulance Service and NHS 24)

- £0.5 billion to national programmes, such as immunisations, health and social care integration, health improvement and health inequalities.

8. Between 2008/09 and 2015/16, the total health budget increased by 16 per cent in cash terms. Taking into account inflation, the real-terms increase was five per cent.[2] In 2015/16, the health budget increased by 2.7 per cent in real terms from the previous year. This includes a:

- 3.2 per cent increase in the revenue budget (for meeting day-to-day expenses, such as staff costs, medical supplies, rent and maintenance)

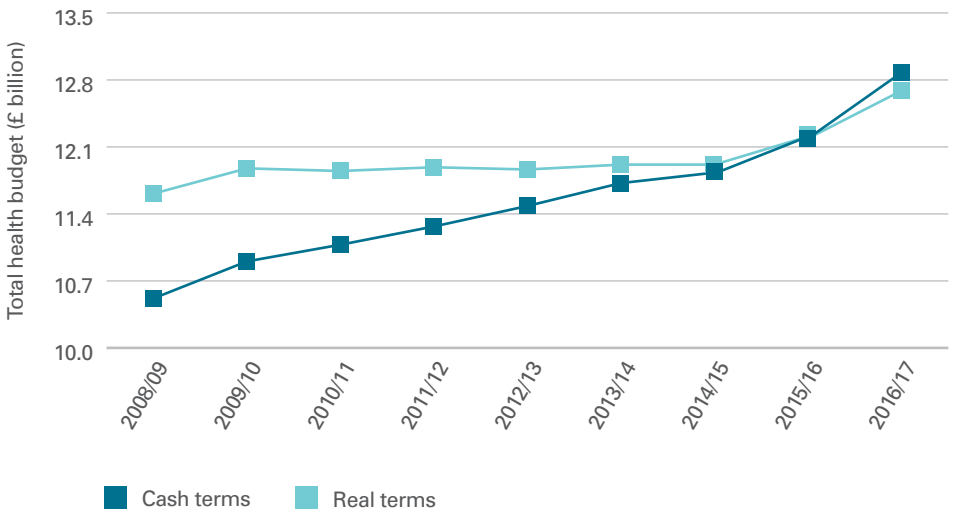
- 20.3 per cent decrease in the capital budget (for developing long-term assets, such as buildings or major IT programmes).

9. Following the economic recession in 2008/09, available public money has reduced overall. Between 2010/11 and 2014/15, the annual percentage change in the total health budget has been less than one per cent and below the UK inflation rate. Health inflation is generally higher and is estimated to be 3.1 per cent in 2016/17.[3] Although the total health budget increased recently, this was preceded by much smaller increases and some decreases (Exhibit 1). The overall trends in revenue and capital expenditure are quite different. Between 2008/09

Exhibit 1

Trend in the health budget in Scotland, 2008/09 to 2015/16, and draft budget figures for 2016/17

Since 2008/09, the health budget has increased in cash terms and had small real-terms increases and decreases each year.



Note: Figures include both the revenue and capital DEL budgets.

Source: Scottish Government

and 2015/16, the revenue budget increased by 8.6 per cent while the capital budget decreased by 64.7 per cent.

10. Despite the recent real-terms increase in the revenue budget, NHS spending is not keeping pace with the growing and ageing population, increasing demand and rising costs. Spending on drugs increased by over ten per cent between 2012/13 and 2014/15 and the Scottish Government predicts that drugs spending will continue to rise by five to ten per cent each year (paragraph 37-38, page 18). The number of emergency admissions increased by six per cent and the associated costs increased by five per cent (between 2010/11 and 2013/14).[4] Since 2008/09, although the real-terms increase in the total health budget was five per cent:

- the budget per head of population only increased by 1.6 per cent
- the population aged 75 and over increased by 11.8 per cent
- the number of patients waiting for an inpatient or day case appointment increased by 5.6 per cent and the number waiting for an outpatient appointment increased by 89 per cent.[5,6]

11. The Scottish Government forecasts that the overall health budget for 2016/17 will increase by 5.6 per cent to £12.9 billion in cash terms. This includes a smaller increase in the revenue budget compared to 2015/16 (1.8 per cent in real terms). The Scottish Government has ring-fenced just under two per cent of the health budget for 2016/17 (£250 million) for health and social care integration. This funding is to be transferred to integration authorities to support additional spending on social care aimed at improving outcomes in social care. The remaining £12.6 billion of the NHS budget equates to a 0.3 per cent real-terms reduction in the revenue budget and a 2.1 per cent real-terms increase in the total budget. In 2016/17, the Scottish Government has reduced some of the funding allocations to territorial NHS boards. For example:

- Funding for Alcohol and Drug Partnerships has reduced by 22 per cent in cash terms, from £69.2 million in 2015/16 to £53.8 million in 2016/17. However, NHS boards are expected to maintain existing services, resources and outcomes at 2015/16 levels. A further £1.5 million is being provided centrally for developing alcohol and drug treatment services.
- Eleven funding streams have been combined into one single source of funding of £161.2 million. An efficiency saving of 7.5 per cent has been applied to the overall fund in 2016/17, which boards are expected to manage locally. This funding is part of an overall outcomes framework that aims to provide boards with more local flexibility on decisions about the funding. It focuses on prevention and reducing health inequalities, including dental services, infant nutrition and maternity services.

12. The capital budget is set to more than double, from £202.5 million in 2015/16 to £494.5 million in 2016/17. The increase is mainly to fund a £215 million investment in four new facilities. These are: the Royal Hospital for Sick Children and Department of Clinical Neurosciences in Edinburgh; the Dumfries and Galloway Royal Infirmary; the Scottish National Blood Transfusion Service Centre; and a new hospital in Orkney. The Scottish Government expects to reduce the capital budget again after 2016/17.

NHS boards struggled to achieve financial balance in 2015/16

13. To meet Scottish Government annual financial targets, NHS boards must end the financial year with at least a break-even position. This means they must spend no more than the limits of their revenue and capital budgets. All boards ended 2015/16 within their final revenue and capital limits.

14. After spending more than planned for every month during the year, the NHS in Scotland had an overall surplus of £4.5 million against its revenue budget of £10.9 billion (0.04 per cent) at the end of March 2016. This was a turnaround from having spent £12 million more than planned at February 2016. All boards reported at least a balanced revenue position (break-even or surplus), with surpluses ranging up to £0.7 million. There was an overall surplus for the NHS in Scotland of £0.4 million against the final capital budget of £329 million. All boards reported at least a balanced capital position, with surpluses ranging up to £0.147 million.[7]

15. The break-even position was achieved in a number of ways. For example, NHS Tayside required a loan from the Scottish Government (known as brokerage) of £5 million. This was on top of brokerage of £15 million received in previous years that the board was not able to repay. The board and the Scottish Government are discussing a revised timescale for repaying the total £20 million brokerage. NHS 24 was also unable to repay brokerage in 2015/16. At the start of 2015/16, the board repaid £0.79 million of a total £20.36 million brokerage received in previous years, but this was returned by the Scottish Government later in the financial year. NHS 24 was due to repay its outstanding brokerage by 2019/20. It has now agreed with the Scottish Government that it will not make any repayment in 2016/17. Instead repayments will recommence in 2017/18 and be made over a five-year period up to 2021/22. We have prepared separate reports on the 2015/16 audits of NHS Tayside and NHS 24.[8]

16. Three other boards that received brokerage in previous years are due to conclude repayment in 2016/17. The boards and amounts due to be repaid are NHS Highland (£1 million), NHS Orkney (£1.06 million) and NHS Western Isles (£0.54 million). The need for small amounts of brokerage highlights that NHS boards are facing real challenges in managing their budgets. Repaying brokerage reduces the amount boards have available to spend in future years.

17. There is evidence of boards increasingly using short-term approaches to meet the annual financial targets in 2015/16. Some boards only managed to achieve financial balance through one-off measures. In NHS Ayrshire and Arran, the auditors identified a prepayment for the cost of public holidays of over £1 million that was contrary to proper accounting practice. This involved the board moving costs from 2015/16 into 2016/17 to achieve financial balance. The auditor concluded that this was not an acceptable approach by the board to achieve its financial targets and the board corrected the accounting treatment.[9]

18. Other approaches that enabled boards to break even in 2015/16 include:

- additional funding allocations from the Scottish Government late in the financial year or after the year-end
- making savings by delaying or under-spending on services or capital projects
- transferring capital funding to revenue funding to allow it to be used to cover increasing operational costs

- reclassifying core funding as non-core to release additional funding for operational costs (non-core funding is provided to boards for unpredictable costs such as capital and pension accounting adjustments)

- other approaches, such as one-off benefits from rates and VAT.

19. These short-term approaches, and the significant amounts (up to £17 million) involved in some cases, illustrate how much pressure NHS boards' budgets were under in 2015/16 and into 2016/17. These approaches are unsustainable and make it difficult for boards to plan and invest in longer-term policy aims, such as developing more community-based services and treating people in homely settings.

20. A new sustainability and value programme board, jointly chaired by the chief executive of NHS Dumfries and Galloway and the Scottish Government's Director of Health Finance, was set up in September 2016. It is overseeing four work streams that will focus on delivering efficiencies. The aim is to make efficiency savings of up to two per cent over the next three years. The four areas are:

- Clinical transformation: improving theatre and outpatient productivity and eliminating unwarranted clinical variation.

- Effective prescribing: minimising harm, waste and unwarranted variation in prescribing.

- NHS workforce: improving recruitment and retention of the workforce and reducing locum and agency staff costs.

- Shared services: identifying opportunities for shared use of buildings and facilities and improving procurement of services.

Some boards are still below their target funding allocation

21. Since 2009/10, the Scottish Government has used a formula developed by the National Resource Allocation Committee (NRAC) to allocate most of territorial boards' budgets. The formula is based on the number of people living in each board area and adjusted to reflect age and gender within the local population. It is also adjusted for additional needs based on local circumstances such as geography, sickness and deprivation levels. When the formula was introduced, some boards' allocations were considerably below the amount proposed by the formula. Territorial boards receive an increase in funding each year and boards below their target allocation have received additional funding to gradually bring them closer to it. The Scottish Government made a commitment that all boards would be within one per cent of the target allocations by 2016/17. However, initial funding allocations provided to NHS boards for 2016/17 (excluding the £250 million for integration) indicate that four boards are still more than one per cent under their target allocation:

- NHS Grampian: 1.4 per cent below target (£12.2 million)

- NHS Highland: 1.5 per cent below target (£8.5 million)

- NHS Lanarkshire: 1.5 per cent below target (£15.9 million)

- NHS Lothian: 1.5 per cent below target (£18.8 million).

22. While these amounts are relatively small in terms of the overall budgets for each NHS board, all four of these boards are finding it challenging to meet key performance targets and have seen large increases in spending on temporary staff. NHS Lothian subsequently received a further £6 million and NHS Lanarkshire further £2 million of recurring funding from the Scottish Government in 2016/17. This was to bring the two boards closer to their target allocations and help them deliver their financial and performance targets. Three other boards that have previously received less than their target allocations are now within one per cent: NHS Fife (0.2 per cent below target), NHS Forth Valley (1.0 per cent below) and NHS Shetland (0.9 per cent below). The remaining territorial boards have received more than their target allocations (up to 9.4 per cent more in NHS Western Isles).

NHS boards found it difficult to achieve the savings required in 2015/16 and this will be even more challenging in 2016/17

23. At March 2016, boards reported overall savings of £291.3 million, which was £1.8 million (0.6 per cent) less than the target savings of £293.1 million stated in their local delivery plans (LDPs). Special boards exceeded their target by 25 per cent, while territorial boards were three per cent behind. Three territorial boards missed their savings targets: NHS Lothian (by 17 per cent), NHS Tayside (by 13 per cent) and NHS Western Isles (by one per cent). Boards retain the savings they make for reinvestment in local services.

24. Recurring savings are savings that, once achieved, recur year-on-year from that date, for example savings on costs as a result of streamlining services. Non-recurring savings are one-off savings that apply to one financial year, and do not result in ongoing (recurring) savings in future years, for example not filling a vacancy on a temporary basis. Identifying new recurring savings becomes more difficult for NHS boards each year. Boards that make high levels of non-recurring savings will have to find further savings in future years. Non-recurring savings are typically short-term decisions rather than initiatives to change the way services are provided.

25. In 2015/16, five territorial boards and one special board achieved around 60 per cent of their planned savings through non-recurring means (NHS Borders, Fife, Highland, Shetland and Tayside and The State Hospital). Only three boards (Healthcare Improvement Scotland the National Waiting Times Centre Board and NHS Forth Valley) were successful in achieving more recurring savings than they had planned in their LDP. Overall non-recurring savings were 32 per cent of total savings (compared to 25 per cent in 2014/15).

26. Boards are setting higher savings targets, from an average of three per cent in 2015/16 to an average of 4.8 per cent in 2016/17. Some boards are reporting that they will need to make unprecedented levels of savings in 2016/17, up to around eight per cent in NHS Shetland and NHS Tayside. The total savings that boards are aiming to make has increased by 65 per cent in real terms, from £293 million in 2015/16 to £484 million in 2016/17 (£492 million in cash terms). This is by far the largest annual percentage increase in the savings target over the last four years. Case study 1 (page 15) illustrates the level of savings NHS Lothian needs to make to break even in 2016/17. The percentage of savings that NHS boards have classified as at high risk of not being achieved increased from nine per cent in 2013/14 to 14 per cent for 2016/17. Seventeen per cent of savings had yet to be identified by boards, and boards estimated that 30.5 per cent of savings will be non-

recurring (these are both higher compared to previous years) (Exhibit 2, page 16). This will put considerable pressure on boards during 2016/17 and there is a significant risk that some boards will not be able to remain within their budgets.

NHS boards need to balance maintaining high-quality hospitals with increasing investment in community-based care

27. NHS boards need to manage their hospital and community buildings and other assets, such as medical equipment, to ensure patients receive high-quality care. This includes:

- investing capital funding in new assets in line with national policy and local requirements
- maintaining and modernising current assets to ensure they are of a good standard, fit for purpose and used efficiently
- disposing of assets that are no longer fit for purpose or not required.

28. The NHS owns physical assets worth around £6.3 billion. This includes an estate of land and buildings of £5.7 billion. The remaining £0.6 billion relates to medical equipment, IT equipment and vehicles. Because of their significant value, it is important for NHS boards to manage assets well. In 2015/16, NHS Shetland was unable to locate over four per cent of its assets included in its fixed asset register. The total cost of assets which could not be located was £1.4 million (the value of these was £48,000 allowing for depreciation). The auditor's overall conclusion was that adequate accounting records had not been kept in relation to elements of property, plant and equipment assets.[10]

Case study 1

NHS Lothian's financial position in 2016/17 and level of savings required to break even

NHS Lothian identified a gap of £20.1 million in its budget for 2016/17. It received a further £6 million from the Scottish Government to bring it closer to its target NRAC position. To break even in 2016/17, the board needs to deliver £73.1 million of savings; at July 2016, it had still to identify £14.9 million of these. It carried over unmet efficiency savings from previous years of around £13 million. At 31 July 2016, NHS Lothian had overspent against its revenue budget by £7.1 million, mainly driven by over-spending on pay and prescribing. NHS Lothian has a financial recovery plan in place and is closely monitoring its financial position, which has been reported clearly to its Board. A new clinical quality approach is being led by a Quality Director to improve patient care and efficiency. This includes identifying and reducing unwarranted variation and cost across specialties.

Source: NHS Lothian Board papers for meeting on 3 August 2016, NHS Lothian Finance and Resources Committee, Quarter One Financial Review and Financial Position to July 2016, 14 September 2016. NHS Lothian Local Delivery Plan 2016/17

Exhibit 2

Percentage of planned non-recurring, unidentified and high-risk savings by NHS board, for 2016/17

Across many boards, a significant proportion of planned savings for 2016/17 are non-recurring, at risk of not being achieved or still to be identified.

	Total savings as % baseline resource funding	Of the total planned savings: % non-recurring	% unidentified	% high risk
Territorial boards				
Ayrshire and Arran	3.7%	0.0%	27.4%	9.7%
Borders	5.9%	33.0%	0.0%	54.8%
Dumfries and Galloway	4.6%	45.1%	11.0%	28.4%
Fife	5.1%	42.2%	33.0%	44.2%
Forth Valley	5.5%	0.0%	7.9%	26.6%
Grampian	3.0%	55.4%	28.0%	20.9%
Greater Glasgow and Clyde	5.0%	24.5%	24.5%	8.3%
Highland	5.0%	10.4%	8.0%	13.7%
Lanarkshire	4.1%	15.5%	8.8%	22.1%
Lothian	5.6%	45.2%	20.4%	0.0%
Orkney	5.1%	27.4%	4.0%	15.4%
Shetland	8.7%	37.7%	0.0%	20.6%
Tayside	8.4%	60.0%	10.2%	12.1%
Western Isles	5.9%	38.8%	18.3%	11.5%
Special boards				
National Waiting Times Centre	8.5%	0.0%	0.0%	11.4%
NHS 24	5.1%	2.3%	7.8%	0.0%
NHS Education for Scotland	0.5%	15.9%	15.0%	0.0%
NHS Health Scotland	5.3%	8.8%	6.3%	0.0%
NHS National Services Scotland	5.1%	0.0%	0.0%	3.2%
Healthcare Improvement Scotland	11.3%	17.2%	0.0%	0.0%
Scottish Ambulance Service	4.4%	33.3%	0.0%	0.0%
The State Hospital	5.2%	72.2%	0.0%	0.0%
All territorial boards	**5.0%**	**31.9%**	**18.0%**	**15.4%**
All special boards	**3.5%**	**13.9%**	**1.7%**	**2.4%**
All boards	**4.8%**	**30.5%**	**16.7%**	**14.4%**
Key				
High	>5%	>50%	>20%	>20%
Medium	3-5%	20-50%	1-20%	3-20%
Low	<3%	<20%	<1%	<3%

Notes:
1. Total savings as a percentage of baseline resource funding was calculated using baseline funding allocations that include £250 million funding for health and social care integration.
2. The Mental Welfare Commission for Scotland does not provide savings figures.
3. The key is based on Audit Scotland's assessment of the level of savings in each category.

Source: Audit Scotland using information from NHS boards' Local Delivery Plans, June 2016

29. The Scottish Government's latest annual review of NHS assets (for 2015) shows a number of improvements overall in the management and physical condition of property assets, but this varies considerably by board:[11]

- Overall 79 per cent are less than 50 years old (compared to 75 per cent in 2014). More than 60 per cent of properties are 30 years and older in four NHS boards (NHS Ayrshire and Arran, Dumfries and Galloway, Tayside and Shetland). In NHS Shetland, 47 per cent of properties are over 50 years old.

- 66 per cent are in good condition (compared to 59 per cent in 2014), with 29 per cent requiring investment to improve their condition. The remaining five per cent are in an unsatisfactory condition and require major investment or replacement. In NHS Ayrshire and Arran, Highland and Orkney, more than 50 per cent of buildings require some level of investment to improve their condition (including Balfour Hospital in NHS Orkney which is being replaced).

- 81 per cent are fully utilised (compared to 77 per cent in 2014). NHS Ayrshire and Arran and NHS Dumfries and Galloway have high levels of overcrowded properties (24 and 30 per cent). NHS Highland and NHS Orkney have high levels of under-used properties (59 and 40 per cent). Both of these boards face challenges in providing critical healthcare facilities in locations with relatively low levels of population. In four boards, over five per cent of properties were empty (NHS Dumfries and Galloway, Fife, Grampian and Tayside). These boards have plans to sell unused properties over the next five years.

30. In 2015, the outstanding maintenance required to keep the NHS estate across Scotland up to a good standard amounted to £898 million. This is £101 million (13 per cent) more than in 2014.[12] High-risk and significant maintenance requirements reduced to 44 per cent overall in 2015, compared to 47 per cent in 2014. However, in some boards it increased, particularly in NHS Dumfries and Galloway, Greater Glasgow and Clyde, and Tayside. In five boards, the level of high-risk and significant backlog maintenance is over 50 per cent (NHS Dumfries and Galloway, Greater Glasgow and Clyde, Lothian, Tayside and Shetland). Most of these boards have new properties recently completed or under way and are rationalising their property portfolios.

31. Based on NHS boards' property and asset management strategies, and depending on approval and availability of funding, around £2.8 billion investment in assets is planned over the next five years. This relates to property, medical equipment, IT equipment and vehicles and will combine capital and revenue funding. Of the total of £1.1 billion planned for investment in major projects, the majority of this is for new hospitals (70 per cent).[13] A further £290 million is planned for new primary and community care projects for new models of care, to help deliver the Scottish Government's overarching health and social care policy which aims to provide more care in community-based and homely settings.

32. NHS boards need to balance maintaining high-quality hospitals with increasing investment into community-based care. A clear national strategy is required for capital investment that will support a shift in the balance of care. Boards can use revenue funding for major projects, rather than capital funding, to spread costs over a long period of time, such as non-profit distributing (NPD) projects. However, revenue budgets are under increasing pressure.

33. The National Clinical Strategy recommends that more specialist care should be provided on a regional or national basis. The capital budget has reduced significantly over recent years and the Scottish Government is providing limited additional funding for transforming services. NHS boards need to change the NHS estate to allow investment for new services. This includes reorganising acute services to free up more resources for investing in community-based facilities. This is happening to some extent, but boards can face considerable public and political resistance to proposed changes to local services. It is important that the Scottish Government has an ongoing discussion with the public about the way services will be provided in the future and manages expectations. A significant cultural shift is needed in terms of how people access, use and receive services. The Scottish Government, NHS boards and integration authorities need to work with the public about the need for and benefits of change, and develop and agree options for providing services differently.

NHS boards continue to face increasing cost pressures

34. The NHS is facing continuing pressure from increasing demand for services and a growing, ageing population, as we have highlighted in previous reports. The number of frail, elderly people is growing more rapidly than the rest of the population. People are living longer with multiple long-term conditions and increasingly complex needs. Overall, healthy life expectancy (the number of years people might live in good health) has improved. But significant health inequalities still exist and people living in the most deprived areas of Scotland have a much lower healthy life expectancy. The number of people being admitted to hospital in an emergency is increasing and GP practices are seeing increasing demand for their services.[14]

35. Other cost pressures include drug costs, salaries and wages, other staff costs, achieving national waiting time targets, and new technologies. In real terms, since 2010/11:

- total NHS staff costs have increased by 6.4 per cent to £6.2 billion in 2015/16
- NHS spending on national insurance has increased by 3.4 per cent, from £386 million to £399 million in 2015/16 (an increase of 2.2 per cent since 2014/15 from £390 million)
- total NHS spending on pensions increased by 18.6 per cent, from £550 million to £652 million in 2015/16 (an increase of 12 per cent since 2014/15 from £582 million).

36. Most NHS boards overspent on their acute budgets by a considerable amount in 2015/16. For example, NHS Ayrshire and Arran overspent on its acute budget by £8.5 million (3.2 per cent) and NHS Grampian overspent by £14.3 million (3.6 per cent).

Rising spending on drugs is a major pressure

37. Territorial NHS boards highlight spending on drugs, in both hospitals and the community, as a significant cost pressure.[15] The NHS in Scotland's total spending on drugs increased steadily between 2004/05 and 2011/12. Since decreasing by

a small amount in 2012/13, spending has been rising at a higher rate Exhibit 3 (page 20). The NHS spent £150 million more on drugs in 2014/15 than in 2012/13, after adjusting for inflation.[16,17] This is an increase of over ten per cent. In 2014/15, three times more was spent on drugs in the community (£1.2 billion) than on hospital drugs (£388 million). In 2015/16, examples of the main drugs prescribed in terms of volume and cost were:

- omeprazole, prescribed for reducing stomach acid. This was the most commonly dispensed drug in the community (3.6 million items at a cost of £11.7 million)
- inhalers that contain salmeterol with fluticasone propionate, prescribed for respiratory conditions such as asthma. This drug had the highest total cost in the community (£35.5 million)
- adalimumab, used to treat inflammatory conditions including arthritis, Crohn's disease and psoriasis. This accounted for the highest spending in hospitals on one drug (£32.5 million)
- paracetamol, ibuprofen and antihistamines; common drugs also available to buy over the counter. In total, over 4.3 million of these three drugs were dispensed at a cost of around £17 million.[18] Over the last ten years, the quantity dispensed has increased by two-thirds. This is double that of the increase in quantity of all drugs dispensed in the community.

38. Between 2012/13 and 2014/15, spending on drugs in the community rose by nearly eight per cent in real terms, while spending on drugs in hospitals increased by 20 per cent (Exhibit 3, page 20). The Scottish Government is predicting that overall spending on drugs will continue to rise by five to ten per cent each year.[19]

39. NHS boards in Scotland have been successful in increasing the prescribing of unbranded medicines rather than branded medicines to generate efficiencies.[20] This is known as generic prescribing. Scotland, along with the rest of the UK, has one of the highest generic prescribing rates in the world.[21] Generic prescribing rates have risen slowly and steadily over the last ten years and reached 83.6 per cent in 2015/16. Our 2013 report on GP prescribing found that most of the potential savings from switching to generic drugs have already been made.[22]

Spending on drugs is rising because of increases in demand and cost

40. NHS spending on drugs has increased in recent years owing to:

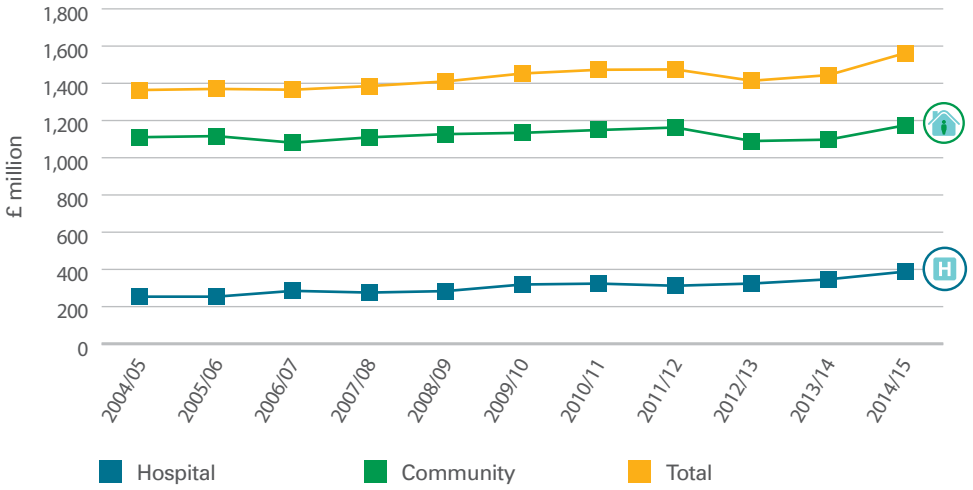
- more drugs being dispensed
- rising costs of many existing drugs
- new drugs becoming available.

41. The quantity of drugs dispensed in the community increased by almost a third between 2006/07 and 2015/16.[23] Reasons for this include an ageing population, more people living with long-term conditions and the increased use by GPs of evidence-based guidelines that recommend drugs to treat certain conditions. For example, statins (drugs to lower people's cholesterol level) are routinely prescribed for patients with heart disease.[24]

Exhibit 3

Spending on drugs by NHS boards in Scotland, in real terms, 2004/05 to 2014/15

Spending on drugs in the community has been rising since 2012/13. Between 2004/05 and 2014/15, spending on drugs in hospitals increased by 53 per cent.



Source: Cost book – drugs, ISD Scotland, November 2015

42. The cost of existing drugs has increased for a number of reasons:

- Increasing global demand for drugs has led to higher prices. Global pharmaceutical sales are projected to increase by an average of 6.9 per cent each year between 2014 and 2018.[25]

- There has been a global shortage of some drugs, caused either by rising demand or by manufacturing problems. This has resulted in prices rising or patients being prescribed more expensive alternatives.

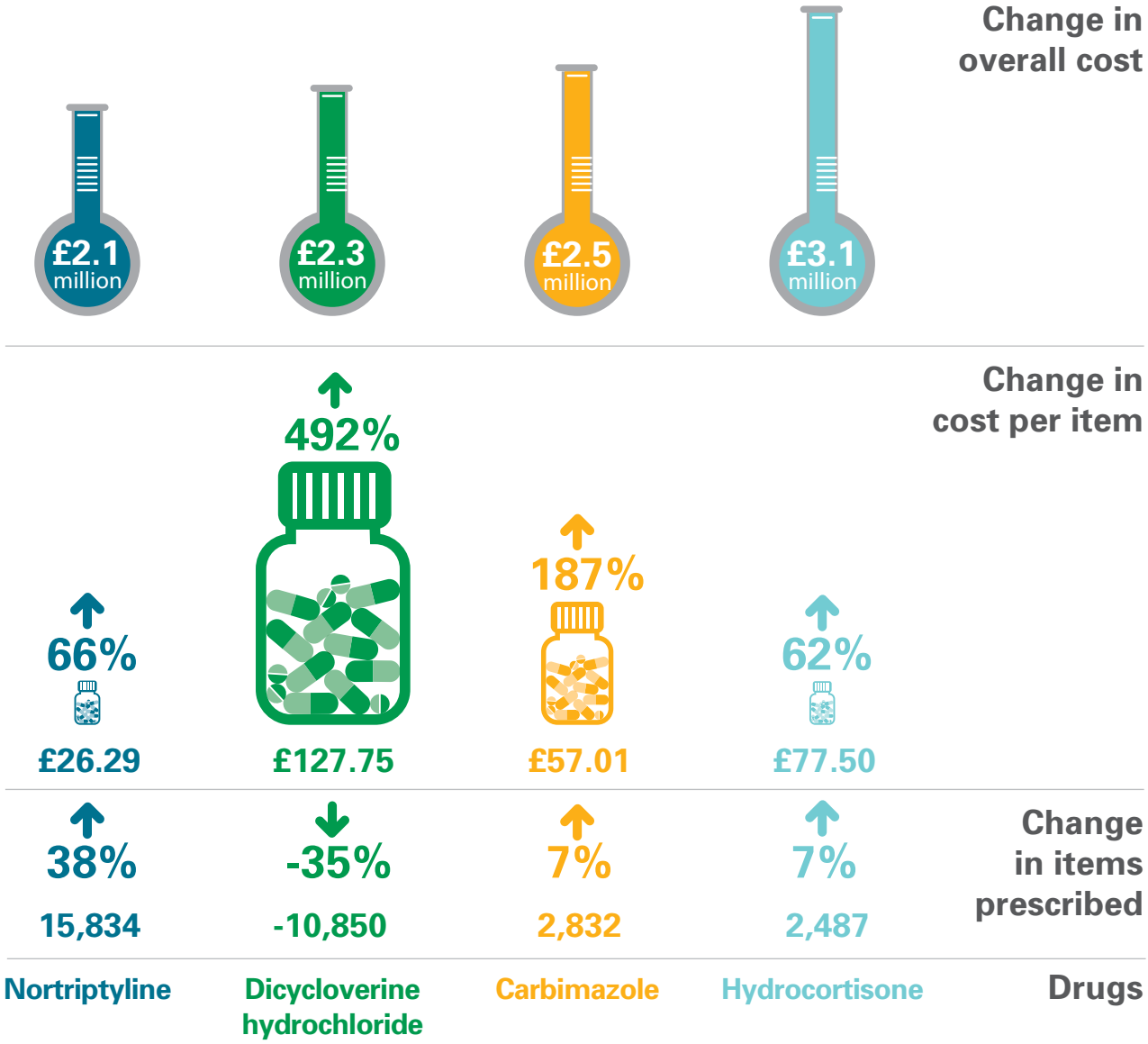
- Some pharmaceutical companies have sold the rights to a small, but significant, number of branded drugs to other companies that then sell them on under their generic name at a much higher price.[26] These tend to be drugs that do not have a big market and have few, if any, alternatives. In many cases it is unsafe or difficult to switch patients away from these drugs and NHS boards have no choice but to pay the higher price. Exhibit 4 (page 21) illustrates the financial impact of this practice on the NHS between 2013/14 and 2015/16. For example, prescribing of dicycloverine hydrochloride (a drug commonly used for irritable bowel syndrome) fell by a third but the overall cost to the NHS rose by nearly 300 per cent (£2.3 million) because of an increase in price of nearly 500 per cent.[27]

43. It can be difficult for NHS boards to predict these types of price increases as there is often little warning of which drugs will be affected. However, the UK Government has made progress in controlling excessively high prices of some unbranded medicines. The UK-wide Health Service Medical Supplies (Costs)

Exhibit 4

Examples of cost increases in four branded drugs sold under their generic name, 2013/14 to 2015/16

Four branded drugs that were sold under their generic name cost the NHS over £10 million (128 per cent) more in 2015/16 than in 2013/14. Over this period, overall demand for these drugs rose by seven per cent while prices rose by between 62 and 492 per cent.



Source: Drugs analysis provided to Audit Scotland by ISD, July 2016

Bill, introduced in September 2016, intends to limit the price of unbranded medicines where competition in the market fails and companies charge the NHS unreasonably high prices. The Bill is expected to be enacted in spring 2017.[28]

New drugs are a cost pressure for NHS boards

44. The Scottish Medicines Consortium (SMC) is the body that assesses new medicines for use in Scotland. The SMC analyses information supplied by the

medicine manufacturer on the health benefits of the medicine and justification of its price. The introduction of new approaches by the SMC, including an appeals process involving patients and clinicians, has increased access to new high-cost drugs.[29] Between May 2014 and March 2016, the SMC approved 75 per cent of medicines (for treating very rare and rare conditions and for use at end of life). This compares to 48 per cent of medicines approved by the SMC between 2011 and 2013 (for cancer medicines and those for treating rare conditions).

45. Access to some of these new drugs can be life-changing for patients and their families. Advances in research mean that more treatments are becoming available for rare conditions that previously had no or little treatment options. The SMC assesses the effectiveness of new drugs, but not affordability. This means that NHS boards have to fund an increasing number of very high-cost drugs. This has a significant impact on boards' budgets. For example, in 2015/16, the cost of drugs to treat:

- cardiovascular disease increased by nearly £14 million compared to 2013/14 as a result of the introduction of new anticoagulant drugs[30]
- hepatitis C was £50 million compared to £32 million in 2014/15, an increase of over 50 per cent (Case study 2, page 23).[31]

46. The Scottish Government has commissioned a review to consider how the changes made to the SMC process in 2014 have improved patient access to medicines for rare and end-of-life conditions. It will also look more broadly at how the whole system for getting patients access to newly licensed drugs safely and quickly is working. The review is due to report in late 2016. The SMC also provides early intelligence to NHS boards on new medicines in development through an annual horizon-scanning report with the aim of improving boards' financial planning.[32]

47. The Scottish Government has provided additional funding for new drugs through the New Medicines Fund (NMF). NHS boards received £21.5 million from the NMF in 2014/15, and £85 million in 2015/16. The NMF provides additional funding to NHS boards to cover costs incurred for increasing patient access to treatments for very rare conditions and end-of-life medicines. It does not cover the cost of high-cost new drugs, such as those to treat hepatitis C, or other new treatments for more common conditions. The Scottish Government has yet to advise boards of the total amount of additional funding available from the NMF in 2016/17.[33] If the NMF reduces in 2016/17, this will place further pressure on boards' drugs budgets.

Staff costs are a major cost pressure for NHS boards

48. The NHS is going through a period of major reform. A number of wide-ranging strategies including the National Clinical Strategy, integration of health and social care services and a new GP contract are likely to change the roles and skills required of the workforce. NHS staff provide a wide range of healthcare services and are essential to ensuring high-quality, safe and effective care. The number of people working in the NHS in Scotland continues to rise despite a third of NHS boards reducing their staff numbers during 2015/16. Overall staff levels are at the highest level ever, with 138,458 whole-time equivalent (WTE) staff employed as at March 2016. This is an increase of 0.6 per cent (855 WTE) in the last year.[34]

Case study 2

Curative treatments for hepatitis C

It is estimated that around 37,000 people in Scotland are infected with hepatitis C (20,000 diagnosed, 17,000 undiagnosed). The effectiveness of treatments which eradicate hepatitis C infection has increased dramatically over the last 20 years. In 2014, new highly effective, short-duration, safe and easy-to-administer treatments became available and offered a cure to more than 90 per cent of hepatitis C patients for the first time. These cost over £13,000 per patient for a month's supply in 2015/16 but are expected to reduce spending in the future. Courses of treatment tend to range from two to six months.

The key aim of investing in hepatitis C services in Scotland is to reduce the number of people who develop hepatitis C virus (HCV)-related liver failure, liver cancer and the number of people who die from HCV-related disease.

Given the current high cost of the new treatments, NHS boards are prioritising treatment for people at risk of developing severe life-threatening or seriously debilitating liver disease and non-liver hepatitis C-related disease. However, the longer-term aim is to offer therapy to all people with chronic hepatitis C, as early treatment is likely to deliver benefits throughout the population in terms of prevention and onward transmission.

It is estimated that a minimum of 1,500 patients need to start treatment each year during 2015-20 to reduce the number of new liver failure or cancer presentations from the current level of nearly 200 down to 50 presentations by 2020.

The annual cost to the NHS in Scotland of treating hepatitis C-related liver disease is estimated to more than double between 2008 and 2030, from £9.9 million to £20.2 million, totalling £362 million over this period. This figure does not include economic costs such as costs related to patients not being able to work. Further health economic work focusing on the cost-effectiveness of different models of diagnosis, assessment, treatment and care still needs to be carried out.

Source: Audit Scotland; ISD; Scottish Medicines Consortium - SMC No 964/14 (sofosbuvir), SMC No 1002/14 (daclatasvir); National Clinical Guidelines for the treatment of HCV in adults, Health Improvement Scotland, 2015; The Scottish Government Hepatitis C Treatment and Therapies Group Report, Health Improvement Scotland, Scottish Government, 2015; Expansion of HCV treatment access to people who have injected drugs through effective translation of research into public health policy: Scotland's experience, Hutchison, S International Journal of Drug Policy 26 (2015) 1041–1049

49. Staff costs are the largest spending area in the NHS. In 2015/16, they were £6.2 billion, accounting for around 55 per cent of total revenue spending. This is an increase of 6.4 per cent in real terms since 2010/11. The majority of staff costs, just under £5 billion, were for salaries and wages, including overtime pay. A further £1 billion was spent on national insurance and pension costs and £175 million was spent on agency staff.[35]

50. The Scottish Government surveys NHS staff regularly. In the latest survey for 2015, with a 38 per cent response rate, almost two-thirds of staff said they would

recommend their workplace as a good place to work. However, only a third of respondents said there were enough staff to allow them to do their job properly.[36] This has remained unchanged over the last three years. This tended to be more positive in special boards (around half of respondents said there were enough staff), excluding the Scottish Ambulance Service, where it was 15 per cent. In a survey of 1,800 GPs in Scotland in 2015, a quarter of GPs described their workload as unmanageable and over two-thirds felt that workload had a negative impact on their personal commitment to their career.[37]

The NHS is facing problems recruiting and retaining staff

51. The NHS in Scotland is under pressure from rising staff vacancies owing to difficulties in recruiting and retaining staff on permanent contracts. Retaining staff has become an increasing problem for boards with turnover rates increasing since 2012/13 (Exhibit 5, page 25). In 2015/16:

- staff turnover was 6.4 per cent (WTE leavers divided by the number of staff in post as at 31 March). The highest turnover was at two special boards, NHS 24 (13 per cent) and NHS Health Scotland (14.8 per cent). Among the territorial boards, the three island boards had the highest turnover (9.5-11.5 per cent), followed by NHS Tayside (9.2 per cent). High turnover can be a way of getting new skills into the organisation on a short-term basis. However, it can also affect consistency and costs if boards are required to frequently provide training for new staff

- nursing and midwifery vacancy rates were 3.6 per cent overall but this varied among boards. NHS Orkney and NHS Shetland had the highest rates at over eight per cent. NHS Ayrshire and Arran and NHS Western Isles both had rates of less than one per cent[38]

- health visitor nursing had the highest vacancy rates of all nursing specialties (nine per cent, 182 vacancies). This was followed by paediatric, district and public health nursing, which all had vacancy rates of almost five per cent. NHS Shetland had the highest vacancy rate of all boards for health visitor nursing and district nursing (39.6 and 22.8 per cent respectively)

- consultant vacancy rates were 6.5 per cent overall. This is a reduction from 7.7 per cent in 2015. However, there is variation among territorial boards. NHS Orkney had the highest rate by far at 37 per cent, followed by NHS Dumfries and Galloway, Ayrshire and Arran, and Fife at 14.5, 13.9 and 12.6 per cent. These vacancy rates are likely to be an underestimate owing to the way the data is collected[39]

- clinical radiology and anaesthetic consultants had the highest number of vacancies of all specialties, at 40.3 WTE (11 per cent) and 32 WTE (four per cent) vacancies. Psychotherapy and occupational medicine consultants had the highest vacancy rates (23 and 22 per cent) as a percentage of the establishment (when the total establishment was more than ten). Vacancy rates for other grades of hospital medical staff are not available

- GP vacancy rates were 4.8 per cent (this figure is for the most recent data from 2015), but again there is wide variation. The three island boards had the highest vacancy rates (8.6 per cent in NHS Orkney, 16.5 per cent in NHS Western Isles and 17.9 per cent in NHS Shetland), along with NHS Forth Valley at 8.9 per cent[40]

- five per cent of GP practices (49) are being run directly by their local NHS board, mainly due to GPs retiring, the rural location of practices and problems recruiting GPs. The number of practices taken over by boards has been steadily increasing since 2013/14[41]

- sickness absence was 5.2 per cent overall. The Scottish Government has set boards a target of a maximum of four per cent. Only three boards had rates below the target (NHS Education for Scotland, NHS Health Scotland and Healthcare Improvement Scotland). The highest rates were at NHS Western Isles (5.9 per cent), the Scottish Ambulance Service (7.6 per cent) and The State Hospital (8.1 per cent).[42] High sickness rates put more pressure on boards to cover posts on a temporary basis.

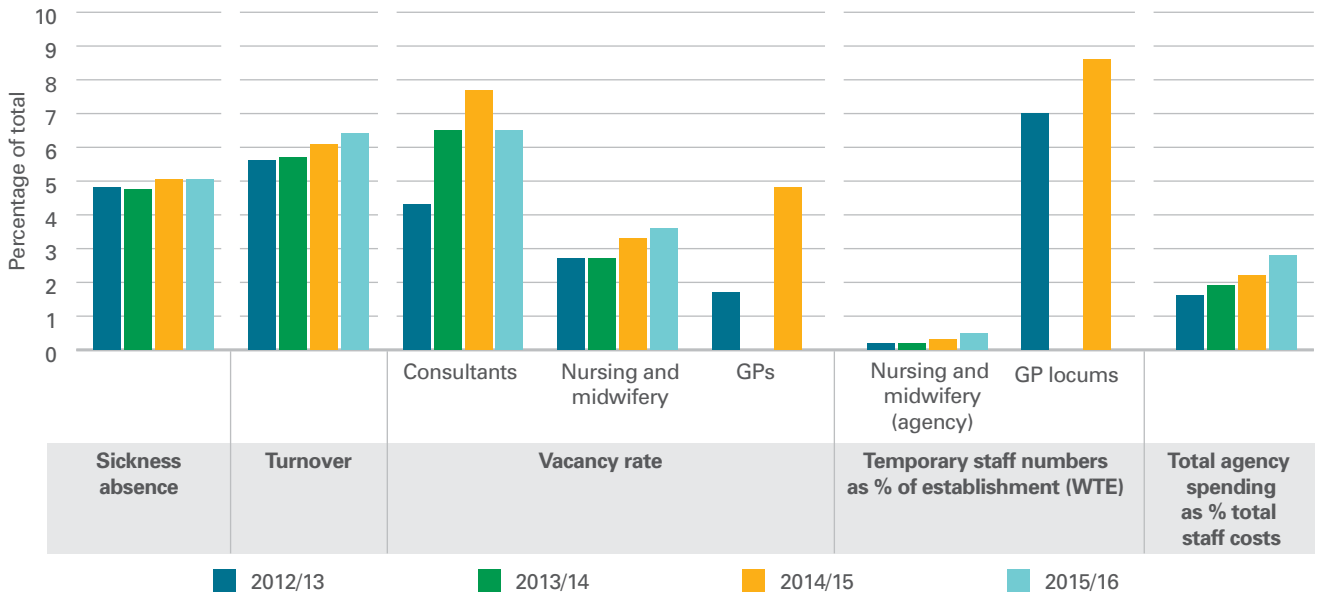
There are challenges filling junior doctor training posts

52. Junior doctors complete two-year foundation training after graduating from medical school. They can then apply for a core training post, which provides general grounding in a particular specialty and lasts around two to three years. After this, they can undertake higher-level specialist training that can ultimately lead to a consultant post. For some specialties, the core and higher-level specialist training is combined into one course, for example GP training.

Exhibit 5

Trends in key workforce indicators, 2012/13 to 2015/16

Rising sickness absence, turnover and vacancy rates are contributing to an increase in NHS boards' spending on high-cost agency staff.



Notes:
1. Sickness absence rate is the number of hours lost as a percentage of total contracted hours. The LDP standard is four per cent.
2. Turnover is the number of WTE leavers divided by staff in post as at 31 March each year.
3. Vacancy rate is the number of vacant posts as a percentage of the establishment.
4. Data on GP vacancy rates and locums was only available for 2013 and 2015.
5. ISD do not publish data on temporary consultant numbers.
6. Total agency spending includes medical, nursing, other clinical and other non-clinical staff.

Source: Audit Scotland using NHS Scotland Workforce Information as at 31 March 2016, ISD Scotland; and for total agency spend, the Scottish Government consolidated accounts, June 2016

53. In 2016, there were 850 foundation year one posts advertised across the NHS in Scotland, with a 100 per cent fill rate. For recruitment and training commencing in August 2016, 820 core and specialty training posts were advertised across the NHS in Scotland. Only 718 of these posts were filled, leaving 12.5 per cent of posts unfilled. Most specialties were filled. The main exceptions were general practice (90 unfilled posts) and psychiatry (11 unfilled posts). This is eight per cent and seven per cent of the total establishment of funded training posts for each of these specialties. This has worsened compared to 2015, where 66 GP training posts and three psychiatry training posts were unfilled (six and two per cent of the training post establishment). For recruitment to higher-level specialty training, 374 posts were advertised. Only 266 of these posts were filled, leaving 29 per cent of posts unfilled. Specialties with the highest unfilled vacancy rates were old age psychiatry (eight posts and 32 per cent of the establishment) and clinical oncology (nine posts and 22 per cent of the establishment). While the unfilled vacancy rate for old age psychiatry is equal to that in 2015, the rate for clinical oncology has worsened since 2015, when it was 15 per cent.[43]

Rising costs for temporary staff are a significant pressure

54. As a result of these recruitment and retention problems, and pressure to meet waiting time targets, the amount NHS boards are spending on temporary staff has increased each year over the last four years. It increased from 1.6 per cent of total staff costs in 2012/13 to 2.8 per cent in 2015/16. In 2015/16, NHS boards spent:

- £135 million on internal bank nursing and midwifery staff, an increase of four per cent compared to 2014/15. The largest percentage increase was at NHS Borders (14 per cent, to £1.8 million) and The State Hospital (16 per cent, to £0.2 million). NHS Greater Glasgow and Clyde spent the highest amount (£48.7 million)

- £23.5 million on agency nursing and midwifery staff, an increase of 47 per cent compared to 2014/15. Spending more than doubled at five boards (NHS Ayrshire and Arran, Borders, Forth Valley, Grampian, and Lanarkshire). Of all territorial boards, NHS Tayside spent the most (£5 million), followed by NHS Lothian (£4.8 million)

- £30 million on internal medical locums, four per cent less than 2014/15. Eight boards spent less on internal medical locums. NHS Borders, Highland, Greater Glasgow and Clyde, Lanarkshire, Orkney and Tayside spent more. In NHS Highland, spending increased by 78 per cent to £2.9 million

- £101 million on agency medical locums, an increase of 33 per cent compared to 2014/15. NHS Lanarkshire saw the biggest percentage increase (80 per cent), to £11 million. NHS Greater Glasgow and Clyde spent the highest amount of £20 million. [44]

55. The increasing use of temporary staff, that can cost significantly more than permanent staff, is putting considerable pressure on NHS boards' budgets and does not represent value for money. For example, in 2015, while the average cost of salaried nursing staff was £36,000 per WTE, agency nursing staff cost more than twice this, at £84,000 per WTE.[45] A review of the use of temporary staff in NHS Greater Glasgow and Clyde by auditors found that the board is using agency medical

locums to cover long-term vacancies. An analysis of the top value invoices by individual agency workers identified a small number of individual consultants being paid over £400,000 to provide cover for periods of less than a year.

56. The Scottish Government launched a national Managed Agency Staffing Network in December 2015 to review temporary staffing across Scotland. It aims to reduce spending, improve the quality and governance of temporary staffing, and roll out good practice. The steering group is exploring several options and has still to identify the level of efficiency savings for 2016/17. Options under consideration include:

- ensuring consistent and reasonable rates for temporary staff
- ensuring nursing and medical staff banks are set up in all boards to reduce the need for higher-cost agency staff
- preventing permanent staff within a board from carrying out some shifts through an agency at considerably higher cost.

Staff shortages and high use of temporary staff can affect quality of care

57. Difficulties in recruiting and retaining staff and greater use of temporary staff may pose risks to patient safety and quality of care. These risks can arise from poor continuity of staff, temporary staff being unaware of local systems and processes, or a lack of staff to provide safe care. As part of its remit, Healthcare Improvement Scotland (HIS) carries out inspections of healthcare facilities, such as scrutiny of safety and cleanliness, and care of older people. Since April 2015, HIS reports have included 12 care of older people inspections, 31 safety and cleanliness inspections, one review of hospital-based clinical care in NHS Lothian and five joint inspections of health and social care conducted with the Care Inspectorate. These reports cover many different issues and the findings are largely positive. We have drawn out the concerns that specifically relate to staffing shortages and the use of temporary staff. Seven care of older people reports stated that vacancies, staff shortages or a high number of bank and agency staff affected quality of care or patient safety. Examples of concerns highlighted in the inspection reports are set out below:

- The review in NHS Lothian was carried out in response to issues highlighted in a complaint made about the care provided in hospital facilities. Failures to adequately document care requirements and care were found. The report stated that it was not possible to be clear if the record keeping or the care provided needed to improve. Examples of poor documentation included records indicating patients with pressure ulcers being left in the same position for most or the whole of a day and patients being fed by tube not receiving the appropriate oral care. The report stated that staff shortages were affecting the time staff were able to spend with patients. This made it difficult for staff to have sufficient time to fully meet individual patient needs and treat them with dignity and respect. Bank and agency staff were used regularly and the board acknowledged that the quality and continuity of care had the potential to be compromised.[46]
- At the Langlands Unit, part of the new Queen Elizabeth University Hospital site in NHS Greater Glasgow and Clyde, an acute stroke and rehabilitation ward was short-staffed each day of the inspection. The absence of a senior charge nurse meant there was a lack of leadership and risks for patient

safety. There were particular issues in relation to poor nutritional care of patients. Some patients on the ward said that there were not enough staff and that nurses were too busy to check up on them or answer their requests for help with toileting or bathing.[47]

- In the Aberdeen Royal Infirmary and Woodend Hospital in NHS Grampian, staff expressed concerns about staff shortages and patient safety. This included being unable to provide sufficient care for patients with pressure ulcers and an increasing number of patient falls.[48]

- In several rural areas, challenges in recruiting and retaining GPs, consultants and community mental health teams were reported to have led to a reduction in the quality of services (Argyll and Bute and Western Isles).[49]

There are major challenges for the future NHS workforce

58. In addition to the current workforce problems, there are a number of challenges for the future. As the general population is ageing, so is the NHS workforce:

- Around one in two community nurses were aged 50 and over, compared with one in three hospital nurses in 2015.[50]

- A third of all GPs and 42 per cent of GP partners were aged 50 and over in 2015.[51]

- At March 2016, 20 per cent of the total of hospital and community medical staff and 37 per cent of nursing and midwifery staff were aged 50 and over. Of all staff groups, support services and administrative services had the highest percentage aged 50 or over (54.6 and 43.9 per cent).[52]

59. We are carrying out a separate audit looking at the NHS workforce in more detail. We plan to publish a report in 2017.

NHS boards continue to struggle to meet key national performance targets

60. The Scottish Government agrees a performance contract with NHS boards through its annual LDP guidance.[53] Within this guidance, the Scottish Government sets out a number of performance targets that NHS boards are required to meet. These are referred to as LDP standards. These LDP targets intend to help achieve the Scottish Government's overall purpose and national outcomes, as well as the quality standards that NHS Scotland seeks to meet. Introducing targets has helped to improve performance within the NHS and reduce waiting times for patients. However, national targets have become more challenging at the same time as finances have been tightening. Over recent years, NHS boards have found it increasingly difficult to meet some of the key performance targets.

61. Overall at March 2016 NHS Scotland failed to meet seven out of eight key targets (Exhibit 6, page 29). The only target met nationally was the drug and alcohol treatment target. The cancer 31 days referral to treatment target was just missed by 0.1 per cent. There has been an improvement in the four-hour A&E target over the last year. At March 2016, NHS Scotland was two per cent below the interim target of 95 per cent. During 2015/16, NHS Ayrshire and Arran, Lanarkshire and Highland particularly struggled to meet performance targets (Exhibit 7, page 30).

Exhibit 6

National performance against key waiting time standards, 2013 to 2016

The national performance has declined in six of the eight key waiting standards over the last four years.

		Year			
Standard		**2013**	**2014**	**2015**	**2016**
A&E, four-hours[1]	98% (95% interim)	91.9	93.3	92.2	93.1
Referral to treatment (RTT), 18-weeks[1]	90%	90.6	89.2	87.8	86.6
Child and Adolescent Mental Health Services (CAMHS), 26-weeks in 2013 and 2014 and 18-weeks thereafter[2]	90%	96.0	91.4	78.9	84.2
Drug and alcohol treatment, three-weeks[2]	90%	94.4	96.0	95.1	94.8
Inpatient/day case appointment treatment time guarantee (TTG), patients who waited less than 12-weeks[2]	100%	98.2	97.0	94.7	92.7
Referral to outpatient appointment, patients waiting less than 12-weeks[2]	100% (95% interim)	96.7	96.9	92.2	88.8
Cancer: 62-day referral to treatment[2]	95%	94.5	91.5	91.8	90.2
Cancer: 31-day decision to treat to first treatment[2]	95%	97.7	96.2	96.5	94.9

Key: Red = standard missed. Green = standard met. Orange = within 5 per cent of standard. Orange = within 5 per cent of interim standard.

Notes:
1. Month-ending March.
2. Quarter-ending March.

Source: Audit Scotland using ISD Scotland data as at June 2016

62. Although none of the 14 territorial boards met all eight key targets, only three boards missed the three-week drug and alcohol treatment target (NHS Highland, Lothian and Shetland). Over half of all territorial boards failed to meet three targets (12-week first outpatient appointment, 12-week treatment time guarantee (TTG), and 62-day cancer referral to treatment). Boards' declining performance against hospital waiting time targets is an indication of the building pressures they are facing from increasing demand.

63. Five out of the 14 territorial boards failed to meet the 18-week children and adolescent mental health services (CAMHS) target. Between March 2015 and 2016, performance against the CAMHS target improved (from 78.9 to 84.2 per cent) but still failed to meet the 90 per cent target. Over the same period, the total number of CAMHS patients seen has increased by four per cent, from 4,269 to 4,436 patients. We plan to carry out an audit in this area in 2017.

Exhibit 7

Comparison of key indicators by NHS territorial board at 2015/16

There is significant variation in the pressures individual boards are facing.

Indicator/ Board	Population aged 75+	Finance				Performance		
		Core revenue outturn (£m)	Total savings made (£m)	Non-recurring savings	NRAC: distance from parity	Treatment Time Guarantee	Treatment Time Guarantee unavailability	Referral to outpatient appointment
Territorial boards								
Ayrshire and Arran	9.3%	703.6	19.1	34.5%	-0.5%	88.3%	14.1%	77.7%
Borders	10.2%	210.2	6.9	59.3%	1.6%	99.2%	17.5%	93.8%
Dumfries and Galloway	10.8%	299.3	8.0	23.4%	3.8%	90.4%	8.9%	95.0%
Fife	8.5%	637.2	18.0	60.0%	-1.1%	97.4%	7.2%	96.5%
Forth Valley	7.9%	515.5	13.7	2.5%	-1.5%	95.8%	12.4%	84.1%
Grampian	7.6%	927.1	25.1	34.6%	-2.0%	88.3%	17.3%	84.6%
Greater Glasgow and Clyde	7.6%	2,197.3	59.6	19.3%	3.0%	99.9%	27.3%	98.7%
Highland	9.5%	639.7	16.0	61.9%	-1.2%	81.0%	8.7%	64.7%
Lanarkshire	7.5%	1,160.9	31.7	26.7%	-1.6%	83.3%	11.2%	93.0%
Lothian	7.2%	1,392.2	30.5	32.7%	-1.2%	94.6%	9.8%	85.4%
Orkney	9.7%	49.1	1.4	35.8%	-1.7%	96.6%	16.5%	71.9%
Shetland	7.9%	52.8	2.2	67.2%	-1.9%	100.0%	53.5%	89.9%
Tayside	9.5%	764.0	23.4	65.2%	-0.1%	83.8%	16.2%	90.1%
Western Isles	11.0%	78.1	2.5	25.5%	7.9%	100.0%	9.0%	90.3%
Scotland	**8.1%**	**9,627.0**	**257.9**	**34.9%**	**N/A**	**92.7%**	**16.8%**	**88.8%**
Key				>50%	<-1%	<95%	>20%	<90%
				20-50%	-1 to 0 %	95-99.9%	10-20%	90-94.9%
				<20%	>0%	100%	<10%	≥95%

Notes:
1. Core revenue outturn and savings data is at 2015/16 financial year end. Non-recurring savings are expressed as a percentage of total savings. NRAC is the NHS Scotland Resource Allocation Committee and is expressed as the percentage distance from parity.
2. Treatment Time Guarantee (TTG) performance is expressed as the percentage of patients who waited less than 12-weeks for an inpatient/ day case appointment for the quarter-ending March 2016. Treatment Time Guarantee unavailability is expressed as the percentage of patients who were unavailable for an appointment for the month-ending March 2016.
3. Referral to outpatient appointment performance is expressed as the percentage of patients waiting less than 12-weeks for the quarter-ending March 2016.

Notes continued...(page 31)

Exhibit 7 continued

	Performance		Workforce					
	Accident and emergency	Change in bed days occupied by delayed discharge patients	Sickness absence rate	Consultant vacancy rate	Change in consultant agency spending	Nursing and midwifery vacancy rate	Change in nursing and midwifery agency spending	Total agency staff costs as % total staff costs
	91.2%	-17.8%	5.01%	13.9%	61.7%	0.4%	125.6%	2.7%
	95.2%	-10.6%	4.36%	7.2%	5.6%	3.7%	103.7%	3.3%
	94.3%	-21.3%	5.08%	14.5%	20.4%	4.4%	-45.7%	6.2%
	95.5%	5.2%	5.12%	12.6%	12.2%	2.4%	-19.6%	2.9%
	92.0%	-13.2%	5.10%	3.6%	4.6%	3.4%	116.3%	2.4%
	96.1%	-17.4%	4.62%	6.2%	72.6%	7.3%	110.0%	3.4%
	90.5%	-30.5%	5.39%	3.9%	29.5%	4.3%	86.4%	2.0%
	97.0%	11.9%	5.09%	6.1%	40.5%	5.4%	41.5%	4.3%
	91.9%	16.1%	5.20%	10.1%	-28.2%	3.3%	183.1%	3.3%
	92.1%	-10.9%	5.02%	3.5%	79.6%	1.6%	-11.6%	3.0%
	98.8%	54.6%	5.10%	37.0%	62.9%	8.8%	-100.0%	5.2%
	96.5%	-56.9%	5.20%	0.0%	-68.6%	8.1%	-37.4%	6.8%
	99.2%	12.0%	5.04%	6.9%	14.8%	2.9%	61.3%	1.9%
	99.5%	-2.1%	5.93%	0.0%	76.2%	0.8%	*	6.2%
	93.1%	**-8.9%**	**5.16%**	**6.5%**	**32.9%**	**3.6%**	**46.6%**	**2.8%**
	<90%	>0%	>5%	>10%	>50%	>10%	>50%	>3%
	90-94.9%		4-5%	5-10%	0-50%	5-10%	0-50%	1-3%
	≥95%	<0%	<4%	<5%	<0%	<5%	<0%	<1%

4. Accident and emergency performance is expressed as the percentage of patients who waited less than four hours to be seen in March 2016.
5. Change in the number of bed days occupied by delayed discharge patients is expressed as the annual percentage change between 2014/15 and 2015/16.
6. Sickness absence is the number of hours lost as a percentage of the total contracted hours in 2015/16. The LDP standard for this is four per cent.
7. Vacancy rates are expressed as a percentage of the establishment at March 2016.
8. Agency spending is expressed as the percentage change in spend between 2014/15 and 2015/16. *NHS Western Isles spent £0 on nursing and midwifery agency costs in 2014/15, but £158,000 in 2015/16.
9. The key is based on Audit Scotland's assessment of the performance of boards against each indicator.

Source: Audit Scotland using financial data from the Scottish Government financial reports and consolidated accounts, performance and workforce data from ISD Scotland, and agency spend data using information provided by individual NHS boards.

64. NHS boards can record patients waiting for outpatient or inpatient treatment as being unavailable for treatment. This means that the period when a patient is unavailable for treatment or unable to attend an appointment is not included in the patient's overall waiting time. The national average in March 2016 was 17 per cent, which is a slight improvement from 18.5 per cent in March 2015. The main reasons for patients being unavailable were personal commitments (22 per cent), other medical conditions (22 per cent), patients requesting a named consultant (23 per cent) and patients requesting to be treated within their local NHS board (14 per cent).

65. The trend in reasons for unavailability has been fairly consistent since April 2014. Patient unavailability against the TTG standard at March 2016 was highest at NHS Shetland (54 per cent), NHS Greater Glasgow and Clyde (27 per cent) and NHS Borders (17 per cent). NHS Greater Glasgow and Clyde has consistently been one of the top three boards for patient unavailability throughout the year. The board recorded the main reasons for patient unavailability as patients requesting a named consultant (44 per cent of unavailable patients), followed by patients requesting to be treated within their local NHS board (22 per cent of unavailable patients).

66. The target that no patient should wait in hospital for more than 14 days from when they are clinically ready for discharge was not met by any board throughout 2015/16. An exception was in NHS Borders, Orkney and Shetland in some months of the year. However, there have been some improvements in performance compared to 2014/15:

- At March 2016, 49 per cent of patients delayed for discharge from hospital were delayed for more than 14 days, a slight improvement from 51 per cent at March 2015 (excluding code 9 delays).[54]

- The total number of bed days occupied by delayed discharge patients in 2015/16 reduced by nine per cent compared to 2014/15, from 623,438 to 567,853. However, this pattern masks wide variation among boards.

- In 2015/16, the overall delayed discharge bed day rate per 1,000 population aged 75 and over was 915. This is a 12.5 per cent reduction from 1,044 in 2014/15.

67. There have also been improvements in performance against some other targets. This includes more people in deprived areas stopping smoking and an increasing proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer. Performance against the target that at least 80 per cent of pregnant women will have booked for antenatal care by the twelfth week of gestation was exceeded in 2014/15, at just over 82 per cent (data for 2015/16 is still to be published). NHS boards are also trying to reduce their spending on the private sector. Boards use the private sector to increase short-term capacity and when specialist treatment is not available in the NHS. Private sector spending does not include agency staff costs. Since 2010/11, NHS spending on using the private sector increased by 18 per cent in real terms, from £69.5 million to £81.8 million in 2015/16 (0.7 per cent of total revenue expenditure). However, this reduced over the last year by four per cent from £85.3 million in 2014/15.

68. The Scottish Government has a strong focus on national targets. We have commented in previous reports about the extensive effort that NHS boards put into meeting these targets. NHS boards are under significant pressure to meet hospital waiting time targets, in particular. This does not help to support the overall strategy of moving to more community-based care. Funding is focused on meeting acute targets and it is unclear what the unmet need in the community is as this is not measured. Most boards are overspending on their acute budgets. Some NHS boards have agreed with their Boards that they face risks in continuing to achieve performance targets while remaining in financial balance and meeting financial targets (NHS Ayrshire and Arran, Lothian and Grampian).

69. The Scottish Government announced in June 2016 that it will review national NHS targets. The review's aim is to ensure the targets deliver better outcomes for patients and make best use of NHS resources. It will also look at how targets help to deliver the national strategy for the future direction of NHS and social care services. An expert group will be set up to lead the review and work with staff, stakeholders, social care and clinical bodies. The group is due to report its findings by early 2017.

Part 2

Service reform

Key messages

1. The NHS is undergoing significant changes in how it delivers its services. This is at a time of great uncertainty about the detail and implications of many of the changes planned, and while it is facing considerable financial challenges.

2. The Scottish Government has had a policy to shift the balance of care for over a decade. It has published a number of strategies aimed at reducing the use of hospitals and supporting more people in the community. But most spending is still on hospitals and other institutional-based care.

3. New integration authorities are still developing and some progress is being made in shifting to new models of care, but it is not happening fast enough to meet the growing need. Effective leadership and a clear plan are required to manage the change.

the NHS is undergoing significant change, but the shift to more community-based services is slow

The NHS is undergoing significant change

70. Over the last decade, there have been improvements in the way services are delivered and reductions in the time that patients wait for hospital inpatient treatment. There have also been improvements in overall health, life expectancy, patient safety and survival rates for a number of conditions, such as heart disease. However, the health of Scotland's population is still poor compared to other developed countries and significant health inequalities still exist. A review of public health in Scotland states that 'The population health challenge remains complex and persistent and current measures are not seen to be sufficiently accelerating improvement in the country's public health.' The report highlights that in Scotland there:

- is lower life expectancy than our European counterparts, with no single explanation
- are high levels of preventable death, disease and poor health in the ageing population
- are continued increases in the numbers of overweight and obese people, which could overturn life expectancy gains achieved in recent decades
- are high levels of poor health from multiple conditions, in particular of people with both physical and mental health conditions.[55]

71. The NHS in Scotland is undergoing major reform. A number of significant changes to the way health and social care services are delivered are under way or planned. These include:

- national policy aimed at transforming the way services are delivered, including shifting the balance of care from hospital-based services to more community-based services:
  - 2020 Vision for health and social care
  - National Clinical Strategy
- integrating health and social care services
- a new GP contract from April 2017
- a review of the current structure of NHS boards.

72. The Scottish Government has had a policy to shift the balance of care for over a decade. It has published a number of strategies aimed at reducing the use of hospitals and supporting more people in the community. In 2004, the then Scottish Executive commissioned an expert group to consider the necessary changes required to 'build a health service for the future'. The report, published in 2005, made various recommendations and outlined a new way of delivering care to expand services in the community and deliver care as locally as possible and as specialised as necessary. It highlighted the need for a whole-system approach with partnership working and better integration of primary, secondary and social care.[56]

73. In response, the Scottish Executive set out an action plan that aimed to shift the balance of care through Community Health Partnerships (CHPs) and expanding community services. It identified four main priority areas for investment and reform to transform the NHS:

- the NHS is as local as possible
- systematic support for people with long-term conditions
- reducing the inequalities gap
- actively managing hospital admissions.

74. In September 2011, the Scottish Government set out an ambition to enable everyone to live longer, healthier lives at home or in a homely setting by 2020.[57] This restated many of the aims set out by the Scottish Executive in 2005. These were to have a healthcare system with integrated health and social care, and a focus on preventing and anticipating problems, and helping people to manage their conditions. Two years later, the Scottish Government set out high-level priority areas for action during 2013/14 for its 2020 Vision for health and social care.[58]

75. In June 2015, the Cabinet Secretary for Health and Sport confirmed that the Scottish Government and NHS boards had not made sufficient progress towards delivering the 2020 Vision. The Scottish Government published a National Clinical Strategy in February 2016, including new measures for delivering the 2020 Vision and setting out its plans for health and social care in Scotland over the next ten to 15 years.[59] It describes a number of new proposals and changes to current services. This includes the following:

- GPs to focus on care that is more complex and the wider primary care team to develop extended skills and responsibilities
- a new structure for a network of hospital services with more specialties planned and provided on a regional or national basis
- the development of up to six new centres for planned diagnostic and surgical procedures and four major trauma centres
- a strong focus on the need to reduce waste, harm and variation in treatment and to make more use of technology to support and improve care.

76. The Scottish Government has introduced several major strategies, reviews and reform since 2015 aimed at addressing the changing needs of the population and improving health (Exhibit 8, page 37).

The Scottish Government's long-term aim to shift the balance of care has still to be realised

77. Since 2005, there have been improvements in the way services are delivered with more of a focus on developing community services. There have been reductions in the time that patients wait for hospital inpatient treatment and the length of time they stay in hospital. There has also been a shift to more day case and outpatient treatment. There have been improvements in overall health, life expectancy and survival rates for a number of conditions, such as heart disease. However, there has not been a significant shift in the balance of care.

78. The latest available figures show that in 2014/15, for health and social care combined, 56 per cent of spending was on hospital care, care homes and other accommodation-based social care, compared to 44 per cent spent on community-based care. For the NHS alone, 62 per cent of expenditure was for hospital services, compared to 38 per cent spent on community health services. These percentages have remained the same for the last five years and most spending is still on hospitals and other institutional-based care.[60]

79. It is not clear what the Scottish Government's aim of shifting the balance of care looks like and how it will be achieved. But indications of a shift would include reducing A&E attendances, emergency admissions to hospital and delayed discharges from hospital. This will require either reducing acute spending to shift resources into the community, or investing additional resources in the community while maintaining spending on acute services. The NHS cannot continue to do everything within the current resources and needs to slow the rate of growth of hospital demand. In Canterbury, New Zealand, spending was prioritised 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. We provide more information on this on page 31 of our *Changing models of health and social care* report and Case study 10 of the accompanying supplement.

Exhibit 8

Key national NHS policy and service reform in Scotland

There are many national policies and reforms that NHS boards are expected to deliver, working with integration authorities, councils and other partners.

Overarching policy

Quality Strategy (May 2010) The three quality ambitions – safe, patient-centred and effective – underpin all healthcare policy	**2020 Vision for health and social care** (September 2011) The overall aim is to provide care closer to home or in a homely setting	**Everyone Matters: 2020 Workforce Vision** (June 2013) Sets out a vision of what will be required from the workforce	**Health and social care integration** All integration authorities were in place by April 2016. They are expected to coordinate health and care services to improve outcomes for their local population

National Clinical Strategy (February 2016)

Includes new measures for delivering the 2020 Vision

Sets out plans for health and social care over the next 10-15 years

- A new structure for a network of hospital services with more specialties planned and provided on a regional or national basis
- Development of up to six new centres for planned diagnostic and surgical procedures and four major trauma centres
- GPs to focus on care that is more complex and the wider primary care team to develop extended skills and responsibilities

Consultation with the public

Creating a healthier Scotland: What matters to you? (March 2016) Consultation with people who use or work in health and social care services	**Our Voice** (June 2016) To support people to get involved in planning and improving health and social care services

Changes to General Practice Contract

Removal of the quality and outcomes framework (QOF) – April 2015	Groups of GP practices (clusters) in local areas working together more closely and setting clear outcomes focusing on providing integrated care – during 2016/17	New GP contract from April 2017

National strategies and reports

Realistic Medicine (January 2016) Chief Medical Officer report focusing on reducing waste, harm and variation in treatment	**Palliative Care Framework** (December 2015) Sets out a vision for the next 5 years, with outcomes and 10 commitments to support improvements in the delivery of palliative and end-of-life care	**Cancer Strategy** (March 2016) Sets out ambitions and actions in 7 key areas, including prevention, improving survival, early detection and diagnosis, and improving treatment	**6 Essential Actions to Improving Unscheduled Care** (May 2015) A national two-year programme which aims to improve unscheduled care
Review of Public Health (February 2016) Highlights that the health of Scotland's population is still poor and significant health inequalities still exist Makes recommendations for development of a national public health strategy	**7-day Services Interim Report** (March 2015) Considers the implications of delivering a sustainable seven-day clinical service across NHS Scotland and includes proposals for working towards achieving it	**Mental Health Strategy Consultation** (July 2016) Proposed framework and priorities for mental health for the next ten years Strategy due to be published in late 2016	**Out-of-Hours Review** (November 2015) Recommends a model for out-of-hours and urgent care in the community Delivery plan due to be published in late 2016, with £10 million funding

Source: Audit Scotland

80. The population is growing and ageing, and people are living longer with multiple conditions and more complex needs. This is putting increasing pressure on NHS boards' finances, as funding is not keeping pace with the increasing needs of the population. Demand for hospital services continues to rise. This makes it difficult for NHS boards to release resources to invest in more community-based services. At the same time, demand for community services, such as GP appointments, is also rising (Exhibit 9). But there are not significant additional resources available.

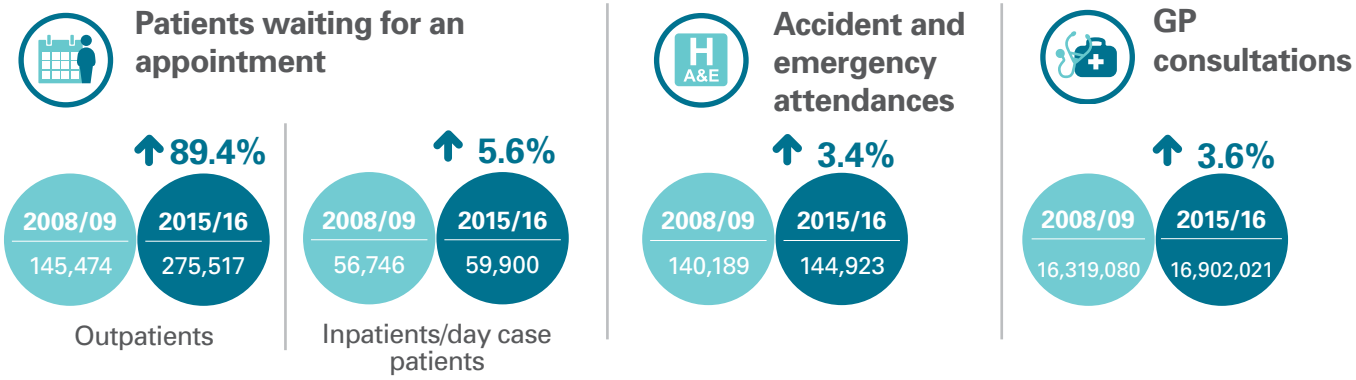
New integration authorities are still developing

81. Integrating health and social care is central to delivering transformational change and shifting the balance of care from hospitals to more homely and community-based settings. Under new arrangements for health and social care, 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 to 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. This means providing care for people in their home or local community, and reducing admissions to hospital. Our recent report on progress towards integration of health and social care services sets out the structure and requirements of integration authorities in more detail.[61]

Exhibit 9

Indicators of demand for NHS services, 2008/09 to 2015/16

Demand for NHS services in Scotland continues to increase.



Notes:
1. Outpatients waiting: the number of patients waiting for an outpatient appointment at March.
2. Inpatients waiting: the number of inpatient or day case patients waiting for an appointment at March.
3. Accident and emergency attendances: the number of patients that attended Accident and Emergency in March.
4. GP consultations: The number of GP consultations carried out in that year. Data is actual for 2008/09, but projected for 2015/16 using the same figures as the Changing models of health and social care report, Audit Scotland, March 2016.
5. 2015/16 outpatient appointment data includes referrals from all sources, but 2008/09 data only includes referrals from GPs and general dental practitioners.

Source: Audit Scotland using ISD Scotland data as at June 2016

82. All 31 integration authorities were operational by the statutory deadline of 1 April 2016.[62] However, there have been difficulties in agreeing budgets and delays in developing comprehensive strategic plans. Councils normally set their budgets by February, whereas many NHS boards do not finalise their budgets until June. In April 2016, integrated joint boards (IJBs) in five NHS board areas had not yet finalised their budgets (Fife, Lanarkshire, Lothian, Orkney and Tayside). None of the integration authorities have set budgets for future years, although some have indicative budgets. For 2016/17, the amount that NHS boards delegated to integration authorities and the total income that NHS boards received from their integration authorities was either the same, or almost the same. This indicates there has been little change in the way services are being provided during 2016/17.

83. As at April 2016, most integration authorities were still developing performance management frameworks and establishing how progress towards delivering the national outcomes for health and wellbeing will be measured.[63] Dumfries and Galloway IJB has agreed a three-year workforce plan, but workforce plans covering more than one year have still to be developed in other integration authorities. The governance arrangements for integration authorities can be complex and in several NHS board areas there are different reporting regimes in place. In some areas, local auditors of NHS boards highlighted the governance arrangements, such as roles, responsibilities and oversight, as a risk (Borders, Fife, and Lanarkshire). Local auditors also highlighted that reporting arrangements between NHS boards and the IJBs need to improve (Lanarkshire and Greater Glasgow and Clyde).

84. NHS boards in some areas have highlighted challenges they are facing owing to the way IJBs are operating in their area. These include:

- difficulties in decision-making – where IJBs have different views or priorities from each other or from the NHS board. It can also take a lot longer to reach decisions if separate discussions are being held in the NHS board and the IJBs. In Grampian, a senior leadership team, with representation from the NHS board and three IJBs, meets quarterly to review performance and make joint decisions about services

- a potential for services to become fragmented – some services are board-wide but decisions about how they are provided have to be agreed across multiple IJBs. In Ayrshire and Arran, each of the three IJBs host different specialist services on behalf of the other IJBs, such as inpatient mental health services. The board reports that this is often more practical and cost-effective than setting up separate arrangements to deliver services for individual IJBs

- clarity of operational and strategic responsibilities – accountability is not always clear, particularly when issues affect services that are not required to be delegated to the IJB. For example, delayed discharges involve a wide range of hospital specialties. In most IJBs, hospital services included in integration are those inpatient medical specialties which have the largest proportion of emergency admissions to hospital. Other hospital specialties are often not included. Argyll and Bute IJB and Dumfries and Galloway IJB are overseeing all NHS acute services, including planned and unplanned hospital services. In theory, this should allow these IJBs to better coordinate all health and care services in their area.

85. During 2015/16, a lot of time and effort was put into setting up the new bodies. Although integration authorities are now operational, there is still considerable work to do to ensure they are operating effectively. It is important for integration authorities to get these arrangements working, so they can focus on delivering their objectives and work towards improving outcomes for their local populations. It is therefore unlikely they will make a major impact during 2016/17. We plan to carry out further work on the progress made by integration authorities after their first year of being established and on their longer-term impact.

Some progress is being made in developing approaches to transformational change

86. In our report *Changing models of health and social care*, we highlighted that the shift to new models of care, that is transforming how care services are provided, is not happening fast enough to meet the growing need. We found that the new models of care in place were generally small-scale and were not widespread. We also recommended that the Scottish Government develops a clear framework to guide local development and consolidate evidence of what works. NHS boards and integration authorities also need to ensure that new models for how they provide care are properly planned, implemented, monitored and evaluated. This is to ensure they provide value for money and sustainability.

87. Although there is still limited evidence of transformational change, some progress is being made in developing approaches that aim to enable more change to happen:

- Testing new models of care in the community – in May 2016, the Scottish Government allocated £20 million of primary care transformation funding plus £10 million of mental health funding to NHS boards to test new ways of working. It is also supporting ten primary and community care 'test sites'.[64] The Scottish Government is providing support and advice to local areas in how to monitor and evaluate projects. It is also coordinating regional and national events to ensure learning is shared. It is still too early to see benefits or improved outcomes from these new models, but the Scottish Government is developing a framework to consolidate emerging evidence.

- Primary care teams to play a lead role – this approach is being tested in local areas. The new GP contract has still to be agreed. It needs to recognise and support the role of general practice in helping to implement the changes required to shift the balance of care. GPs are taking on more strategic roles and working with new integration authorities to help lead change. During 2016/17, a new approach is being introduced that requires groups of GP practices (clusters) in local areas to work together more closely. GP clusters are required to agree a clear set of outcomes with local partners, such as the NHS board and integration authorities, that focus on providing integrated services that benefit patients.

- Realistic medicine – the Chief Medical Officer's annual report and the National Clinical Strategy outline the need to reduce waste, harm and variation in treatment. There is evidence of oversupply of some services or interventions, including some that are of limited value. It is estimated that up to 20 per cent of mainstream clinical practice brings no benefit to the patient. This includes increased over-investigation and treatment, prescribing multiple drugs that are of limited benefit and lead to excessive

side-effects, surgical procedures with low benefits to patients, and clinical variation that is not reasonably explained by patient need.[65] The Scottish Government is working with NHS boards to resolve these issues. It is also trying to ensure patients are more involved in making decisions and receive better information about potential treatments to enable them to make informed decisions.

- **Improving efficiency** – NHS boards will need to make unprecedented levels of savings in 2016/17 and identifying recurring savings is becoming increasingly difficult. However, it is recognised that there is still significant variation among boards and opportunities for further efficiencies to be made. This includes making better use of technology. A national sustainability and value programme board has been set up (paragraph 20, page 13). The Cabinet Secretary for Health and Sport has also committed to review the number, structure and roles of NHS boards. The timescales for this are not clear yet. The National Clinical Strategy sets out a case for reorganising services. This includes reducing the number of hospitals providing more specialist services and reducing the number of acute sites. These measures aim to make hospital services more efficient and will potentially release resources that could be invested into the community. However, this will take a considerable period of time to put in place. High levels of investment will also be required over the coming years to fund the proposed new diagnostic and treatment centres, due to be completed by 2021/22, and trauma centres. The Golden Jubilee National Hospital is aiming to complete the initial phase of the expansion of its diagnostic and treatment centre by the end of 2016/17. An investment in MRI scanners will provide an additional 10,000 scans per year from 2017/18. The Golden Jubilee is also testing new ways of working to roll out across Scotland, for example learning from an approach in India in treating cataracts with the potential to improve efficiency and outcomes for patients.

A clear plan for change is needed

88. We have previously reported that the Scottish Government is not making sufficient progress in achieving its policy aim of shifting the balance of care or keeping pace with the changing needs of the population.[66] The 2020 Vision lacks 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. 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.

89. The National Clinical Strategy includes new measures for delivering the 2020 Vision and also comments on how health care in Scotland is likely to develop beyond 2020. The new strategy continues to focus on providing more care and support in the community and people being able to live longer, healthier lives at home, or in a homely setting. However, there is also a major focus on hospital services. There is currently considerable uncertainty about the implications of this strategy and other proposed changes. This includes the new GP contract, new models of care, review of NHS board structures and review of national targets. This makes capacity planning particularly challenging for NHS boards as it is not yet clear what resources are needed for the many new models

of care proposed in various strategies. Implementation of the strategy needs to incorporate the principles of the Scottish Government's wider public service reform. This focuses on prevention and tackling inequalities, working closely with the public to help improve services and meet the needs of communities, and effective partnership working across the public, third and private sectors. Integration authorities in particular will have an important role to play in helping to deliver public service reform.

90. The Scottish Government carried out a consultation with people who use or work in health and social care services during 2015/16 and published a summary of the findings in March 2016.[67] The Scottish Government has committed to consider the findings when developing existing and future policy. In June 2016, the Cabinet Secretary for Health and Sport launched 'Our Voice', an approach to support people to get involved in planning and improving health and social care services at an individual, community and national level.[68]

91. The Scottish Government has set up a transformational change programme board with the aim of accelerating progress towards the 2020 Vision. It has membership from across the Scottish Government health directorate, NHS boards, integration authorities, councils, the third sector (such as charities and voluntary groups), and people who use health and social care services. In addition to the National Clinical Strategy, the programme board has identified a number of areas that it will focus on to help to make change happen. It is reviewing the current position with each of these strands and then plans to identify priorities for implementing change. These are:

- public health reform
- health and social care integration
- supporting the wellbeing of children and young people.

92. Many elements of the National Clinical Strategy remain uncertain and a clear plan has yet to be put in place:

- There are no measures or milestones in place that will allow progress to be measured against the strategy.
- The financial implications of implementing the strategy are unknown and it is unclear what funding will be available for it.
- The implications for the workforce have still to be identified. This includes the numbers of various professions, training and skills required for the new ways of working outlined in the strategy.

93. Evidence is still emerging about new models of care, including the impact and outcomes of proposed new ways of working. It is important that the new models of care being tested are properly evaluated and the cost implications fully understood. New ways of working need to be sustainable and affordable within current financial constraints. The Scottish Government, in partnership with NHS boards and integration authorities, should use financial modelling to estimate the cost of implementing its national strategy and how this will be funded. It is challenging for boards to make significant changes to services while continuing to react to immediate pressures. But this makes it more important than ever

to find more efficient ways of working. There also needs to be a real focus on implementing more preventative measures to reduce admissions to hospital. Increasing demand for hospitals is putting more pressure on NHS boards' acute budgets each year. It is also better for patients to be treated in the community in a more homely setting where possible.

94. The workforce is critical to delivering new models of care. The right staff, with the right skills, need to be available to provide the new ways of working. However, it is not clear yet what number and levels of staff will be required until further work is done on testing new models and a clearer plan is in place. The Scottish Government has published a workforce implementation plan for 2016/17. It states that activity will focus on identifying workforce actions to help tackle health inequalities across Scotland; and developing a workforce to deliver integrated health and social care services across NHS boards, councils and third party providers. However, the plan is high level and does not outline the workforce requirements to deliver the 2020 Vision and the National Clinical Strategy.

95. Each NHS board is required to produce its own workforce plan. Many of these acknowledge the changes that will be required to deliver the national strategies, but they are still working on more detailed plans. There is a lack of long-term workforce planning (more than five years) and many boards' plans do not sufficiently address problems with recruitment and retention or succession planning. A clear plan for the workforce must be a priority for the programme board. The time to train new staff varies, but it takes several years (at least seven years to train a junior doctor), and this needs to be built into workforce plans. In their manifesto, Scottish ministers have committed to introduce a national and regional workforce planning system across the NHS in Scotland.

96. The King's Fund, drawing on learning from high-performing healthcare organisations across the world, has identified key areas for reforming the NHS in England. However, the principles identified about what needs to be done to implement new models of care in the medium and longer term are applicable to NHS organisations across the UK. These include:

- engaging doctors, nurses and other staff in improvement programmes
- investing in staff to enable them to achieve continuous quality improvement in the long term so improvement is based on commitment rather than compliance
- recognising the importance of leadership continuity, organisational stability, a clear vision and goals for improvement, and the use of an explicit improvement methodology
- the need for leadership in NHS organisations to be collective and distributed, with skilled clinical leaders working alongside experienced managers
- NHS organisations prioritising leadership development and training (preferably in-house) in quality-improvement methods.[69]

Endnotes

1 *Scotland's Spending Plans and Draft Budget 2016-17*, Scottish Government, December 2015.

2 Real terms figures have been calculated using *GDP deflators at market prices, and money GDP: June 2016 (Quarterly National Accounts)*, National Statistics, July 2016.

3 *Economic assumptions 2016/17 to 2020/21,* NHS England, March 2016.

4 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.

5 Audit Scotland using *Mid-year population estimates: Scotland and its NHS Board areas by single year of age and sex: 1981 to 2015,* National Records of Scotland, April 2016.

6 *Inpatient, Day case and Outpatient Stage of Treatment Waiting Times - Monthly and quarterly data to 31 March 2016,* ISD Scotland, June 2016. 2015/16 outpatient appointment data includes referrals from all sources, but 2008/09 data only includes referrals from GPs and general dental practitioners.

7 These figures exclude non-core funding which is provided to boards for unpredictable costs such as capital and pension accounting adjustments.

8 *The 2015/16 audit of NHS Tayside: Financial sustainability*, Audit Scotland, October 2016; *The 2015/16 audit of NHS 24: Update on management of an IT contract*, Audit Scotland, October 2016.

9 *2015/16 Annual Audit Report for the Board of NHS Ayrshire and Arran and the Auditor General for Scotland*, Audit Scotland, June 2016.

10 *2015/16 Annual Audit Report for the Board of NHS Shetland and the Auditor General for Scotland*, Audit Scotland, June 2016.

11 *Annual State of NHS Scotland: Assets and Facilities Report for 2015,* Scottish Government, August 2016.

12 The increase of £101 million in the maintenance backlog includes an adjustment for inflation (this was not applied in previous years). It also includes a real-terms reduction of around £40 million in most NHS boards' backlog position in 2015. NHS Greater Glasgow and Clyde has identified around £50 million of new maintenance from recent surveys.

13 Investment planned for new hospitals: completion of the Queen Elizabeth University Hospital, Royal Edinburgh Hospital, Royal Hospital for Sick Children in NHS Lothian, East Lothian Community Hospital, new hospitals in NHS Dumfries and Galloway, Highland and Orkney.

14 *Changing models of health and social care*, Audit Scotland, March 2016.

15 Thirteen out of the 14 territorial NHS boards in Scotland included drug costs as a financial risk in their LDPs.

16 2015/16 data on total spending by the NHS in Scotland on drugs in hospitals and the community is not available until November 2016. However, 2015/16 data is available on the cost of NHS prescriptions dispensed in the community (£1.1 billion). Also, ISD provided Audit Scotland with data on the top ten drugs used in hospitals for 2015/16.

17 *Costs book – drugs*, ISD Scotland, November 2015.

18 This statistic relates to items reimbursed. ISD data provided to Audit Scotland, August 2016.

19 *A National Clinical Strategy for Scotland,* Scottish Government, 2016.

20 A generic, or unbranded, drug is comparable to the equivalent branded drug in dosage, strength and quality but is usually cheaper. Prescribing by generic name ensures that when a product comes out of patent, generic drugs/devices can be dispensed against the prescriptions, allowing savings to be realised without any change having to be made to the prescription.

21 *Better value in the NHS: the role of changes in clinical practice,* The King's Fund, 2015.

22 *Prescribing in general practice in Scotland*, Audit Scotland, January 2013.

23 Information provided to Audit Scotland from ISD Scotland, July 2016.

24 *Chief Medical Officer's Annual Report 2014-15: Realistic Medicine,* Scottish Government, January 2016.

25 *Global outlook: Healthcare,* The Economist Intelligence Unit, March 2014.

26 The cost of all patented drugs is regulated at a UK level to reduce the cost to the taxpayer. The NHS does not cap the price of generic drugs because they are meant to be widely available with prices driven down through competition.

27 ISD data provided to Audit Scotland, August 2016.

28 *Health Service Medical Supplies (Costs) Bill Factsheet,* Department of Health, 2016.

29 *Access to newly licensed medicines progress update, Health Improvement Scotland, HS/S4/16/12/1,* Health and Sport Committee, Scottish Parliament, 1 March 2016.

30 ISD data provided to Audit Scotland, August 2016. This figure relates to drugs dispensed in the community.

31 ISD analysis for the Scottish Government, provided to Audit Scotland, August 2016. This relates to drugs dispensed in the community and in hospitals.

32 *Guidance on horizon scanning process,* Scottish Medicines Consortium, 2015.

33 The New Medicines Fund is funded from rebate payments from the UK Pharmaceutical Price Regulation Scheme (PPRS). The receipts for Scotland from this scheme have not yet been finalised for 2016/17.

34 *NHS Scotland Workforce Information - as at 31 March 2016,* ISD Scotland, June 2016. For March 2016, there was a coding issue which excluded a small number of staff (approximately 200 WTE) on fixed term secondments within NHS boards. NHS Tayside figures were affected by this the most.

35 *NHS consolidated accounts*, Scottish Government, June 2016.

36 *NHS Scotland Staff Survey 2015 National report,* Scottish Government, November 2015.

37 *The future of general practice - survey results,* British Medical Association (BMA), February 2015.

38 *Vacancies – NHS Scotland Workforce Information - as at 31 March 2016,* ISD, June 2016.

39 ISD consultant vacancy data shows advertised vacancies only. It does not include vacant posts that are not advertised and being covered by other staff such as temporary agency or bank staff.

40 *Primary Care Workforce Survey Scotland 2015,* ISD Scotland, June 2016.

41 Information provided by NHS boards to auditors, June 2016.

42 *NHS Scotland Workforce Information - as at 31 March 2016,* ISD Scotland, June 2016.

43 *Information on the national recruitment for junior doctors in Scotland in 2016,* NHS Education for Scotland, July 2016.

44 *NHS Scotland Workforce Information - as at 31 March 2016,* ISD Scotland, 2016; and information provided by NHS boards to auditors, June 2016.

45 *Scottish Health Service Costs year ended 31 March 2015,* and NHS Scotland Workforce Information - as at 31 March 2016, ISD Scotland.

46 *Review of hospital-based complex clinical care: NHS Lothian,* HIS, May 2016.

47 *Unannounced Inspection Report – Care for Older People in Acute Hospitals: Queen Elizabeth University Hospital, NHS Greater Glasgow and Clyde,* HIS, December 2015.

48 *Unannounced Inspection Report – Care for Older People in Acute Hospitals: Aberdeen Royal Infirmary and Woodend Hospital, NHS Grampian,* HIS, November 2015.

49 *Services for older people in Argyll and Bute; Services for older people in the Shetland Islands; Services for older people in the Western Isles: Reports of a joint inspection of health and social work services for older people,* The Care Inspectorate and HIS, February 2016, November 2015 and March 2016.

50 *Community nursing staff in post and vacancies,* ISD Scotland, June 2015; *Nursing and midwifery staff in post,* ISD Scotland, September 2015.

51 *Number of GPs in Scotland by age, designation and gender,* ISD Scotland, December 2015.

52 *Overall NHS Scotland workforce summary by staff grouping,* ISD Scotland, June 2016.

53 *Local Delivery Plan Guidance 2016/17,* Scottish Government, January 2016.

54 Patients recorded under 'code 9' are those with complex needs. This includes patients delayed due to waiting for a place in a high-level needs specialist facility where no facilities exist or where an adult may lack capacity under adults with incapacity legislation.

55 *2015 Review of Public Health in Scotland: Strengthening the function and re-focusing action for a healthier Scotland,* Scottish Government, February 2016.

56 *A National Framework for Service Change in the NHS in Scotland,* Scottish Executive, May 2005.

57 *2020 Vision: Strategic Narrative,* Scottish Government, September 2011.

58 *Route map to the 2020 Vision for health and social care,* Scottish Government, May 2013.

59 *A National Clinical Strategy for Scotland,* Scottish Government, February 2016.

60 *IRF–NHS Scotland and Local Authority Social Care Expenditure–Financial Years 2010/11–2014/15,* ISD Scotland, March 2015 and May 2016.

61 *Health and social care integration: Progress update*, Audit Scotland, December 2015.

62 All areas, apart from Highland, are following the body corporate model, creating an Integration Joint Board to plan and commission integrated health and social care services in their areas. Highland is following the lead agency model, continuing arrangements established in earlier years for integrated services. In this model, the NHS board and the council delegate some of their functions to each other.

63 The national health and wellbeing outcomes are high-level statements of what health and social care partners are attempting to achieve through integration and improving quality across health and social care. http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes

64 *A Stronger Scotland: The Government's Programme for Scotland 2015-16,* Scottish Government, September 2015.

65 *Chief Medical Officer's Annual Report 2014-15: Realistic Medicine,* Scottish Government, January 2016.

66 *Changing models of health and social care*, Audit Scotland, March 2016.

67 *Creating a healthier Scotland: What matters to you?*, Scottish Government, March 2016.

68 https://ourvoice.scot/

69 *Reforming the NHS from within: Beyond hierarchy, inspection and markets,* The King's Fund, June 2014.

Appendix

NHS financial performance 2015/16

	£(000)			£(000)		
NHS board	**Revenue Resource Limit**	**Outturn**	**Variance**	**Capital Resource Limit**	**Outturn**	**Variance**
Ayrshire and Arran	725,762	725,697	65	43,409	43,408	1
Borders	214,209	214,119	90	2,375	2,369	6
Dumfries and Galloway	306,487	306,427	60	60,075	60,058	17
Fife	665,244	665,010	234	12,552	12,550	2
Forth Valley	533,973	533,772	201	3,894	3,894	0
Grampian	963,459	963,316	143	11,249	11,249	0
Greater Glasgow and Clyde	2,311,134	2,310,894	240	81,370	81,344	26
Highland	662,779	662,680	99	10,925	10,925	0
Lanarkshire	1,187,796	1,187,515	281	33,210	33,210	0
Lothian	1,462,183	1,461,834	349	107,875	107,875	0
Orkney	50,290	50,118	172	2,688	2,541	147
Shetland	54,992	54,593	399	362	286	76
Tayside	809,022	808,877	145	11,090	11,090	0
Western Isles	80,065	80,060	5	1,640	1,639	1
Territorials total	10,027,395	10,024,912	2,483	382,714	382,438	276
National Services Scotland	405,066	404,324	742	27,182	27,150	32
The Scottish Ambulance Service	227,688	227,634	54	10,773	10,772	1
NHS Education for Scotland	432,775	432,372	403	712	702	10
NHS 24	74,237	74,182	55	90	87	3
National Waiting Times Centre	70,112	70,112	0	6,387	6,387	0
The State Hospital	21,240	21,229	11	300	271	29
NHS Health Scotland	19,925	19,699	226	100	53	47
Healthcare Improvement Scotland	23,004	22,599	405	50	50	0
Mental Welfare Commission	4,417	4,417	0	0	0	0
Specials total	1,278,464	1,276,568	1,896	45,594	45,472	122
Total	**11,305,859**	**11,301,480**	**4,379**	**428,308**	**427,910**	**398**

Note: Figures include core and non-core revenue and capital funding (resource limit) and expenditure (outturn).
Source: Scottish Government consolidated accounts, June 2016

NHS in Scotland 2016

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SUPPLEMENT 1

Prepared by Audit Scotland | October 2016

NHS in Scotland 2016

Checklist for NHS non-executive directors

AUDITOR GENERAL

Checklist for NHS non-executive directors

The following checklist is designed to help non-executive directors with their role in overseeing the performance of NHS boards and is aimed at promoting good practice, scrutiny and challenge in decision-making.

The checklist should be read in conjunction with the report, NHS in Scotland 2016, published in October 2016. This report analyses the performance of the NHS during 2015/16, comments on its future plans and the extent to which public service reform is being implemented.

The checklist is divided into two sections covering:

- Financial and service performance
- Service reform.

The questions should help non-executive directors seek evidence, and subsequently gain assurance, on their board's approach in these areas. If the answer to any question is 'no', then we would encourage non-executive directors to speak with the board's senior executive team, or, where appropriate, the Chief Executive, to discuss how improvements can be made.

Section 1: Financial and service performance

NHS boards are facing an extremely challenging financial position and many had to use short-term measures in order to break even in 2015/16. NHS boards are facing increasing costs each year and will need to make unprecedented levels of savings in 2016/17. There is a risk that some will not be able to achieve financial balance. In addition, NHS boards continue to struggle to meet key national performance targets. Overall NHS Scotland failed to meet seven out of eight key targets. The following questions consider financial health, savings and service performance.

1. Do I have a good understanding of the overall financial health of the board?	Yes/No
Am I aware of the current underlying financial performance of the board against its annual revenue and capital budget limits?	☐ ☐
Do I have sufficient assurance that both annual revenue and capital limits will be met?	☐ ☐
Am I aware of all significant cost pressures facing the board and their implications? Cost pressures may include: • increased demand for services from a growing, ageing population • increasing staff costs, in particular spending on temporary staff • rising spending on drugs.	☐ ☐
Do I know the extent to which the board is using short-term approaches / one-off measures to achieve financial balance?	☐ ☐
Am I satisfied that appropriate action is being taken to address potential future funding gaps?	☐ ☐
Do I have confidence that appropriate action is being taken to help improve the financial health of the board?	☐ ☐
Does the board have a long-term financial strategy (covering five to ten years)?	☐ ☐
Do I have a good understanding of the current condition and future investment needs of the board's estate and other assets (such as medical equipment)?	☐ ☐

2. Does the board have a robust savings plan in place?	Yes/No
Where savings are identified, do plans demonstrate how savings will be achieved within the timescales given?	☐ ☐
It is important that the majority of savings are recurring to ensure the sustainability of the board's financial position. Am I confident that the board has an appropriate balance between recurring and non-recurring savings to ensure the board will meet its future savings targets?	☐ ☐
Where savings are unidentified, does the board have appropriate plans to identify them within the underlying financial period?	☐ ☐

3. Do I have a good, overall understanding of the board's service performance and quality?	Yes/No
Do I have a good understanding of the board's performance against national waiting time targets and standards?	☐ ☐
Am I aware of the general short-term and long-term trends in performance against each target and standard?	☐ ☐
Am I satisfied that appropriate action is being taken to improve both short-term and long-term performance?	☐ ☐
Am I aware of the costs involved in trying to improve performance?	☐ ☐
Am I made aware of any potential difficulties in meeting targets and standards in the future?	☐ ☐
Am I aware of staff and patients' views on the quality of service provided and actions planned to address concerns?	☐ ☐

Section 2: Service reform

The NHS is undergoing significant changes in how it delivers its services. A number of wide-ranging strategies propose significant change. The following questions consider boards' progress in changing and improving services, their long-term workforce requirements and how they are working with the public to change how people access, use and receive services.

1. Is the board taking ownership of changing and improving services?	Yes/No
Am I aware of what the board is doing to change and improve services?	☐ ☐
Am I satisfied with the board's level of engagement with integration authorities and other relevant partner organisations to change and improve services?	☐ ☐
Am I satisfied that changes and improvements to services are happening fast enough?	☐ ☐
Am I satisfied that the board and integration authorities are working together effectively, for example in relation to: • governance arrangements • reporting arrangements • budget-setting processes?	☐ ☐ ☐ ☐ ☐ ☐
Am I aware of what the board is doing in line with national policy on realistic medicine in: • working to reduce over-investigation and variation in treatment • ensuring patients are involved in making decisions and receive better information about potential treatments?	☐ ☐ ☐ ☐

2. Am I confident the board is making good progress in addressing long-term workforce requirements?	Yes/No
Does the board have a good understanding of its long-term workforce requirements such as the number and types of jobs needed, including skills required, roles and responsibilities?	☐ ☐
Is the board developing a long-term workforce plan (more than five years) in partnership with integration authorities?	☐ ☐

2. Am I confident the board is making good progress in addressing long-term workforce requirements? (Cont)	Yes/No
If yes to above, does the long-term workforce plan address: • recruitment • retention • succession planning?	☐ ☐ ☐ ☐ ☐ ☐

3. Is the board engaging with the public about the need for change in how they access, use and receive services?	Yes/No
Am I aware of what the board is doing to engage with the public about the need for, and benefits of, changing how services are provided?	☐ ☐
Am I aware of what the board is doing to encourage the public to take more responsibility for looking after their health and managing long-term conditions?	☐ ☐
Do I know the extent to which the board is working with partner organisations when engaging with the public about the need for change in how services are provided?	☐ ☐

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WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 7th December 2016

Subject: Audit Scotland Report on Social Work in Scotland

1. Purpose

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

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 January 2016 meeting, the Audit Committee were informed that Audit Scotland would be undertaking a national audit of Social Work in Scotland. It was also confirmed that Audit Scotland had specified that this audit would explicitly not look at health and social care integration (although the logic for doing so remains unclear).

3.3 This national audit has now been completed with the report published in September 2017 and appended here.

4. Main Issues

4.1 The specific findings of this report are arguably limited by the relatively small number of areas that the audit team engaged with in gathering evidence; and by what still appears to be a counter-intuitive disconnectedness from the more ambitious and comprehensive audit of health and social care integration that Audit Scotland are continuing with. Nonetheless, its key messages within the report are worthy of general consideration:

- The significant challenges that arise from a combination of financial pressures caused by a real-terms reduction in overall council spending, demographic change, and the cost of implementing new legislation and policies.
- The imperative to instigate a frank and wide-ranging debate with communities about the long-term future for social work and social care to

meet statutory responsibilities, given the funding available and the future challenges.
- The need to work with stakeholders to review how to provide social work services for the future and future funding arrangements.

5. People Implications

5.1 With respect to the workforce considerations highlighted within the Audit Scotland report, Audit Committee members will recall that two key themes of the Health & Social Care Partnership's Workforce & Organisational Development Strategy are a "capable workforce" and a "sustainable workforce", with an update having been presented at the November 2016 meeting of the Partnership Board.

6. Financial Implications

6.1 With respect to the financial pressures highlighted within the Audit Scotland report, Audit Committee members will appreciate that the Chief Financial Officer has articulated the financial challenges that the Health & Social Care Partnership faces (and as recognised within the Strategic Plan 2016-19) within their regular budgetary reports to the Partnership Board.

7. Professional Implications

7.1 With respect to the consideration given to the role of the Chief Social Work Officer within the Audit Scotland report, Audit Committee members will recall from the May 2016 meeting of the Partnership Board that the Chief Social Work Officer of the Council separately and independently presents their Annual Report to the Council and the Partnership Board.

8. Locality Implications

8.1 None associated with this report.

9. Risk Analysis

9.1 With respect to the issues pertaining to governance in the report, the Audit Committee will have been reassured by the positive report on Audit Scotland's Annual Audit Report and Accounts 2015/16 for West Dunbartonshire Health & Social Care Partnership Board that was presented by Audit Scotland at the September 2016 meeting.

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 on-going implementation of the current Strategic Plan.

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Date: 7th December 2016

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Appendices: Audit Scotland: Social Work in Scotland (September 2015)

Background Papers: Audit Committee Report: Forthcoming Audit Scotland Report - Social Work in Scotland (January 2016)

Audit Committee Report: Audit Scotland Report on Health & Social Care Integration (January 2016)

HSCP Board (May 2016): Chief Social Work Officer's Annual Report 2015-2016 (May 2016)

Audit Committee: Annual Audit Report and Accounts 2015/16 (September 2016)

HSCP Board: Workforce & Organisational Development Support Plan Update (November 2016)

Wards Affected: All

Health and social care series

Social work in Scotland

ACCOUNTS COMMISSION

Prepared by Audit Scotland
September 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.

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Our work includes:

- securing and acting upon the external audit of Scotland's councils and various joint boards and committees
- assessing the performance of councils in relation to Best Value and community planning
- carrying out national performance audits to help councils improve their services
- requiring councils to publish information to help the public assess their performance.

You can find out more about the work of the Accounts Commission on our website: www.audit-scotland.gov.uk/about/ac

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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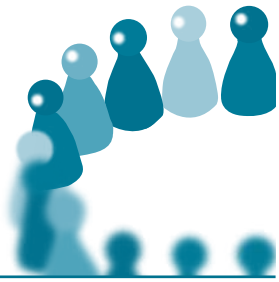

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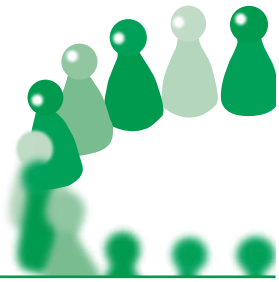


Estimated annual value of the contribution of 788,000 unpaid carers

£10.8 billion

17,400 children are looked after or are on the child protection register

Councils spend £3.1 billion on social work services a year

£3.1 billion

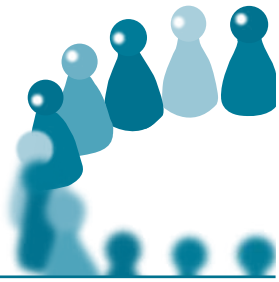
36,000 adults are in care homes and 61,500 people receive homecare

Councils spend £1.6 billion a year on social work services purchased from the third and private sectors

£1.6 billion

200,000 people are employed in social work/care, including 10,000 professional social workers

Summary



Key messages

1 Current approaches to delivering social work services will not be sustainable in the long term. There are risks that reducing costs further could affect the quality of services. Councils and Integration Joint Boards (IJBs) need to work with the Scottish Government, which sets the overall strategy for social work across Scotland, to make fundamental decisions about how they provide services in the future. They need to work more closely with service providers, people who use social work services and carers to commission services in a way that makes best use of the resources and expertise available locally. They also need to build communities' capacity to better support vulnerable local people to live independently in their own homes and communities.

2 Councils' social work departments are facing significant challenges because of a combination of financial pressures caused by a real-terms reduction in overall council spending, demographic change, and the cost of implementing new legislation and policies. If councils and IJBs continue to provide services in the same way, we have estimated that these changes require councils' social work spending to increase by between £510 and £667 million by 2020 (16–21 per cent increase).

3 The integration of health and social care has made governance arrangements more complex, but regardless of integration, councils retain statutory responsibilities in relation to social work services. Elected members have important leadership and scrutiny roles in councils. It is essential that elected members assure themselves that service quality is maintained and that risks are managed effectively. Elected members have a key role to play in a wider conversation with the public about service priorities and managing people's expectations of social work and social care services that councils can afford to provide in the future. The Scottish Government also has an important role to play in setting the overall context of the debate.

4 With integration and other changes over recent years, the key role of the chief social work officer (CSWO) has become more complex and challenging. Councils need to ensure that CSWOs have the status and capacity to enable them to fulfil their statutory responsibilities effectively.

current approaches to delivering social work services will not be sustainable in the long term

Key recommendations

Social work strategy and service planning

Councils and IJBs should:

- instigate a frank and wide-ranging debate with their communities about the long-term future for social work and social care in their area to meet statutory responsibilities, given the funding available and the future challenges (paragraph 111)
- work with the Scottish Government, their representative organisation (COSLA or the Scottish Local Government Partnership (SLGP)), Social Work Scotland and other stakeholders to review how to provide social work services for the future and future funding arrangements (paragraphs 35–41)
- develop long-term strategies for the services funded by social work by:
  - carrying out a detailed analysis of demographic change and the contribution preventative approaches can make to reduce demand for services (paragraph 52)
  - developing long-term financial and workforce plans (paragraph 81)
  - working with people who use services, carers and service providers to design and provide services around the needs of individuals (paragraphs 69–72)
  - working more closely with local communities to build their capacity so they can better support local people who may be at risk of needing to use services (paragraph 112)
  - considering examples of innovative practice from across Scotland and beyond (paragraphs 54, 67–68)
  - working with the NHS and Scottish Government to review how to better synchronise partners' budget-setting arrangements to support these strategies (paragraph 36).

Governance and scrutiny arrangements

Councils and IJBs should:

- ensure that the governance and scrutiny of social work services are appropriate and comprehensive across the whole of social work services, and review these arrangements regularly as partnerships develop and services change (paragraphs 87– 93)
- improve accountability by having processes in place to:
  - measure the outcomes of services, for example in criminal justice services, and their success rates in supporting individuals' efforts to desist from offending through their social inclusion
  - monitor the efficiency and effectiveness of services

  - allow elected members to assure themselves that the quality of social work services is being maintained and that councils are managing risks effectively
  - measure people's satisfaction with those services
  - report the findings to elected members and the IJB (paragraph 90, 108–109).

Councils should:

- demonstrate clear access for, and reporting to, the council by the CSWO, in line with guidance (paragraphs 104–106)
- ensure the CSWO has sufficient time and authority to enable them to fulfil the role effectively (paragraphs 102–107)
- ensure that CSWO annual reports provide an annual summary of the performance of the social work service, highlighting achievements and weaker areas of service delivery, setting out the council's response and plans to improve weaker areas and that these are actively scrutinised by elected members (paragraphs 108–110).

Workforce

Councils should:

- work with their representative organisation (COSLA or the SLGP), the Scottish Government and private and third sector employers to put in place a coordinated approach to resolve workforce issues in social care (paragraphs 21–23)
- as part of their contract monitoring arrangements, ensure that providers who use zero hours contracts allow staff to accept or turn down work without being penalised (paragraph 24).

Service efficiency and effectiveness

Councils and IJBs should:

- when planning an initiative, include evaluation criteria and extend or halt initiatives depending on the success of new approaches in improving outcomes and value for money (paragraphs 53–53)
- work with COSLA to review the eligibility framework to ensure that it is still fit for purpose in the light of recent policy and legislative changes (paragraphs 46–47)

Councils should:

- benchmark their services against those provided by other councils and providers within the UK and overseas to encourage innovation and improve services (paragraphs 54, 67–68).

Introduction

1. Scottish councils' social work departments provide and fund essential support to some of the most vulnerable people in society. They supported and protected over 300,000 people in 2014/15, around 70 per cent of whom were aged 65 and over.[1] Social work departments also provide and fund social care, for example care at home for older people who require help with dressing and taking medication. People supported by social work and social care in Scotland in 2014/15 included:

- 15,404 looked-after children (LAC), that is children in the care of their local authority
- 2,751 children on the child protection register, a list of children who may be at risk of harm[2]
- 61,500 people who received homecare services[3]
- 36,000 adults in care homes.[4]

2. In 2014/15, councils' net expenditure on social work was £3.1 billion.[5] Net spending is total spending less income, for example from charges for services. Just over 200,000 people work in social work and social care, around one in 13 people in employment in Scotland.[6] Many are employed in the private and third sectors that councils commission to provide services.[7] In addition, the Scottish Government estimates that there are 759,000 unpaid carers aged 16 and over in Scotland, 17 per cent of the adult population, and 29,000 young carers under 16.[8]

3. Social work services have recently been reorganised. The Public Bodies (Joint Working) (Scotland) Act 2014 requires councils and NHS boards to create an integration authority to be responsible for the strategic planning of adult social care services, some health services and other functions delegated to it. It is also responsible for ensuring the delivery of those functions. The Integration Joint Board (IJB) also has an operational role as described in the locally agreed operational arrangements set out within their integration scheme. The Act also allows councils to integrate children's and families' services and criminal justice social work.

4. Councils delegate their responsibility for strategic planning of adult social services, and any other services they have decided to include, to the integration authority. All council areas, apart from Highland, have created an IJB to plan and commission integrated health and social care services in their areas. The voting membership of IJBs comprise equal numbers of council elected members and NHS board non-executive directors. Our recent report *Health and social care integration* includes a description of the integration arrangements in each council area.[9]

5. The Scottish Government sets the legislative basis and the overall strategic framework for the delivery of social work. Its overall vision is 'a socially just Scotland with excellent social services delivered by a skilled and valued workforce which works with others to empower, support and protect people, with a focus on prevention, early intervention and enablement'.[10] The Scottish Government also sets the key outcomes that councils' social work services are expected to contribute to achieving, for example 'Our people are able to maintain their independence as they get older and are able to access appropriate support

when they need it.' This report focuses on councils' social work services, but recognises the role of the Scottish Government in setting the overall context in which councils operate.[11]

About the audit

6. The overall aim of the audit was to examine how effectively councils are planning to address the financial and demographic pressures facing social work. The objectives were to assess:

- the scale of the financial and demand pressures facing social work
- the strategies councils are adopting to meet these challenges
- the effectiveness of governance arrangements, including how elected members lead and oversee social work services
- the impact of financial and demand pressures on people who use services and on carers, and how councils involve them in planning how services are provided.

7. Social work comprises a wide range of services, and we have not covered all of them in this report. We also did not examine health and social care integration arrangements, which will be the subject of separate audit work, but we did consider their impact on councils' financial, operational and governance arrangements. Our methodology included:

- fieldwork interviews with elected members, senior managers and social workers in six council areas, Midlothian, East Renfrewshire, Comhairle nan Eilean Siar, Glasgow City, Perth and Kinross and West Lothian
- meetings and focus groups with stakeholders, including:
  - 33 focus groups and 12 interviews with service users and carers (165 participants)
  - four focus groups with service providers (over 40 participants)
  - attending the Coalition of Carers in Scotland Annual General Meeting
- desk research, including analysing both the impact of legislation and policy, and financial and demographic data.

8. Our audit took into account the findings of previous audits including:

- *Commissioning social care* (March 2012)
- *Reshaping care for older people* (February 2014)
- *Self-directed support* (June 2014)
- *Health and social care integration* (December 2015)
- *Changing models of health and social care* (March 2016)

In addition, we are planning further audit work on health and social care integration and following up our report on self-directed support.

9. We have produced four supplements to accompany this report:

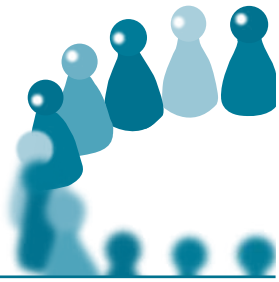
- Supplement 1 presents the findings of our survey of service users and carers.
- Supplement 2 lists advisory group members, who gave advice and feedback at important stages of the audit. It also describes the detailed audit methodology, the roles and responsibilities of the key social work organisations and social work legislation.
- Supplement 3 describes the governance and scrutiny arrangements in each of our fieldwork councils, providing an illustration of the variety and complexity of arrangements across Scotland.
- Supplement 4 is a self-assessment checklist for elected members.

10. This report has three parts:

- Part 1 Challenges facing social work services.
- Part 2 Strategies to address the challenges.
- Part 3 Social work governance and scrutiny arrangements.

Part 1

Challenges facing social work services



Key messages

1 Councils' social work departments provide important services to some of the most vulnerable people across Scotland. But they are facing significant challenges. These include financial pressures caused by a real-terms reduction in overall council spending, demographic changes, and the cost of implementing new legislation and policies. We have estimated that these changes require councils' social work spending to increase by between £510 and £667 million by 2020 (16–21 per cent increase), if councils and IJBs continue to provide services in the same way. Additional funding provided to IJBs via the NHS may partially relieve the financial pressures.

2 Councils are implementing a wide range of legislation and policy changes aimed at improving services, better supporting carers, improving outcomes for people and increasing the wages paid to adult care workers. This has significant financial implications. Councils are also under pressure due to increasing demand associated with demographic changes, particularly people living longer with health and care needs.

3 Since 2010/11, councils' total revenue funding has reduced by 11 per cent in real terms. Social work spending increased by three per cent in real terms over the same period, and now accounts for a third of overall council spending. Further reductions in councils' budgets are an additional pressure on social work services, particularly as their financial commitments continue to increase.

4 Social care providers have difficulty recruiting and retaining suitably qualified staff, particularly homecare staff and nursing staff. However, the number of social workers has increased over recent years.

councils' social work departments provide important services to some of the most vulnerable people across Scotland

Social work is a complex group of services

11. Social work departments provide and fund a wide range of specialist services for children, adults and families, and other specific groups. These services aim to improve the quality of their lives and help people to live more independently (Exhibit 1, page 12). Each of these client groups will include people requiring care, support or protection. For example, through care at home, child protection or helping people overcome addiction. Social workers deal with people with complex problems and with vulnerable people who need support at different

times or sometimes throughout their lives. They often specialise in particular service areas, for example criminal justice, children and families or mental health.

Social work services are implementing a considerable volume of legislation and policy change

12. Since the Scottish Parliament was established, there has been an increase in the volume of legislation related to social work. Councils are currently implementing several important pieces of legislation (Exhibit 2, page 13). This legislation is designed to improve services and the outcomes for people who use them, for example by bringing about increasingly personalised services to meet individuals' needs. However, implementing legislation can increase financial pressures and staff workload in the medium term.

Exhibit 1

Social work and social care services

Social work provides a variety of services to protect and support people in three client groups.

Children's services	Adult services	Criminal Justice services
Support for families	Residential care	Offender services
Child protection	Care at home	Providing social enquiry reports
Adoption services	Day care	Supervision of community payback and unpaid work
Kinship care	Hospital discharge coordination	Supporting families of prisoners
Fostering	Adult support and protection	Supervision of offenders on licence
Child care agencies	Mental health and addiction services	
Looked-after young people	Dementia and Alzheimer's services	
Day care	Supporting people with disabilities	
Residential care	Services to support carers	
Child and adolescent mental health	Provision of Aids and adaptations	
Supporting child refugees	Re-ablement services	
Supporting trafficked children	Supported living	
Support for young people involved in offending behaviour	Supporting refugee families	
Support for children with disabilities and their families	Supporting victims of people trafficking	
	Intermediate care	

Source: Audit Scotland

Exhibit 2

Social work and social care services

Councils are implementing a great deal of legislation, some with significant cost implications.

Legislation	Key features of legislation	Associated costs (from the financial memorandum to the Bills)
Social Care (Self-Directed Support) (Scotland) Act 2013	The Act aims to ensure that adults and children (including carers and young carers) have more choice and control over how their social care needs are met. It stipulates the forms of self directed support (SDS) that councils must offer to those assessed as requiring community care services.	• All local authorities are at different stages in the self-directed support agenda, meaning costs will vary widely.
The Children and Young People (Scotland) Act 2014	The Act makes provisions over a wide range of children's services policy, including 'Getting it Right for Every Child'. It includes: • local authorities and NHS boards having to develop joint children's services plans in cooperation with a range of other service providers • a 'named person' for every child • extending free early learning and childcare from 475 to 600 hours a year for all three and four-year-olds and two-year-olds who have been 'looked after' or have a kinship care residence order • a statutory definition of 'corporate parenting' • increasing the upper age limit for aftercare support from 21 to 26.	Additional annual costs estimated to be: • £78.8 million in 2014/15 • £121.8 million in 2016/17 • £98.0 million in 2019/20 • Cumulative total from 2014-15 to 2019-20 is £595 million.
The Public Bodies (Joint Working) (Scotland) Act 2014	The aim of the Act is to achieve greater integration between health and social care services to improve outcomes for individuals. It also aims to improve efficiency by 'shifting the balance of care' from the expensive acute sector, such as large hospitals, to less expensive community settings. The Scottish Government estimates partnerships should achieve potential efficiencies of £138-£157 million a year by providing support to keep people out of hospital and enabling them to return home as soon as they are well enough.	Costs to health boards and local authorities: • 2014/15: £5.35 million • 2015/16: £5.6 million • 2016/17: £5.6 million.

Cont.

Legislation	Key features of legislation	Associated costs (from the financial memorandum to the Bills)
The Carers (Scotland) Act 2016	The Act aims to improve support to carers by: • changing the definition of a carer so that it covers more people • placing a duty on local authorities to prepare an adult care and support plan or young carer statement for anyone it identifies as a carer, or for any carer who requests one • introducing a duty for local authorities to provide support to carers who are entitled under local criteria • requiring local authorities and NHS boards to involve carers in carers' services • introducing a duty for local authorities to prepare a carers strategy • requiring local authorities to establish and maintain advice and information services for carers.	Estimated additional costs for local authorities are: • £11.3-£12.5 million in 2017/18, rising to £71.8-£83.5 million by 2021/22. • The total estimated impact on councils between 2017/18 and 2022/23 is £245-£289 million.
The Community Justice (Scotland) Act 2016	The Community Justice (Scotland) Bill seeks to establish new arrangements for providing and overseeing community justice. Currently eight community justice authorities (CJAs) bring together a range of agencies to coordinate local services for offenders and their families. They will be abolished and replaced by a model involving national leadership, oversight and support for community justice services by a new body called Community Justice Scotland, funded by, and responsible to, Scottish ministers.	The provisions will have few if any financial implications for local authorities other than during the transitional period.
The UN Convention on the Rights of Persons with Disabilities (UNCRPD) (Scottish framework and delivery plan)	The delivery plan provides a framework to allow people with disabilities to have the same equality and human rights as non-disabled people. It includes legislation, such as Self-Directed Support and the Children and Young People (Scotland) Act 2014. The draft delivery plan groups the UNCRPD articles into four outcomes covering equal and inclusive communication and access to: • the physical and cultural environment, transport and suitable affordable housing • healthcare and support for independent living, with control over the use of funding • education, paid employment and an appropriate income and support whether in or out of work • the justice system.	It is difficult to predict the overall impact in terms of cost, but it may have a significant impact on the way councils deliver services.

Note: Cost information is taken from the financial memorandum that accompanies each Bill.

Source: Audit Scotland

13. In addition to changes in legislation, there have been a number of significant policy developments, some backed by legislation, that require considerable change to the way that social work services are provided. These include:

- Increased personalisation of services – Personalisation of services, for example through self-directed support (SDS), is a major change to the way councils support people with social care needs. The human rights principles of fairness, respect, equality, dignity and autonomy for all form the basis of SDS. Social work professionals need to see people as equal partners in determining their care needs and controlling how they meet their needs. This means they are not limited to choosing from existing services. Social work services may need to move spending away from existing services towards giving people their own budget to spend. This can lead to a reduction in use of some services. However, it can be difficult for councils to withdraw existing underused services because of public and political pressures.

- An increased focus on prevention – The report from the Commission on the Future Delivery of Public Services (the Christie Commission) highlighted the need to transform the way public services are planned and delivered.[12] The report identified prevention, early intervention and providing better outcomes for people and communities as key to this transformation.

- An increased focus on joint working – A series of initiatives over recent years has aimed to encourage a more joined-up approach to health and social care. These include the creation of Local Health Care Cooperatives (LHCCs) in 1999, and their replacement by Community Health Partnerships (CHPs) in 2004. LHCCs and CHPs lacked the authority to redesign services fundamentally.[13] The Public Bodies (Joint Working) (Scotland) Act 2014 aimed to achieve greater integration between health and social care services to improve outcomes for individuals and improve efficiency by 'shifting the balance of care' from the acute sector to community settings.

14. New legislation often has financial consequences and, to allow MSPs to consider the full impact of legislation, a financial memorandum to each Bill sets out the estimated cost of implementation. These are the best available estimates at the time, but have sometimes proved inaccurate. The Scottish Government may fund or partially fund these costs but councils sometimes dispute these estimates and the level of funding required.

15. New legislation can also affect how councils deliver services by creating entitlements to services based on specific criteria. Councils need to respond to these and manage the expectations of people who use services and carers. These entitlements can be based on needs assessments, or on the expected outcomes, or they can create rights to services for particular groups. Transitions are important as entitlements change depending on age. For example:

- Children have the right to specific support that adults may not have. As a result, councils have to be careful in managing the expectations of parents as children reach adulthood.

- People aged over 65 may be entitled to free personal care, but 64-year-olds with similar needs may have to make a financial contribution to their care.

I receive 37 hours of support and seven sleepovers. I get personal care, support with the running of my flat, to shop and support to be involved in the community. They also enable me to attend university.

Service user, physical disabilities

When [grandchild] turned 16 I was told that this Saturday service was going to stop because he would now be under adult services. I had no forewarning, no-one from adult services contacted me; I contacted them and they couldn't offer any support. It's a funding issue.

Carer

Social work services face significant demographic challenges

16. The impact of demographic change on health and social care spending has already been well reported.[14] Between 2012 and 2037, Scotland's population is projected to increase by nine per cent. All parts of the population are projected to increase, but by different amounts:

- the number of children by five per cent
- the working age population by four per cent
- the number of people of pensionable age by 27 per cent.[15]

17. Overall demand for health and social care will depend significantly on the number of older people and the percentage who require care. Although life expectancy continues to increase, healthy life expectancy (HLE), that is the number of years people can expect to live in good health, has not changed significantly since 2008 (Exhibit 3). This means that a larger number of older people may require support for longer, unless HLE increases. Councils and the Scottish Government have taken steps to try to increase HLE. This includes measures to reduce smoking, alcohol consumption and environmental pollution and providing information to the public about the benefits of a healthy lifestyle.

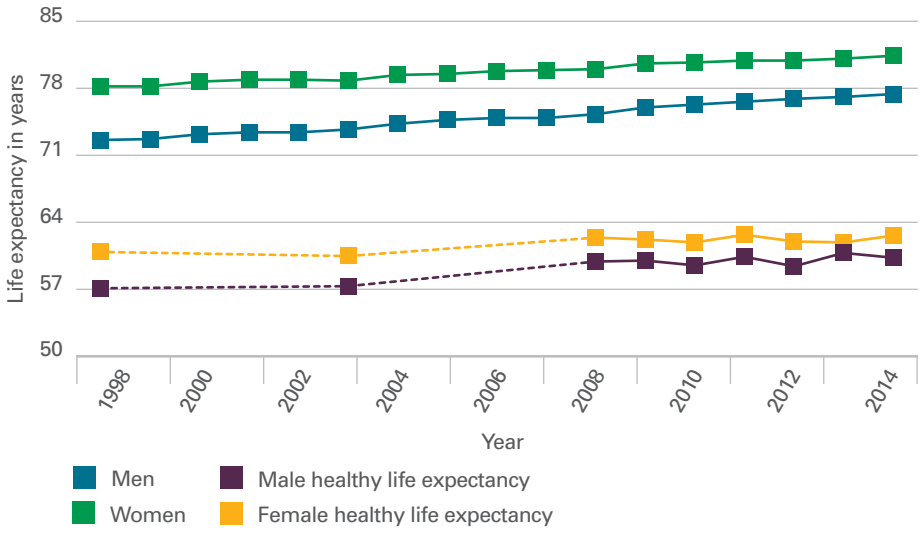
Supporting looked-after children and child protection has increased demand on social work services

18. Looked-after children (LAC) are children in the care of their local authority. They may live in their own home, with foster or kinship carers or in a residential

Exhibit 3

Changes in life expectancy and healthy life expectancy

Life expectancy is increasing faster than healthy life expectancy, potentially increasing service pressures.



Note: Data on healthy life expectancy was not collected annually until 2008.

Source: Scottish Health Survey, Scottish Household Survey, National Records of Scotland births, deaths and populations data

home. Most become looked after for care and protection reasons. The term also includes unaccompanied children seeking asylum and young people who have been illegally trafficked. As at July 2015, 17,357 children in Scotland, around 1.8 per cent of the total, were looked after or on the child protection register.[16,17] Of these 15,404 were looked after, 2,751 were on the child protection register and 798 were both looked after and on the register. While there has been a recent reduction, possibly due to improvements in prevention, the number of LAC has increased by 36 per cent since 2000, although the numbers and trends vary among councils. The number of children on the child protection register increased by 34 per cent between 2000 and 2015, with three in every 1,000 children under 16 now on the register. In smaller councils, the number of children on the register (and resultant workload) can fluctuate significantly, particularly when sibling groups in large families are registered.

19. The reasons for these increases are likely to be complex. Many of the councils we visited think that increases in drug and alcohol use by parents are important factors. Others have seen an increase in reporting of domestic abuse and alcohol-related incidents in more affluent areas that might have gone unreported in the past. In addition, early intervention policies are likely to have led to an increase in the number of looked after children, but a decrease in the time that councils look after them. Early intervention means identifying people at risk and intervening to prevent the risk. Between 2007 and 2014, the number of children removed from the register who had been on it for less than a year increased from 2,421 (79 per cent of the total) to 3,930 (87 per cent). Over the same period, the number of children who had been on the register for more than a year fell from 663 to 569.

Councils and service providers face difficulties in recruiting staff

20. Just over 200,000 people work in social work and social care services, representing around one in 13 people in employment in Scotland.[18] Almost half work part time and 85 per cent are women. The private sector is the biggest employer (42 per cent of staff), followed by the public sector (31 per cent) and the third sector (28 per cent). This distribution varies considerably among councils, and the public sector is the biggest provider in the three island authorities.

21. Many third and private sector providers raised staff recruitment as a significant issue for them. Councils have fewer recruitment problems, the exception being in remote rural areas, where it can be difficult to recruit specialised staff. Third and private sector providers reported that the apparent causes for these difficulties included:

- Low pay – providers in both the private and third sectors felt that the rates councils pay under their contracts only allowed them to pay staff at, or near, the minimum wage. In addition, travel time between clients is sometimes unpaid.
- Antisocial hours – providing homecare often requires carers to assist people to get out of bed in the morning and into bed at night. This can mean weekend working, split shifts and antisocial hours, with no additional pay. The increased personalisation of care has contributed to this as carers increasingly provide care to suit individuals, rather than fitting individuals into the care system.

Driving down costs to the extent that staff are recognised as being in a 'low wage sector' increases the problem of recruitment.

Service provider

- **Difficult working conditions** – staff have to take care of people with a variety of care needs that some find difficult, for example, assisting people with bathing and personal hygiene, or who have dementia or incontinence.

22. The cycle of continually recruiting and training staff is costly and could potentially have an impact on the quality of services provided. Service provider focus groups highlighted a need to provide staff with a sustainable career path to improve recruitment and retention. Overall, the public sector has the most stable workforce and the private sector the least, although this does not appear to be the case for all categories of staff (Exhibit 4).[19]

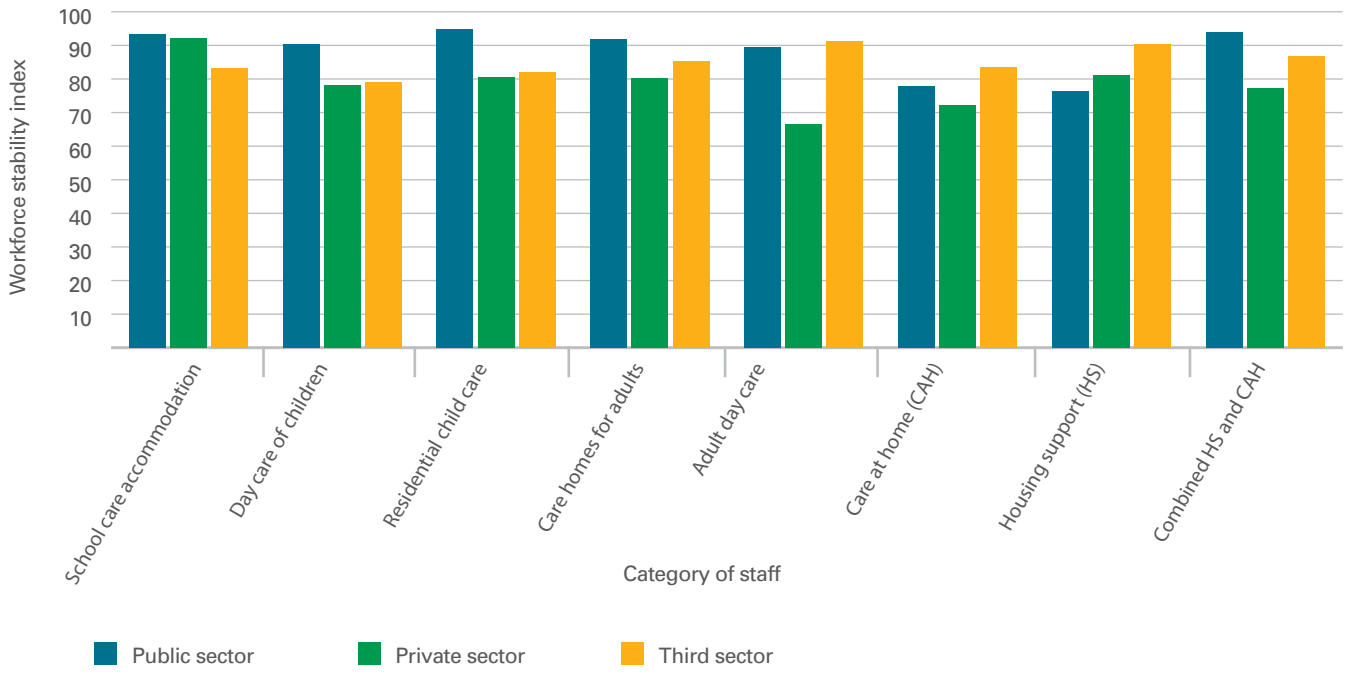
23. Some care providers expressed concerns that leaving the EU and the potential introduction of a points-based immigration system could create problems for staff recruitment. A 2008 workforce survey indicated that 6.1 per cent of the social care workforce in Scottish care homes for older people were EU – non-UK workers, and a further 7.3 per cent were employed under work permits. Most of those employed from within the EU came from Poland and the Czech Republic and those from outside the EU were from the Philippines, India and China.[20]

24. Four per cent of the workforce have a no guaranteed hours (NGH) contract.[21] When combined with the other contract types that may be considered a zero hours contract (bank and casual or relief), they comprise roughly ten per cent of the contracts in the workforce. Providers believe zero hours contracts are

Exhibit 4

Social work workforce stability 2013/14

The public sector workforce is generally the most stable.



Note: Because of data limitations, the SSSC cannot provide an accurate estimate for turnover. However, they are able to calculate a 'stability index' of staff who are still in post after a year. If the index is 90 per cent it means that 10 per cent of staff present at the start of the period are no longer present. It is important to note that this does not mean that turnover is 10 per cent as the measure excludes staff who joined and left within the period under consideration.

Source: Scottish Social Services Council (SSSC)

essential to provide a flexible and personalised service to people, while also providing flexibility for staff. These contracts are suitable as long as they are not exclusive and staff are free to accept or turn down work without being penalised. As part of good contract management, councils should ensure that providers use zero hours contracts properly.

25. There are skills and staffing shortages in several areas of social work and social care, including:

- Homecare staff – 69,690 people work in housing support or care at home.[22] Both third sector and private sector providers find it difficult to recruit staff. Rapid staff turnover is a significant threat to maintaining service standards, particularly in adult day care.

- Nursing staff – 6,620 registered nurses work in the care sector, 4,930 of them in adult care homes. Ninety-one per cent of registered nurses are in the private sector. Care providers in both the private and third sectors are having trouble recruiting qualified nursing staff for care homes. As a result, providers were trying to recruit staff from outside the UK. Although data is not collected on vacancy rates for nursing staff in the care sector, there were 2,207 whole-time equivalent (WTE) vacant nursing and midwifery posts in the NHS in Scotland at 31 March 2016.[23]

- Mental health officers (MHOs) – are specialist social workers with a statutory role in the detention and treatment of people with mental illness. They look into the circumstances of individuals where people have concerns about their mental health. They can apply for a court order that would allow an individual to be taken to a 'place of safety' for up to seven days.[24] In December 2014, the number of registered MHOs was at its lowest level since 2005. However, in 2015 there was a small increase (two per cent) to create a total of 670 practising MHOs. In 2015 there were 15 unfilled posts for MHOs in Scotland and 17 further post holders who were unavailable, for example through career breaks or secondments, about five per cent of the total.[25]

The professional social work role is changing

26. The workforce includes 11,127 professional social workers registered in Scotland. Almost three-quarters, 8,242, work in councils and 2,040 (18 per cent) are employed by other providers. Most of the rest are self-employed, unemployed or recently retired. Not all qualified social workers work in roles where they are required by law to hold a social work qualification (statutory roles), for example they may work in management roles. The number of WTE social workers employed by councils in statutory roles increased significantly between 2001 and 2015, from 3,873 to an estimated 5,630. Of these, 31 per cent work with adults, 49 per cent with children, 15 per cent in criminal justice; five per cent work generically.[26]

27. The majority of social workers in our focus groups were optimistic about their role and their ability to make a positive difference to people's lives. Changes in structural and partnership arrangements in health and social care have introduced more working in multidisciplinary teams, for example with health visitors or occupational therapists. Social workers sharing offices with other disciplines can be both rewarding and effective. We found that social workers who had worked in multidisciplinary teams for some time were convinced that improved

communication with community NHS staff had improved services. However, some were concerned about erosion of their professional identity. Moreover, adapting to working with colleagues from a different culture, for example in approaches to risk, could be challenging.

Unpaid carers provide the majority of social care in Scotland

28. The Scottish Government estimates that there are 759,000 unpaid carers aged 16 and over in Scotland, around 17 per cent of the adult population. Of these, 171,000 (23 per cent) provide care for 35 hours or more a week. In addition, there are an estimated 29,000 young carers under 16, around four per cent of the under 16 population.[27] There are many more unpaid carers providing support to people than those in the paid social services workforce.

29. In 2010, the Scottish Government reported that unpaid carers saved health and social services an estimated £7.68 billion a year.[28] More recently, Carers UK estimated the value of unpaid care in Scotland to be £10.8 billion, more than three times current social work net spending.[29]

30. The Carers (Scotland) Act 2016 became law in March 2016. It provides for the planning and provision of support, information and advice for unpaid carers and encourages councils to become involved in carers' services. It also means councils are required to prepare a carer support plan for carers, including young carers, who want one. A carer support plan sets out information about the carer's circumstances, the amount of care they are able and willing to provide, the carer's needs for support and the support available. The Act also requires each council to establish and maintain an information and advice service for carers who live or care for people in its area.

> **(Unpaid) Carers do everything! Link everything! Anchor everything!**
>
> Carer

> **24/7 carers are there, understanding the person's needs.**
>
> Carer

Social work services are facing considerable financial pressures

31. In 2014/15, councils' net spending on social work services was £3.1 billion (Exhibit 5, page 21). Services for older people made up around 44 per cent of this spending, and services for children and families around 28 per cent. A range of other services make up the remainder.

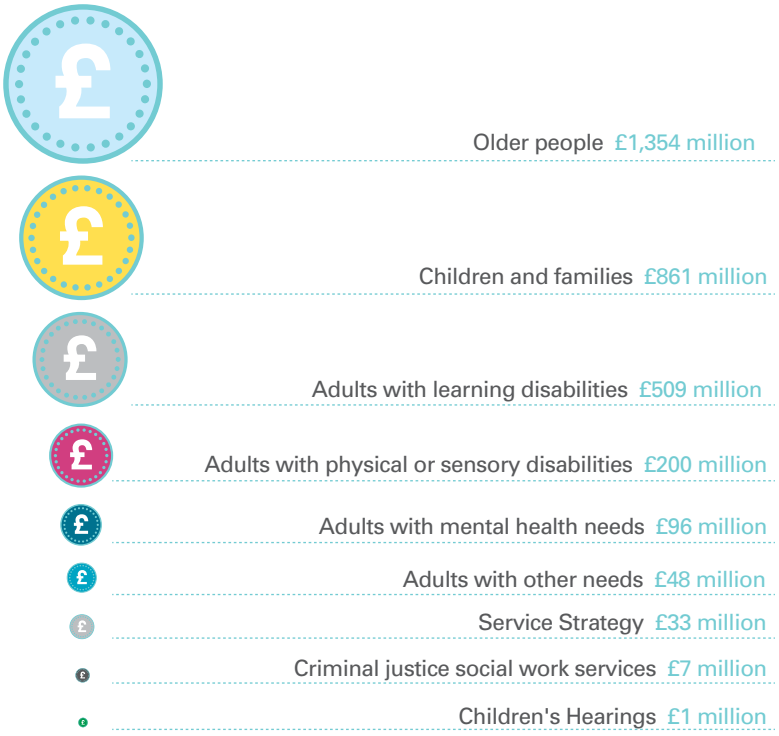
32. In 2016/17, councils' total revenue funding, that is the funding used for day-to-day spending, will be five per cent lower than in 2015/16. This is a reduction of 11 per cent in real terms since 2010/11.[30] This is a significant pressure on all council services, including social work. The 2016/17 figure does not include £250 million that the Scottish Government allocated to health and social care integration authorities to support social care, because the Scottish Government routed it through the NHS boards' budgets rather than council budgets.

33. Against the trend of falling council spending, councils' total social work net spending increased in real terms from £3.2 billion to £3.3 billion between 2010/11 and 2014/15, an average increase of 0.8 per cent a year.[31] As a result, spending on social work increased from 28.9 per cent to 32 per cent of council spending.[32] An analysis of council accounts found that two-thirds of councils reported social work budget overspends totalling £40 million in 2014/15. Most councils identified homecare services for adults and older people as the service under most pressure.

Exhibit 5

Social work spending, 2014/15

Around 44 per cent of the £3.1 billion net social work spending is on services for older people and this percentage is likely to increase with demographic change.



Source: Local Government Financial Statistics 2014-15 (Annex A), February 2016

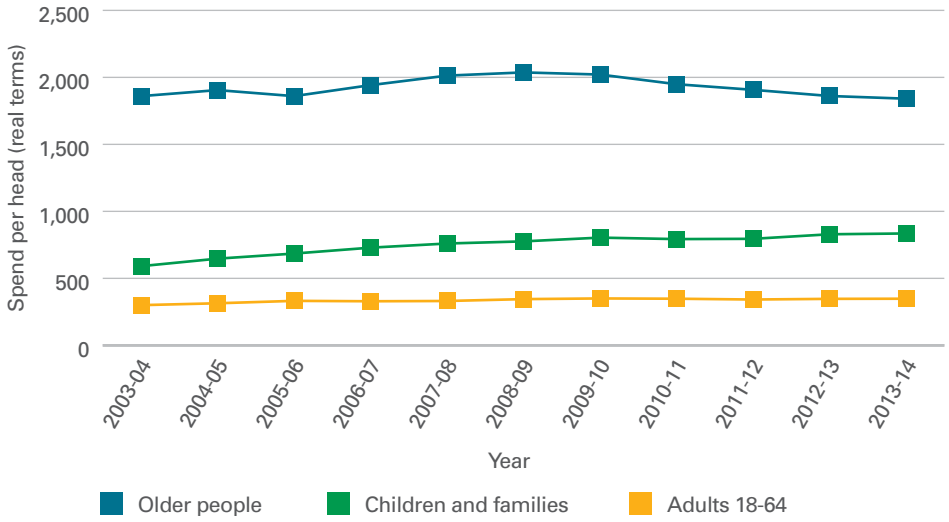
34. There have been significant long-term changes in spending per head among different age groups (Exhibit 6, page 22). The reduction in spending on older people is a combination of a lower percentage of older people receiving services (paragraph 46) and a reduction in the real-terms cost of care homes (paragraph 62) and homecare (paragraph 59). The increase in spending on children and families may be related to an increase in the number of looked after children, an increase in the complexity of children and families' cases and an increased focus on early intervention.

Few councils and IJBs have long-term spending plans for social work

35. We examined council budgets and spending plans for 2015/16, 2016/17 and beyond to assess whether the trends identified above are likely to continue in the medium term. Budget information is more difficult to collect and interpret than historic expenditure information because councils do not present this information consistently. In addition, most IJBs had not finalised their budgets at the time we were conducting our analyses. Budgets for 2016/17 were very similar to 2015/16 in cash terms. We also analysed councils' savings plans. Councils plan to save £54 million from social work budgets in 2016/17, mainly through changing how they provide services, reducing services and making efficiency savings.

Exhibit 6

Real-terms spending on social work services per head, 2003/4 to 2013/14



Source: Expenditure on Adult Social Care Services, Scotland, 2003/4 to 2013/14, Scottish Government

36. Councils and NHS boards work on different financial planning cycles and agree budgets at different times of the year. A survey of IJBs by the Scottish Parliament's Health and Sport Committee found that over half of IJBs were unable to set a budget for 2016/17 before June 2016, and over a quarter before August 2016.[33] A number of responses mentioned delays in receiving the health allocation for the partnership as a cause of difficulty in setting budgets. If councils and NHS boards continue with different budget cycles, it will make it more difficult for IJBs to agree budgets for services in a timely way.

37. In February 2016, as part of the local government settlement, the Scottish Government announced funding of £250 million to support social care for the three years to 2018/19. Some of this funding was to help pay the Living Wage (£8.25 an hour) to all care workers in adult social care, regardless of age from 1 October 2016.

38. The Living Wage Foundation sets the Living Wage. It is up-rated annually and they will announce a new rate in November. The local government settlement does not require councils to increase wages to the new Living Wage rate when the Living Wage Foundation announces it in November.

39. The Scottish Government has estimated that over the period 2012-32, spending on social care for older people will need to increase by between 1.5 per cent and 3.3 per cent a year, depending on changes to healthy life expectancy (HLE).[34] We have calculated lower and upper limits of the cost of demographic change based on Scottish Government projections. Added to this are cost pressures arising from legislation, based on their financial memorandums, and the cost implications of the commitment to the Living Wage for care workers (Exhibit 7).[35]

Exhibit 7

Potential financial pressures facing Scottish councils by 2019/20

Councils face significant cost pressures.

Reason for cost increase	Lower limit (£ million)	Upper limit (£ million)
Demographic change (older people only)	£141	£287
The Children and Young People (Scotland) Act 2014	£98	£98
The Carers (Scotland) Act 2016	£72	£83
The Living Wage	£199	£199
Potential cost increase by 2019/20	**£510**	**£667**

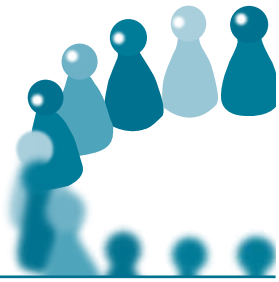
Source: Audit Scotland analysis of financial memorandums and information provided by the Scottish Government

40. Together they imply increases in social work spending of between £510 and £667 million (a 16–21 per cent increase) by 2019/20. Additional Scottish Government funding to implement legislation and to IJBs (via the NHS) may partially relieve some of these pressures, as could potential savings from health and social care integration and by providing services differently.

41. Councils and IJBs need to develop longer-term financial strategies and plans for social work services, taking into consideration the above financial pressures. For example, they need to assess the affordability of options for changing the way they deliver services, so that elected members can consult the public and make informed decisions. Some of the councils we visited had already done this. For example, West Lothian Council had detailed projections of cost pressures for the client groups in social work and had considered the options available to meet those pressures depending on the level of funding available.

Part 2

How councils are addressing the challenges



Key messages

1. Councils have adopted a number of strategies to achieve savings. They have tightened eligibility criteria so that fewer people receive services and targeted funding to people in greatest need. They have also achieved significant savings in the cost of homecare and care homes through competitive tendering and the national care home contract.

2. Current approaches will not be sustainable given the scale of the challenge, and there are risks that reducing costs further could affect the quality of services. Fundamental decisions are required on long-term funding and social work service models for the future.

3. There has been a limited shift to more prevention and different models of care. Many councils have taken an opportunistic or piecemeal approach to changing how they deliver services, often to meet financial challenges or as the result of initiative funding by the Scottish Government.

4. Opportunities for people who use social work services and carers to be involved in planning services are limited. There is scope for councils and IJBs to do more to work with them to design, commission, deliver and evaluate services to achieve better outcomes. Service providers also have an important role to play in commissioning services, and councils are not doing enough to work with them to design services based around user needs.

5. People who use services and their carers value the support they get from social work and social care services. Our focus groups had a number of concerns about homecare, such as shorter visits and people using services seeing a number of different carers.

6. The Scottish Government's Living Wage commitment provides an opportunity to improve recruitment and retention of social care staff, and to create a more stable skilled workforce. But it adds to the financial pressures on councils and providers.

fundamental decisions are required on long-term funding and social work service models for the future

Councils, COSLA and the Scottish Government have agreed approaches intended to address major long-term pressures

42. Social work services operate within a number of national strategies, developed by the Scottish Government and councils that are intended to

respond to the major challenges set out in Part 1, such as demographic change, personalisation and prevention. These include:

- **Social Services in Scotland: a shared vision and strategy for 2015-2020** – this builds on the *21st Century Social Work Review* published in 2005. It covers the whole of social work and its aims include:
  - encouraging a skilled and valued workforce
  - working with providers, people who use services and carers to empower, support and protect people
  - a focus on prevention, early intervention and enablement.[36]
- **The 2020 Vision for Health and Social Care in Scotland** envisages that by 2020 people will live longer healthier lives at home, or in a homely setting and that Scotland will have an integrated health and social care system with a focus on prevention and supported self-management.[37]
- **Reshaping Care for Older People** (RCOP) – a ten-year change programme focused on giving people support to live independently in their own homes and in good health for as long as possible. In 2011/12, the Scottish Government introduced the Change Fund, totalling £300 million to 2014/15, specifically to develop this area of policy.[38]

43. Our report, *Reshaping care for older people* commented on slow progress of RCOP and the need to monitor its impact. It also reported that initiatives are not always evidence-based or monitored and that it was not clear how councils would sustain and expand successful projects.[39] Our report *Changing models of health and social care* concluded 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 not widespread.[40]

Councils have changed eligibility criteria to reduce the number of people who qualify to receive services to balance their budgets

44. Councils have a statutory duty to assess people's social care needs. If they assess a person as needing support and eligible to receive services, they must provide or pay for services to meet these needs.[41] If people are eligible for support, the Social Care (Self-Directed Support) (Scotland) Act 2013 also requires councils to offer people a choice of four options in how their social care is provided:

- a direct payment – this allows people to choose how their support is provided, and gives them as much control as they want over their individual budget
- direct the available support – the person asks others to arrange support and manage the budget
- the council arranges support – the councils choose, arrange and budget for services
- a mix of all the above options.

45. To balance their budgets, councils prioritise funding and staff to those people most in need by setting eligibility criteria and assessing each person's needs against these criteria. Councils have discretion on the thresholds for care they use locally. The level set in each council will depend on the resources available and

I have a say about who is on my team. I got to meet them and do interviews. I did the questions in advance.

Service user, young person with physical disabilities

on the council's policies and priorities. Councils assess people's needs using a common framework of four eligibility levels:

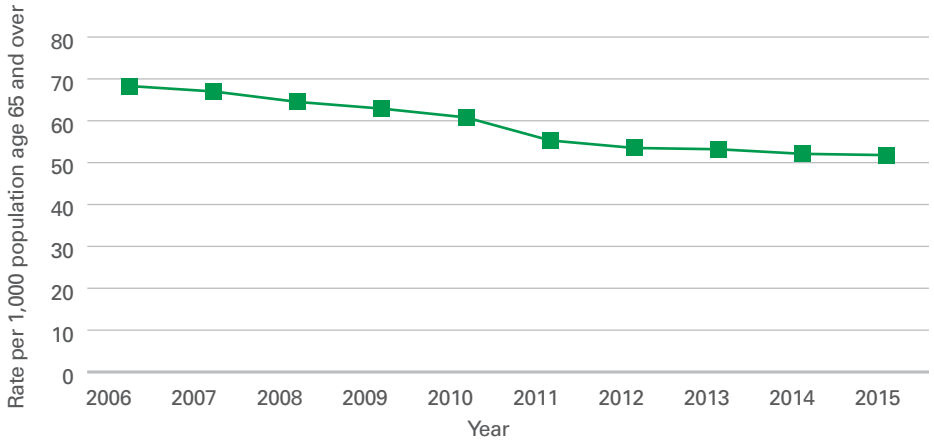
- **Critical Risk (high priority)** – Indicates major risks to an individual's independent living or health and wellbeing likely to require social care services 'immediately' or 'imminently'.
- **Substantial Risk (high priority)** – Indicates significant risks to an individual's independence or health and wellbeing likely to require immediate or imminent social care services.
- **Moderate Risk** – Indicates some risks to an individual's independence or health and wellbeing. These may require some social care services that care providers manage and prioritise on an ongoing basis, or they may simply be manageable over the foreseeable future with ongoing review but without providing services.
- **Low Risk** – Indicates that there may be some quality of life issues, but low risks to an individual's independence or health and wellbeing with very limited, if any, requirement for social care services. There may be some need for alternative support or advice and appropriate arrangements for review over the foreseeable future or longer term.[42]

46. Because of funding pressures, most councils now only provide services to people assessed as being at critical and substantial risk. Focusing services on people with higher levels of need resulted in a reduction in the percentage of older people receiving homecare between 2006 and 2015, from just under 70 per 1,000 population to 50 per 1,000 (Exhibit 8). Of the councils we visited, only West Lothian still provides services to people assessed as at moderate risk.

Exhibit 8

Proportion of people aged 65+ receiving homecare, 2006 to 2015

The proportion of people aged 65 and over receiving homecare has fallen from just under 70 per 1,000 to just over 50 per 1,000.



Source: Expenditure on Adult Social Care Services, Scotland, 2003-04 to 2013-14, Scottish Government

47. Because most councils no longer provide services to people in the two lower risk eligibility criteria, and because of the considerable financial and legislative changes in social work since the current framework was developed, it may be an opportune time for COSLA and councils to review the framework to ensure that it is still fit for purpose.

48. Some councils have also limited the level of service they provide in some areas. Examples from our fieldwork include reducing the length of carer worker visits, providing ready meals and frozen meals, with one hot meal per day (leaving snacks for other meals) and restricting showers to once or twice a week for some people.

> **I had an OT (occupational therapy) assessment, and social work and they gave me 15 minutes of care. It's really not enough time. It's the choice between getting washed or getting dressed**
>
> Service user, physical disabilities

Councils are finding it hard to fund a strategic approach to prevention

49. Developing a strategic approach to prevention is essential for councils to sustain provision of social services. In 2011, the Christie Commission concluded that Scotland needed to 'devise a model of public services that is both financially sustainable and is capable of meeting the significant longer-term challenges'. It also proposed that a radical shift towards preventative public spending was essential. In September 2011, 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.[43] Central to the vision is a focus on prevention, anticipation and supported self-management. The Scottish Government also set up change funds to stimulate prevention work, specifically in the areas of early years, re-offending and re-shaping care for older people.

50. Councils, IJBs and other stakeholders all believe that prevention is the key to meeting the growing demands for social work services within finite resources. However, the councils we visited varied in how well they are developing and implementing preventative strategies. Some, including West Lothian and East Renfrewshire, have a strong focus on prevention, for example they maintain prevention budgets and build prevention into how they plan and provide services. Councils cited various challenges to shifting service models towards prevention:

- a lack of funding because resources are locked into current service models to meet existing demands and savings may not materialise for several years after implementation
- a lack of social worker time – a concern that social work has become crisis based
- managing relatives' expectations – for example, some relatives prefer the council to provide a full care package of residential care rather than have their relation go through a re-ablement programme to allow them to live more independently at home
- community resistance – for example, opposition to closing a local hospital or care facility to free up funding for more accessible community-based care
- cultural differences between councils and the NHS – a common perception among a number of social workers in our focus groups is that the NHS is more risk averse and less used to giving staff responsibility to take the initiative on the care of individuals.

51. Councils have commonly adopted some prevention initiatives, most of which are effective in the short term, but examples of long-term initiatives are more limited. Common prevention activities included:

- Re-ablement – involves encouraging people using services (often people leaving hospital) to develop the confidence and ability to live more independently and be less reliant on social care. This is usually a six-week programme of intensive help; it commonly results in people requiring less or even no ongoing support. Glasgow City Council found that 30 per cent of clients had no further need of a service following a period of re-ablement. The change fund initially funded this project but the council now funds it as the savings justify the investment.

- Using technology to enable people to continue living in their own homes for longer and to give reassurance to their carers and families. All councils provide a community alarm service. More advanced telecare systems use movement sensors and smoke detectors to alert the service to potential problems or prompt people to take medication. For example, West Lothian Council uses technology to help people with dementia, their families and carers manage issues that may arise in and around the home. Examples include:
  - a GPS device to help relatives or carers to find a vulnerable person if they get lost
  - extreme temperature and flood sensors fitted in kitchens
  - sensors to alert a carer when the person gets out of bed
  - removable sensors, called 'just checking', placed at doorways to monitor movement and assess lifestyle patterns.

- Early intervention for children and families is another widely implemented approach. Social work services work with relevant partners to support children and families at risk of needing support that is more intensive in future, or with older children at risk of becoming an offender. Midlothian Council attributed a significant drop in the number of their children on the child protection register from 158 in 2011 to 29 in 2015, at least partially, to early intervention and prevention work.[44]

- Restricting out of area service for looked-after children – out of area placements tend to involve young people with troubled histories and challenging behaviour and children with significant learning disabilities. Some out of area placements will be the most suitable for a child, such as where the child has complex treatment needs that the council cannot meet or to ensure they can be effectively safeguarded. However, such placements are very expensive (weekly fees to independent providers range from £800 to £5,500) and can have negative consequences. For example, children may try to run away, putting themselves at risk, and children away for long periods will lose contact with their peers and find it difficult to re-integrate into the local community when they leave care.[45] Our fieldwork councils reported that keeping children local to their communities, for example in supported foster placements, could achieve better outcomes for children and achieve considerable financial savings for the council.

I have a feature that picks up if I get out of bed for too long, in case I've fallen in the night. I like to get up and wander about if I can't sleep, and then there is this booming voice asking if I am OK! It's a first class service.

Service user, older person

Councils need to measure the impact of prevention initiatives more systematically

52. Measuring and evaluating the success of prevention work is difficult. By its very nature, it is not easy to quantify what has not happened because of

prevention. It is also hard to attribute outcomes to specific courses of action in an environment where many factors are involved. Even so, councils do not always systematically evaluate initiatives, and there is a risk that opportunities for improvement, making savings or stopping ineffective activity are lost. Councils and IJBs should bring together information on the evaluation of successful prevention initiatives. They can use this to make long-term strategic investment decisions towards prevention as a key part of their long-term budget planning, rather than relying on short-term initiative funding as at present. Prevention needs to be seen as an integral part of councils' and IJBs' overall long-term strategies for services they can continue providing over the long term, rather than an add-on financed by short-term funding.

53. In our fieldwork, we found examples of successful evaluation. An evaluation of Glasgow's Recreate service to support ex-offenders found that in 2014/15 it generated a Social Return on Investment of between £6.14 and £9.54 per £1 invested (Case study 1).[46]

Case study 1

Glasgow Recreate

This service gives ex-offenders the chance to volunteer for up to six months in meaningful roles where they gain new skills and experiences to help them to move forward in their life. Volunteers can access various opportunities, including landscaping and gardening, painting and decorating, retail and warehousing, and woodwork.

With the support of skilled tradespeople, they work on projects for organisations such as community groups, charities, housing associations, and Glasgow Land and Environmental Services. Each volunteer has a dedicated mentor who helps them to access additional volunteering opportunities, housing support, employability services, and money advice and make positive changes in their personal life. They also help volunteers to complete CVs, identify training and development needs, and set goals to help them become more work-ready to help them break the cycle of re-offending.

Volunteers benefit from rail, bus and subway travel, lunch, gym membership, training and development, information about other organisations, and employment support. During 2015/16, there were 58 volunteers in the scheme (up from 34 in 2013/2014), 57 per cent of whom moved into employment. Ninety-six per cent of participants did not re-offend and of those who did, the frequency and severity of the offending was reduced.

Source: Glasgow City Council

Recreate is a good mix of volunteering, learning and mentoring. I worked hard and it paid off.

Recreate volunteer

54. Some councils are learning from experience elsewhere to tackle particular issues. For example, East Renfrewshire Council visited Shropshire County Council to explore how it developed a community-led social work service. It has agreed to be one of three organisations that will pilot the programme in Scotland. There is scope for councils to do more to look at what others are doing, nationally and internationally, and share experience and learning.

Councils have achieved savings through competitive tendering

Councils purchased around £1.6 billion of services in 2014/15

55. Currently, councils spend around £1.6 billion a year on outsourced social care services, roughly two-thirds to the private sector and a third to the third sector (Exhibit 9). Spending on private sector services is mainly to provide homecare, residential care and nursing homecare for older people (£800 million). Most third sector spending is to provide services for children with disabilities (£244 million). Larger providers provide services across a large number of councils and are in a good position to identify good practice.

56. In procuring services, councils need to take into account the long-term financial viability of care providers. Providers could be put at risk by a combination of several factors, including:

- a fall in the number of care home residents
- increased paybill costs because of knock-on impacts of Living Wage
- increased uncertainty following Brexit may make it difficult for private sector providers to finance capital investment, such as building or refurbishing care homes.

Exhibit 9

Breakdown of contracted out social care spending by sector, 2014/15

Most private sector services are for adults while the third mostly sector provides services for children.

		Third sector £'000	Private sector £'000	Total £'000
Social care adult	Day care	43	1,113	1,156
	Homecare	18,290	261,403	279,693
	Mental health services	14,297	12,974	27,272
	Nursing homes	19,273	318,376	337,649
	Residential care	1,883	219,962	221,845
Social care children	Adoption	23,208	35,871	59,079
	Childcare services	49,481	30,217	79,698
	Domestic violence	3,229	41,511	44,740
	Children with disabilities	243,878	17,831	261,708
Social care other		195,945	112,363	308,308
Total		**569,527**	**1,051,621**	**1,621,148**

Note: 'Other' includes advice and counselling services, advocacy service providers, alcohol and drug rehabilitation, community centres, community projects, disability and special needs service providers.

Source: Spikes Cavell database

57. Councils and Scotland Excel need to monitor the financial health of providers as part of their contract monitoring activity. The failure of a provider could have significant consequences for care services as well as people who use care services because Section 12 of the Social Work (Scotland) Act 1968 places a duty on Scottish local authorities to provide or arrange care for any individual in their area who requires assistance in an emergency.

Competitive tendering has reduced the cost of homecare

58. Councils have achieved significant financial savings through outsourcing services such as homecare to the private and third sectors through competitive tendering and re-tendering contracts. The percentage of homecare provided directly by council staff has fallen steadily, both in terms of the number of clients served and the number of hours provided (Exhibit 10, page 32).

59. Between 2010/11 and 2014/15, the average cost of providing homecare to people aged over 65 fell by 7.2 per cent in real terms, to £20.01 per hour.[47] An unintended consequence of driving down spending is increased staff turnover, as private and third sector providers employ staff on poorer terms and conditions than some other large employers or councils.

Too many (paid) carers – regular new carers needing shown ropes again! Gah!!

Unpaid carer

60. Third sector and private sector providers in our focus groups described some councils' procurement processes as inefficient and wasteful. They highlighted inconsistencies in how councils used framework agreements. These are agreements with suppliers to establish the terms that will govern contracts that councils may award during the life of the agreement.[48] Some private sector providers were concerned that they had invested time and money in signing up to frameworks, only to find that councils did not use their services.

Councils have made savings in the cost of care home services

61. The National Care Home Contract sets out the cost to councils of care home placements into private or third sector care homes. COSLA negotiates the fee structure annually with the representative bodies for private and third-sector providers in Scotland.[49] These bodies are Scottish Care and the Coalition of Care and Support Providers in Scotland. The contract includes an additional payment for care homes doing well in Care Inspectorate assessments, with penalties for poorly performing homes.

62. Between 2006 and 2015, the number of residents in older people's care homes decreased by two per cent (from 33,313 to 32,771).[50] The net cost of residential care (gross expenditure on care homes minus income) to councils has been falling. Between 2010/11 and 2014/15, the weekly residential costs to councils for each resident aged 65 or over fell by ten per cent in real terms to £372.[51]

63. The pattern of service provision has changed, with an increase in private sector provision and a fall in other sectors. Between 2006 and 2015, the change in the number of older people in residential care in each sector was:

- private sector – increased by five per cent (24,568 to 25,700)
- local authority/NHS – decreased by 23 per cent (4,876 to 3,747)
- third sector – decreased by 14 per cent (3,869 to 3,324).[52]

64. The percentage of adults in care homes who mainly pay for their own care is increasing; the percentage increased from 22 per cent of residents in 2006 to 27 per cent in 2015.[53] In 2015, the average gross weekly charge for people who paid for their own care was £708, compared with the average weekly fee for publicly funded residents of £508.[54]

Service providers want to be more involved in commissioning services

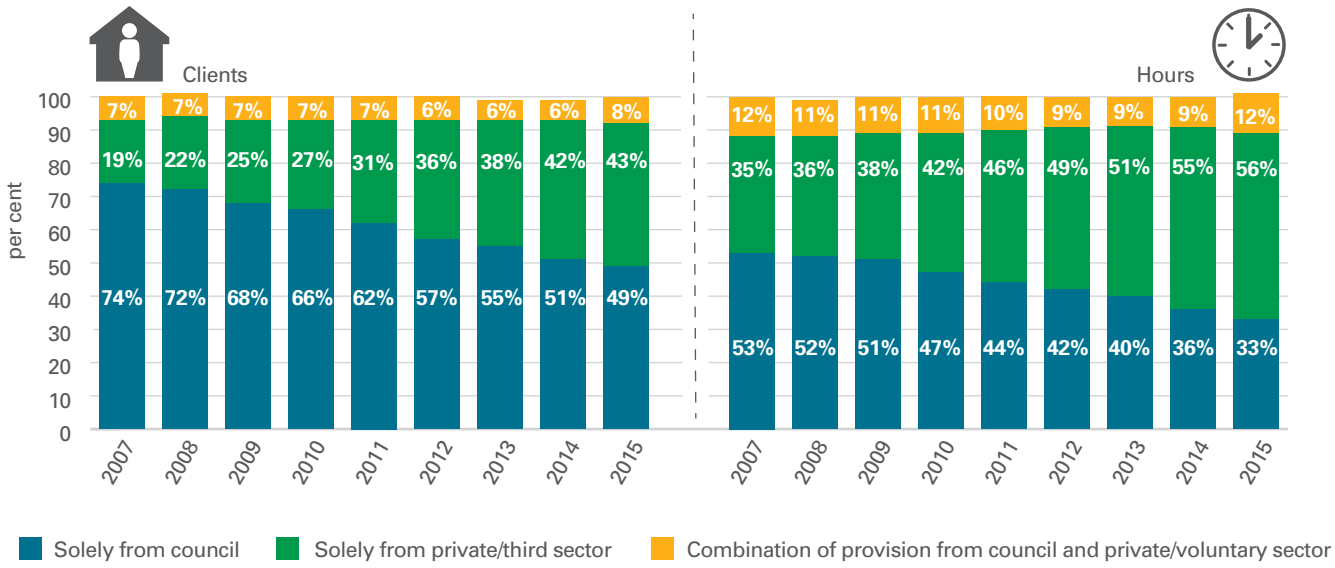
65. Commissioning social care is about how councils, NHS boards and others work together to plan and deliver services that will meet future demands and use resources, such as money, skills and equipment effectively. Jointly planned investment in home or community-based social care can save spending on unnecessary, and relatively expensive, hospital or residential care, and encourage innovation. The Christie Commission concluded that it is particularly important to:

- work closely with individuals and communities to understand their needs, maximise talents, resources, and support self-reliance, and build resilience
- recognise that effective services must be designed with and for people and communities – not delivered 'top-down' for administrative convenience
- maximise scarce resources by using all available resources from the public, private and third sectors, individuals, groups and communities.

Exhibit 10

The share of homecare provided by councils and the private/third sector, 2007 to 2015 (all ages)

Homecare provided directly by councils has fallen steadily over the past ten years.



Note: Of data limitations, the SSSC cannot provide an accurate estimate for turnover. However, they are able to calculate a 'stability index' of staff who are still in post after a year. If the index is 90 per cent it means that 10 per cent of staff present at the start of the period are no longer present. It is important to note that this does not mean that turnover is 10 per cent as the measure excludes staff who joined and left within the period under consideration.

Source: Social care services, Scotland, 2015, Scottish Government, December 2015

66. Councils have a challenging task to manage the market for providing services in their local area. There are potential tensions around making savings while ensuring high-quality services at a fair cost in an environment of increasing demand and financial pressures. There are risks to the quality of services if councils continue to drive down costs at the rate they have in the past without changing how they provide services.

67. Service providers from our focus groups who work across more than one council area found that different councils have different processes, procedures and attitudes to partnership working. They identified commissioning and procurement as common areas for improvement. In particular they felt that councils should:

- ensure they have staff with the appropriate skills for commissioning, such as financial planning and managing contracts, and be open in commissioning and contract decision-making processes. Some participants complained about unnecessary bureaucracy, noting gaps in expertise and risk appraisal and a lack of awareness of the challenges facing providers, for example the cost of employing qualified and experienced staff

- collect evidence about the effectiveness of all services (both in-house and external) and use this evidence in planning and decision-making. Councils face difficult choices, but providers felt councils sometimes protected their in-house services and workforce while cutting externally provided services, without comparing cost-effectiveness

- improve partnership working and relationships with providers. Although there were pockets of good practice, providers suggested that councils needed to work more collaboratively to provide stability to both those who provide and those who use services

- involve providers more in assessing and designing services, taking advantage of the experience and knowledge of good practice that larger providers have gained from working with councils across the UK.

68. One innovative example we identified was the Public Social Partnerships (PSP) approach used at East Renfrewshire Council (Case study 2, page 34). PSPs are strategic partnering arrangements, based on a co-planning approach. In this instance, the council worked with third-sector organisations and people who use services to share responsibility for designing services based around the needs of those who use them. Once designed, the council can then commission the service for the longer term. Several service providers in our focus groups mentioned the inclusive approach taken by East Renfrewshire Council as an example of good practice in commissioning services. It is important that councils have effective means of sharing good commissioning practice and working with practitioner groups within national organisations, such as COSLA and Social Work Scotland.

Some councils think 'out of the box', others are in a box with a very large padlock!

Service provider

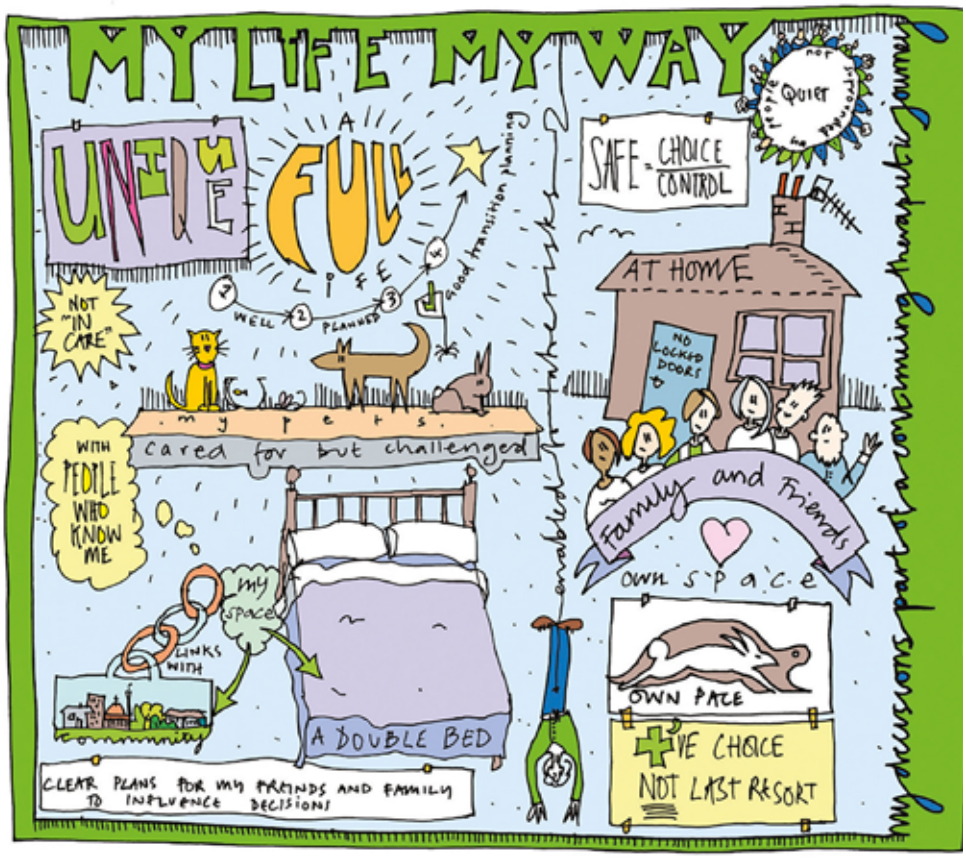
We are left out of planning discussions while having to deal with the consequences of decisions made by councils.

Provider focus group

Case study 2

East Renfrewshire Council: innovation in commissioning services

The Public Social Partnerships approach is a two-year funded programme, supported by the Scottish Government and designed to develop creative ideas for meeting the needs of people in, or about to enter, residential care. The partnership is across sectors and between people who use services. It is designed to develop thinking and support innovation. Participation in the project also helps to build resilience in people and communities by focusing on what people want rather than the services they currently receive. The illustration below describes one of the outputs from the process showing a visualisation of residential care from the point of view of someone who uses services.



Source: East Renfrewshire Council

People who use services, and carers, would value being more involved in planning how services are provided

69. The Christie Commission recognised the importance of people being involved in designing services to meet their needs. This approach is now supported by legislation such as the Community Empowerment (Scotland) Act 2015 and the Carers (Scotland) Act 2016.

70. People in our focus groups, both carers and people using services, valued the support they receive from social work services. Several said that without support they would not be able to cope or maintain employment. Feedback from our survey of 165 people indicated that the type of service provided determined whether service users felt able to influence their service delivery. For example, where service users had one-to-one support or had close relationships with staff in sheltered accommodation, they felt confident about influencing the service.

71. However, a significant number of service users felt that they had little influence over their social care provision. Some had concerns about speaking up in case the care they received was reduced or changed. Others, particularly older people, didn't want to hurt the feelings of the people providing care. While some had experience of raising issues with care providers and services being adapted accordingly, others found that no steps were taken to rectify issues. Some service users then felt care providers did not listen to them. Carers were more likely than people who use services to speak up if they were concerned about any aspects of the service delivery, but carers felt that care professionals did not treat them as partners.[55]

72. People who use social work services, and their carers, are very diverse, with differing needs. Although it is not easy to do, it is important that councils seek views and provide opportunities for involving as wide a range of people as possible in planning services or changing how they are provided. However, we found limited opportunities for people to be involved. Most of the six fieldwork councils involve representatives of both people who use services and carers in planning groups. For example, Perth and Kinross Council includes carer representatives on its multidisciplinary Carers Strategic Group. However, we found less evidence of people who use services and carers being involved more extensively in designing services.

73. Midlothian Council is one example where people who use services and carers are represented on joint planning groups, such as the Joint Older People's Planning Group that developed the Midlothian Joint Older People's Strategy 2011-15. A recent tender exercise for Care at Home in Midlothian included volunteer carers assessing all submissions, interviewing and final scoring. However, carers and people who use services generally have little involvement in commissioning or tendering, and there is scope to do more.

74. All of our fieldwork councils have a carers' strategy. All provide information for carers on their websites, including how and where to get help, which is usually through a carer assessment in the first instance. They also have partnerships with, or links to, other organisations and carers' centres in their area that provide information and support to carers. About half of the carers' centres are network partners of the national organisation Carers' Trust Scotland. Councils use various methods to collect the views of people using services, and of carers, including annual satisfaction surveys, carers' conferences and carer representatives on panels.

75. IJBs' membership must include a representative from people using services and a carer representative.[56] This is intended to ensure that carers have a role in planning and delivering of services delegated to IJBs. However, this alone is not enough to involve and consult the diverse range of people who use services and carers. Glasgow City Council has a carers' champion to represent the views of carers within the council (Case study 3, page 36).

I feel very lucky to live in [local authority]. The services for disabled people are the best in Scotland compared to other areas. [Local authority] listened to what people wanted, like supported living and individually tailored support plans.

Carer

Mental health services don't always recognise the carer input until they need them!

Carer

Everything is subject to funding therefore there is no consistency. Carers' centres need to be funded so that their services are ongoing.

Carer centre staff saved my life.

Carers

Case study 3

Glasgow City Council's Carers' Champion

Glasgow City Council's Carers' Champion represents the collective views of the city's unpaid carers within the council and speaks independently on carer issues. His role includes raising the profile of unpaid carers across the council and its wider network of agencies while also helping to develop strategies and policies that will support carers.

Glasgow has also introduced a privilege card for adult carers living in Glasgow who provide care for a Glasgow resident. It entitles them to various savings including:

- savings as part of Glasgow Life's concessionary discount scheme
- 20 per cent discount at a range of cafes in venues, such as art galleries and museums
- 20 per cent off City Parking multi-storey car parks
- discounts at certain cinemas and other commercial outlets.

In July 2015, Glasgow evaluated its Glasgow Carers Partnership, which includes Glasgow City Council, NHS Greater Glasgow and Clyde and voluntary sector organisations supporting carers within Glasgow. The council will use the resulting report and recommendations in planning and investment in carer services.

Source: Glasgow City Council

I had a procedure in hospital and I was in and out the same day, but the carer came to take me to hospital and came back at midnight to take me home. It was above and beyond.

Service user, physical disabilities

Some people we surveyed who use a homecare service were unhappy with the quality of their service

76. Between 2010/11 and 2014/15, the percentage of adults satisfied with social care or social work has fallen from 62 per cent to 51 per cent.[57] Our survey of 165 people who use services and of carers found that views on homecare dominated their discussions about the quality of care. Generally, participants with positive experiences of their current service provision highlighted some of the following factors:

- the importance of respectful and flexible carer workers
- good relationships with carer workers
- the ability to influence service delivery through self-directed support
- good timekeeping.

77. However, there were many examples of people not happy with their service experience. Common issues identified across all five local authority areas covered included:

- **Length of time a care worker spends with the person** – Most said that the care worker would be in their home for 15–20 minutes at a time. Many reported that this was not enough time to provide good quality care.

I did have [care company], and I got 15 minutes, so I had a choice between having breakfast and them running a bath for me to have on my own once they'd gone, or a shower with no breakfast.

Service user, physical disabilities

- **Timekeeping** – People who receive homecare discussed their experiences of homecare staff arriving earlier or later than expected. People we spoke to were frustrated at the homecare staff's timekeeping and poor communication.

- **Flexibility of role (undertaking tasks)** – Most people felt that the quality of care they received was affected by the limited flexibility of homecare staff in undertaking other household tasks.

- **Meals** – A large number of people receiving homecare and carers were not satisfied with the quality of the meals.

- **Trained homecare staff** – Others questioned the skills of some homecare staff. Their experience was that the homecare staff did not know how to handle them, or use equipment safely.

> **Sometimes they're late and sometimes they don't come at all.**
>
> Service user, learning disabilities

Paying care staff the Living Wage could help to reduce problems recruiting care staff, but may create other risks for providers

78. The Scottish Government's Living Wage commitment provides clear benefits for low-paid workers. However, increases in employee costs and contract costs will put pressure on councils' and service providers' finances. There are a number of risks with the current approach:

- The Scottish Government has no powers to enforce the Living Wage commitment; the UK Government reserves the power to set and enforce the legal minimum wage. The legal minimum wage across the UK is £7.20 for people aged 25 and over. The Living Wage is £8.25.

- There is a risk that providers operating across the UK may choose not to pay the Living Wage in Scotland.

- There is a risk that this could lead to unsustainable paybill increases. As well as increasing wages, National Insurance contributions and pension contributions will also rise, and service providers will need to maintain wage differentials. A recent survey of independent providers found that almost all will struggle to fund increases to £8.25 an hour. Future rises in the Living Wage may increase this pressure.

- Where councils have awarded contracts based on price before the adoption of the Living Wage, there is a risk that contractors who lost contracts, but who already pay wages at or above the living wage (and offering higher quality services) may ask councils to re-tender contracts.

> **Many people felt it was very important to have some continuity of care worker in terms of safety and building a rapport, but this was lacking. Just depressed at so many different (paid) carers coming in at all different times.**
>
> Carer

79. Applying the Living Wage also provides significant opportunities to better manage the staffing issues we describe in Part 1. Reduced staff turnover could potentially offset increased costs and provide an opportunity to improve staff skills. It could also make it easier to create a career structure for care workers and an opportunity to specialise, for example in providing services for younger people with particular disabilities, or for older people suffering from dementia.

> **She gave me a fish pie and it was cold in the middle. She said she didn't have time to do it again, so I had to ask her to make me an omelette."**
>
> Service user, older person

80. Comhairle nan Eilean Siar and Perth and Kinross council felt there were particular challenges in recruiting suitably qualified staff to deliver services in isolated rural areas. In Eilean Siar, the council has set up college courses to encourage young people to view care as a worthwhile career option (Case study 4, page 38).

Case study 4

Comhairle nan Eilean Siar: developing a stable workforce

Comhairle nan Eilean Siar faces major demographic change over the next 20 years including a projected 19 per cent decline in the working age population and a 19 per cent increase in the over 75 population. There are also a high number of single person households with no family carers available. To help arrest the decline in working age population through migration, the council has developed a project to make being a care worker a viable and attractive career for young people leaving school, as well as adults looking at career options. There are four programmes:

- Pre-Nursing Scholarship: developed to encourage people to take up a nursing career locally and part of a national initiative to increase the nursing workforce. A critical aspect of this programme is the facility to provide equitable access to learning across the Western Isles in rural and remote locations.
- Prepare to Care: This course aims to qualify and prepare students for employment, further training, or both of these, within health and social care by developing the knowledge, skills and understanding required to work in the care sector.
- Senior Phase SVQ2 Pilot: Provides flexibility in terms of work-based assessment across health and social care and equips young people to work in the community. The newly revised Social Care and Health SVQ2 is being piloted with young people in Uist and Barra by Cothrom in partnership with the council and NHS Western Isles.
- Foundation apprenticeship: Skills Development Scotland selected the council's Education and Children Services department as a pathfinder authority for the senior phase vocational pathway development in Health and Social Care.

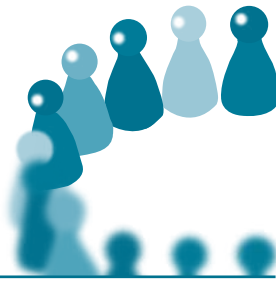
Source: Comhairle nan Eilean Siar

81. As explained in Part 1, the recruitment and retention of suitable staff is a significant problem across the care sector. Councils and providers need to work together and with the Scottish Government on long-term planning to ensure there is an effective, well-trained sustainable workforce to meet future demand. The Scottish Government has commissioned work to identify the recruitment and retention challenges facing the sector and assess whether there is a case for a national workforce-planning tool. In addition, the Scottish Social Services Council (SSSC) is working with partners to develop career pathways within social care. The first is to develop foundation apprenticeships, a vocational pathway to enable young people to experience work in the care sector and encourage care as a positive career choice.

> **The girls that came in didn't know how to use a stand aid, and they couldn't do manual lifting.**
>
> Service user, physical disabilities

Part 3

Governance and scrutiny arrangements



Key messages

1 The integration of health and social care has resulted in complex and varied governance arrangements for social work services. Elected members have important leadership and scrutiny roles, but there are risks that increased complexity could lead to members not having an overall view of social work. At a time of great change, it is essential that elected members assure themselves that the quality of social work services is being maintained and that councils are managing risks effectively. It is important that elected members receive training and guidance on the operation of the new governance arrangements and that elected members not involved in the IJB are fully informed about its operation.

2 The key role of the chief social work officer (CSWO) has changed significantly in recent years and there are risks that CSWOs may have too many roles and have insufficient status to enable them to fulfil their statutory responsibilities effectively.

3 There is scope for councils and their community planning partners to do more to promote and empower communities. This includes working with them to design, commission, deliver and evaluate services to achieve better outcomes, and to build capacity to allow communities to do more to support themselves. Elected members need to play a key role engaging with communities in a wider dialogue about council priorities.

elected members need to play a key role engaging with communities in a wider dialogue about council priorities

Social work governance and scrutiny arrangements are more complex because of health and social care integration

82. Councils' responsibilities in relation to social work are set out in the Social Work (Scotland) 1968 Act. The Act's provisions include promoting social welfare, caring for and protecting children, supervising and caring for people put on probation or released from prison and the children's hearings system.

83. Under the Public Bodies (Joint Working) (Scotland) Act 2014, councils and NHS boards are required to create integration authorities. These are responsible for the governance, planning and resourcing of adult social care services, adult primary care and community health services and some hospital services. Governance describes the structures, systems, processes, controls and behaviours by which an organisation manages its activities and performance. The Act also allows councils and NHS boards to integrate other areas of activity, such as children's health and social care services and criminal justice social work.

84. This means that councils delegate to the integration authority (IA) their responsibility for strategic planning for adult social services and for any other services they decide to include. Councils still carry the ultimate responsibility for the delivery of social work services in their area and elected members need to assure themselves that the council is meeting its statutory responsibilities.

85. IAs are responsible for planning and commissioning functions delegated from the local council and NHS board. IAs can adopt one of two main structures. All areas except the Highland Council area are following the body corporate model. Under this, they have created an Integration Joint Board (IJB) to plan and commission integrated health and social care services in their areas. Highland is following the lead agency model, NHS Highland is the lead for adult health and care services, with Highland Council the lead for children's community health and social care services. IJBs are local government bodies, as defined by Section 106 of the Local Government (Scotland) Act 1973. Councils and NHS boards delegate budgets to the IJB. The IJB decides how to use these resources to achieve the objectives of its strategic plan. The IJB then directs the council and NHS board to deliver services in line with this plan.

86. Councils have adopted various arrangements for integration. Nine councils integrated children's social work services within the IJB and 16 councils integrated social work criminal justice services.[58] The following arrangements were adopted by our fieldwork councils:

- Midlothian Council and Comhairle nan Eilean Siar include criminal justice but not children's social work services.
- East Renfrewshire Council and Glasgow City Council include both children's social work and criminal justice social work services.
- West Lothian Council and Perth and Kinross Council only include adult services.

87. The governance and scrutiny arrangements in four of our fieldwork councils (Comhairle nan Eilean Siar, Glasgow, Perth and Kinross and West Lothian) are included in Supplement 3. These illustrate the variety and complexity of arrangements now in place within councils.

88. At the time of our fieldwork, governance arrangements were still under discussion. Council chief executives were clear that accountability lies with the council for services delegated to the IJB because, under legislation, the council retains statutory responsibility for delivering social work services. But we have previously highlighted the risk that ultimate responsibility might lie with IJBs, which plan and direct councils and NHS boards in how services are to be delivered.[59] All parties need to recognise this risk and set out clearly an agreed understanding of each other's roles and responsibilities. It is essential that the chief officer of the IJB is clear about how this joint accountability will work in practice.

89. Accountability arrangements for the IJB chief officer are complex. The chief officer has a dual role. They are accountable to the IJB for the responsibilities placed on the IJB under the Act and the integration scheme. They are accountable to the council and NHS board for any operational responsibility for integrated services, as set out in the integration scheme.

90. Governance and scrutiny arrangements for IJB and non-IJB services within our fieldwork councils varied, even where the same services are included within

the IJB's remit. For example, in East Renfrewshire, scrutiny of performance happens within the IJB Audit and Performance Committee and an annual report is presented to the Council. While Comhairle nan Eilean Siar concluded that appropriate scrutiny could be provided within its existing council committee structure and that a separate mechanism for IJB functions was not required. Supplement 3 shows the variation in integration arrangements in four of our fieldwork councils. Whatever model councils choose, elected members need to assure themselves that the scrutiny arrangements are working effectively.

91. As governance and scrutiny arrangements for social work were still in transition at the time of our fieldwork visits (some changes were implemented in March 2016), it is too early to make judgements as to whether there are duplications or gaps in scrutiny. Councils indicated that they would review arrangements if they did not appear to be working effectively. Our fieldwork highlighted a number of potential risks. These include:

- the potential for an overall view of governance being lost when social work services (and budgets) are split, for example between education and children's services and the IJB
- a focus on health and adult services could restrict discussion of children's services and, in particular, criminal justice services on IJB scrutiny committees.

92. Council representation on the IJB is generally four or five senior elected members (around ten per cent of elected members), usually including the leader of the council and a senior opposition member. This means that a small subset of elected members of the council and members of the NHS board will be responsible for social work governance and scrutiny within the IJB and its committees. There is a risk that the majority of elected members could feel excluded from social work decision-making and scrutiny. There is also a risk that this arrangement leaves responsibility for governance and scrutiny with a small number of very busy elected members. Councils have set up a variety of mechanisms to ensure they keep all elected members informed. For example, Comhairle nan Eilean Siar and the IJB will hold at least two meetings a year with the wider membership of the council and NHS Western Isles.

93. It is important that elected members receive training and guidance on the operation of the new governance arrangements. The Scottish Government has produced guidance on the roles, responsibilities and membership of the Integration Joint Board.[60] COSLA is working with the Improvement Service and the Scottish Government to support elected members who do not sit on IJB boards to help them fulfil their role, including councils' ongoing statutory duties. COSLA intends to produce an elected member briefing note focusing on councils' role and interests to ensure they are kept informed of the changes. It is also hosting workshops for elected members to share their experiences. We have included an elected member's checklist as Supplement 4. Elected members may wish to use the checklist to help them consider the effectiveness of the arrangements in their council.

Health and social care integration may make strategic planning of services more difficult

94. Each IJB is required to produce a strategic plan that includes strategies for all the services delegated to it. We examined strategies for social work services in our fieldwork councils. Strategies are set out in various ways depending on the health and social care arrangements in each council. While the plans for integrated services were well developed, they are new and untested.

95. Where councils have chosen not to include services for children within their IJB, they usually continue to follow existing arrangements. For example, some align children's social work services with education, in education and children's services. In others, these services are part of an existing Health and Social Care Partnership Directorate. Strategies for services that are not within the IJB are set out in council plans such as the education and children's services plan.

96. Where criminal justice services are included within the IJB, strategies were not always as clearly set out. IJB plans generally included few references to criminal justice and some services did not have a specific criminal justice plan. Whether as part of the IJB or not, councils have, until now, worked in partnership with their Community Justice Authority (CJA) and contributed to its area and action plans. However, under The Community Justice (Scotland) Act 2016, CJAs will be abolished from 2017. Responsibility for community justice will transfer to community planning partnerships. It is important that under the new approach, strategies for criminal justice services are clearly set out as part of the IJB or community planning arrangements.

97. All the social work plans we examined demonstrate links to community planning. As members of the community planning partnerships, both IJBs and councils have signed up to local single outcome agreements (SOA) with the Scottish Government, and share the vision and priorities within these.

98. It is important that there are clear linkages between the planning of those services that are integrated and those that are not, for example the transition from children's services to adult services or between children's services and criminal justice. Planning for these transitions needs to be well coordinated to ensure a seamless service without overlaps or gaps in services, particularly where responsibility is split between the IJB and the council.

99. It is important that the scrutiny arrangements reflect the risks associated with managing transitions. Councils and elected members will need to ensure they have a strategic overview of the whole of social work service and ensure that strategy, budget arrangements, commissioning, procurement and workforce planning are coordinated at a council-wide level.

I'm happy with the services for my daughter but it was a hard fight over many years. As she moves to adult services, am I going to have to start fighting again? It worries me.

Carer

There is a risk that chief social work officers may become over-stretched

100. The Social Work (Scotland) Act 1968 requires local authorities to appoint a single chief social work officer (CSWO) who must be a qualified social worker and registered with the Scottish Social Services Council. The CSWO should demonstrate professional leadership. They have a responsibility to highlight where a council policy may endanger lives or welfare and ensure that they provide councillors and officers with professional advice in relation to social work and social care services. The CSWO should have access to the chief executive and other senior managers, councillors and social work officers. The CSWO is one of five statutory officers in councils: that is, officers that each council is required to appoint by law.[61]

101. Scottish ministers issued revised guidance on the role of the CSWO in July 2016 to reflect the introduction of health and social care integration. This summarises the minimum scope of the CSWO role, recognising the diversity of the structures and partnerships that deliver social work services. The CSWO's responsibilities apply to social work functions whether delivered by the council or

by other bodies under integration or partnership arrangements.[62] The guidance states that management and reporting structures are a matter for councils. But if the CSWO is not a full member of the corporate management team, elected members must be satisfied that the officer has appropriate access, influence and support at the most senior level. We found consensus among elected members and chief executives that it is important that the CSWOs are senior enough to carry out their responsibilities effectively. However, the CSWO's position in the hierarchy, and the arrangements to allow them to contribute to decision-making, varied between councils.

102. When the CSWO role was combined with that of Director of Social Work, the ability to influence was clear. But councils have developed executive team structures and most no longer have a Director of Social Work. At present six CSWOs are at director level and 24 are heads of service, the tier below this, with one tier-three manager in a temporary acting up role. In addition, a large proportion of CSWOs are new to the role. A survey by Glasgow Caledonian University, in November 2015, found that over half had been in post less than three years, and nine for less than a year.

103. CSWOs have strategic and professional responsibility for social work, including monitoring service quality and professional standards. Good practice indicates this should be across the full range of a council's social work functions. Scottish ministers' guidance says the CSWO must have the power and authority to provide professional advice and contribute to decision-making in the council and health and social care partnership arrangements. However, the structure of social work provision has changed over time and CSWOs do not always have operational responsibility across all functions. For example, in Midlothian, the CSWO has operational responsibility for adult services but not for services for children or older people.

104. Integration does not change the CSWO's responsibility to provide professional leadership. However, some CSWOs expressed concerns that, where children's services and/or criminal justice sit within the IJB, health issues and adult care will dominate the IJB both in terms of the agenda and in terms of personnel. They were concerned that representation of these services on the agenda would be small in comparison to adult services.

105. Reporting lines for CSWOs always lie within the council and the establishment of IJBs does not change this. However, CSWOs now have an additional statutory, non-voting place as adviser to the IJB (or the Integration Joint Monitoring Committee in Highland's lead agency model). CSWOs need to establish good, effective working relationships with their IJB chief officer. CSWOs' roles vary across all thirty-one IJBs in terms of what they are accountable for. Integration means that those CSWOs who were previously responsible for adult social care services will lose direct responsibility for their management and budget.

106. Scottish ministers' guidance indicates that the CSWO must be visible and available to any social services worker, and ensure well-grounded professional advice and guidance on practice is available. Social workers in our focus groups generally felt that their CSWO was both visible and accessible, and felt confident about consulting them.

107. The ability of CSWOs to carry out their role effectively and not become too 'stretched' across multiple functions is a potential concern. CSWOs may have

to report to one or more council committees, sit on the IJB, and attend the council corporate management team or senior management team and the IJB management team, as well as undertake day-to-day service management roles. It is important for CSWOs to achieve the trust and confidence of councils' NHS partners in order to have an influence in decision-making. CSWOs had mixed views on whether their role within the IJB would have a negative impact on their visibility or accessibility to elected members and social workers. It is too early to see how effective new arrangements will be.

108. The statutory guidance requires all CSWOs to report annually to the council and IJB on all of the statutory, governance and leadership functions of the role and delivery of the council's social work functions. This applies however they are organised or delivered. A review of CSWO annual reports in 2013 found a lack of consistency in the content and format. After consultation with relevant individuals and groups, the chief social work adviser published guidance on the content and a template for the report. The CSWO annual report gives an opportunity for the CSWO to draw together all the important strands of their work and report on them to elected members. It should provide an opportunity for the CSWO to raise their profile with elected members and, more importantly, draw their attention to any potential concerns about social work or governance issues.

109. The CSWO reports we examined from our fieldwork sites generally followed the template, but varied in the amount and level of information included. For example, Glasgow's report for 2014/15 is more concise (nine pages long with links to relevant reports and strategies), with less detail included compared with Perth and Kinross (71 pages), which contains a lot of activity information and good practice examples. CSWO reports may be considered at various meetings including full council, relevant council committees or panels or the IJB. Social work performance is regularly scrutinised through council or IJB monitoring systems and scrutiny happens through monthly, quarterly or six-monthly performance reports at appropriate committees. CSWO reports are also important in providing a high-level summary of the performance of social work functions during a particular year. It is essential that they are subject to effective scrutiny by elected members. However, we did not find evidence of detailed scrutiny of the report or challenge at these meetings.

110. The Scottish Social Services Council (SSSC) working with universities and others, has recently developed a qualification for CSWOs. The postgraduate diploma is aimed specifically at those currently in the CSWO role or who aspire to the role. There is also an option to proceed to a Masters qualification. CSWOs and social worker managers who we interviewed who are studying for this qualification all found it helpful and useful in practice, as well as helping the council in succession planning.

Elected members are key decision-makers for local social work services

111. During the era of steadily increasing council spending that ended in 2010, people's expectations were raised as to the level of service that social work services could provide. Councils are now in an era of reducing spending. Councils need to play a leading role in a wider conversation with the public about the level of social work services they can realistically provide and how they can best provide it. Current arrangements for providing care are not sustainable in the long term, given the demographic and financial pressures. As we reported in *Changing models of health and social care*: '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'.[63] Elected members need to play a key role in this change, engaging with communities in a wider dialogue about council priorities.

112. The Christie Commission suggested that councils should work closely with individuals and communities to understand their needs, maximise talents and resources, support self-reliance, and build resilience. Communities have a significant role to play, and councils and their community planning partners should do more to encourage and help them to assume more responsibility for supporting themselves. North Lanarkshire's *Making Life Easier* service is a website that helps people to identify problems and develop their own solutions through information, professional advice and direct access to services and support (Case study 5).

Case study 5

Making Life Easier

North Lanarkshire Council worked with ADL Smartcare to develop a website to help those who wish to live independently at home. Making Life Easier provides professional advice and guidance on health issues and on managing daily living tasks. It includes hints and tips and signposts to organisations such as social and support groups, lunch clubs and drop-in cafes.

People and their carers can do an online self-assessment to identify safe and suitable equipment and minor adaptation choices that will help them manage their lives. People can choose to get the equipment and minor adaptations they need without charge through a link to the council's integrated equipment and adaptation service, or there is information on how to buy it for themselves.

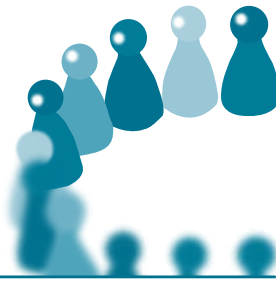
East Lothian Council is developing a similar service, which they will call HILDA – Health and Independent Living with Daily Activities.

Source: North Lanarkshire Council

113. Although health and social care integration will change the way social work services are commissioned and funded, councils remain responsible for promoting social welfare.[64] This includes improving outcomes for people who use services. Councils and IJBs need to ensure they are scrutinising budgets, plans and outcomes, including the effectiveness of services and the impact on individuals.

114. Elected members may find that their role changes, but they remain the key decision-makers for social work services on behalf of their constituents and they ensure effective scrutiny, governance and strategic oversight of the new arrangements. It is essential that elected members assure themselves of the quality of social work services and ensure councils manage risks effectively at a time of great change. With increasing financial pressures, councillors may face a difficult challenge in managing people's expectations, but they have a crucial role in doing so and providing leadership for their communities.

Endnotes



1 Social Care Services 2015, Scottish Government, December 2015.

2 Children's Social Work Statistics Scotland, 2014/15, Scottish Government, April 2016.

3 Social Care Services 2015, Scottish Government, December 2015.

4 Social Work and Social Care Statistics for Scotland: A Summary, Scottish Government, January 2016.

5 Scottish Local Government Financial Statistics, Scottish Government, February 2016.

6 Scottish Social Service Sector: Report on 2015 Workforce Data, August 2016.

7 We use the term 'third sector organisation' to describe organisations that are neither public sector nor private sector, including voluntary and community organisations (both registered charities and other organisations such as community groups), social enterprises, mutuals and co-operatives.

8 In this report, we use the word carer to mean someone who provides unpaid care. Staff who are employed to provide care are referred to as care workers.

9 *Health and social care integration*, Audit Scotland, December 2015.

10 Social Services in Scotland: a shared vision and strategy 2015 - 2020, Scottish Government,

11 National Performance Framework, Scottish Government, March 2016.

12 The Scottish Government established the independent Commission, chaired by Dr Campbell Christie CBE, in November 2010 to develop recommendations for the future delivery of public services. The Commission published its report in June 2011.

13 *Health and social care integration*, Audit Scotland, December 2015.

14 *Changing models of health and social care*, Audit Scotland, March 2016, included Scottish Government analysis of projected health and social care expenditure, provided to Audit Scotland in February 2016.

15 *Scotland's Population, The Registrar General's Annual Review of Demographic Trends 2014*, published August 2015.

16 All local authorities are responsible for maintaining a central register of all children who are the subject of an inter-agency Child Protection Plan. The register provides a system for alerting practitioners that there is professional concern about a child. Social work departments are responsible for maintaining a register of all children in their area who are subject to a Child Protection Plan.

17 Children's Social Work Statistics Scotland, 2014/15, Scottish Government, April 2016.

18 Scottish Social Service Sector: Report on 2015 Workforce Data, August 2016.

19 Experimental Statistics: Staff Retention in the Scottish Social Service Sector, SSSC, March 2016.

20 Workforce Survey of Independent Care Homes for Older People in Scotland, Scottish Care, March 2008.

21 Scottish Social Service Sector: Report on 2015 Workforce Data, August 2016.

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23 NHSScotland Workforce Information, quarterly update of staff in post, vacancies, ISD, March 2016.

24 Mental Health (Care and Treatment) (Scotland) Act, 2003.

25 Scottish Social Services Workforce Data, Mental Health Officers (Scotland) Report 2015, August 2016.

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27 Scotland's Carers, Scottish Government, March 2015.

28 *Caring Together: The Carers Strategy for Scotland 2010 - 2015*, Scottish Government, July 2010.

29 *Valuing Carers; The rising value of carers' support*, Carers UK, 2015.

30 *An overview of local government in Scotland 2016*, Audit Scotland, March 2016.

31 The net expenditure breakdown in Exhibit 5 is taken from Scottish Local Government Financial Statistics 20014-15. The total net expenditure figure of £3.3 billion is from the audited accounts and includes pension costs and capital accounting costs that the £3.1 billion in the local financial returns (LFRs), on a funding basis, will exclude.

32 *An overview of local government in Scotland 2016*, Audit Scotland, March 2016.

33 Scottish Parliament, Health and Sport Committee, Integrated Joint Board survey responses, August 2016.

34 Information supplied by Scottish Government.

35 Scottish Government unpublished analysis, March 2016.

36 *Social Services in Scotland: a shared vision and strategy 2015-2020*, Scottish Government, March 2015.

37 *Route Map to the 2020 Vision for Health and Social Care*, Scottish Government, May 2013.

38 *Reshaping Care for Older People – A Programme for Change 2011–21*, Scottish Government, COSLA and NHS Scotland, 2010.

39 *Reshaping care for older people*, Audit Scotland, February 2014.

40 *Changing models of health and social care*, Audit Scotland, March 2016.

41 The NHS and Community Care Act 1990 provides a statutory framework for community care, which forms the cornerstone of community care law. It places a duty on local authorities to assess an individual's need for 'community care services'.

42 Scottish Government and COSLA guidance on a national framework for eligibility criteria, 2009.

43 *Route Map to the 2020 Vision for Health and Social Care*, Scottish Government, May 2013.

44 Data from Children's Social Work Statistics Scotland, 2011/12, Scottish Government, March 2013 and Children's Social Work Statistics Scotland, 2014-15, Scottish Government, June 2016.

45 *Getting it right for children in residential care,* Audit Scotland, September 2010.

46 Recreate Volunteer Programme: A social return on investment (SROI) analysis, Margaret Smith and Vikki Binnie, 2014. An SROI considers the length of time changes last to assess future value. Because this user group is often associated with a chaotic lifestyle, the study shows a range in value to reflect a conservative estimate and an estimate reflecting the sustained changes possible.

47 Local Government Benchmarking Framework, Improvement Service (website).

48 A framework agreement does not have to be a contract. However, where it is a contract it is treated like any other contract, and the EU procurement rules apply.

49 The 2016/17 fees paid to providers for local authority placements are set at £624.54 a week for nursing care and £537.79 for residential care until 30 September. After that, fees will increase to £648.92 a week for nursing care, and £558.77 for residential care until April 2017 (the £372 figure in paragraph 62 has income from contributions deducted). Fees for self-funders tend to be substantially higher.

50 Scottish Statistics on Adults Resident in Care Homes, 2006-2015, ISD Scotland, October 2015.

51 Local Government Benchmarking Framework, Improvement Service (website).

52 The Care Home Census: Scottish Statistics on Adults Resident in Care Homes 2006-2015. The census includes data on adults living in care homes in Scotland that are registered with the Care Inspectorate.

53 NHS National Services Scotland, Public Health and Intelligence, 2016.

54 These figures are for residents who do not require nursing care. The equivalent figures for residents who do require nursing care are £775 and £590.

55 The Scottish Government is holding a 'national conversation' on health and social care services. Some of the carer's quotes are taken from the Coalition of Carers in Scotland event to support carers to contribute their views, held on 25 November 2015.

56 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

57 Local Government Benchmarking Framework, the improvement service.

58 A full list of the arrangements in all councils is included in Exhibit 8, page 22 of *Health and social care integration*, Audit Scotland, December 2015.

59 *Health and social care integration*, Audit Scotland, December 2015.

60 Roles, Responsibilities and Membership of the Integration Joint Board, Scottish Government, September 2015.

61 The others are: The Head of Paid Service (chief executive) responsible to councillors for the staffing and ensuring the work of the council is co-ordinated; the Monitoring Officer prepares governance documents and advises councillors about legal issues; the Chief Financial Officer; the Chief Education Officer.

62 The Role of Chief Social Work Officer, Guidance Issued by Scottish ministers, pursuant to Section 5(1) of the Social Work (Scotland) Act 1968, Revised Version, July 2016.

63 *Changing models of health and social care*, Audit Scotland, March 2016.

64 Social Work (Scotland) 1968 Act.

Social work in Scotland

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WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 7th December 2016

Subject: The National Health and Social Care Standards Consultation

1. Purpose

1.1 To bring to the Audit Committee's attention the recently launched consultation on the new National Health and Social Care Standards, and the response prepared on behalf of the Health & Social Care Partnership Board.

2. Recommendation

2.1 The Audit Committee Partnership Board is asked to endorse the response prepared on behalf of the Health & Social Care Partnership Board for formal submission to the national consultation.

3. Background

3.1 As Audit Committee members will recall from the March 2016 meeting, the Scottish Government has tasked the Care Inspectorate and Healthcare Improvement Scotland to lead work to co-produce the new standards for care working alongside people using services, providers and other agencies.

3.2 In February 2016, the final overarching principles for new national care standards were signed off by the Cabinet Secretary for Health, Wellbeing and Sport:

- Dignity and respect
- Compassion
- Be included
- Responsive care and support
- Wellbeing

3.3 These overarching principles apply to all health and social care services in Scotland.

3.4 The next phase of this work was to develop a set of general and specialist standards linked to the principles for consultation beginning in Autumn 2016. These proposed (new) health and social care standards were published for consultation in October 2016, with the deadline being 22nd January 2017.

4. Main Issues

4.1 The purpose of the new National Health and Social Care Standards is to set out what we can expect when we use health and social services in Scotland. This includes a diverse range of services from childminding and daycare for

children in their early years, housing support and care at home for adults, to hospitals, clinics and care homes. The new Standards will provide a framework for registration and inspection of individually registered care and health services, but they will also be relevant to all care and health services including those not inspected by the Care Inspectorate or Healthcare Improvement Scotland. Services which are not currently required to register with or be inspected by these regulators will be encouraged to adopt and apply the Standards as a framework for high quality care.

4.2 The final Standards will be published in Spring 2017 and implemented from Spring 2018.

4.3 As Audit Committee members recognised at the March 2016 meeting, the overarching principles reinforce the existing core values of the Partnership Board and the Health & Social Care Partnership 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, as reinforced at its March 2016 meeting, the Audit Committee recognises that 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. That position has underpinned the drafted response to the consultation (appended here) that has been prepared on behalf of the Partnership Board for consideration by the Audit Committee.

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 Care Inspectorate and Healthcare Improvement Scotland have confirmed the new standards have been 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 new draft Standards have been developed by a national Development Group made up of organisations representing people using services, unpaid carers, social care providers and commissioners of care. At an early stage there were focus groups with individuals who use care services and their carers to understand what matters most to people about their care.

11.2 The public consultation on the draft new Standards will run from October 2016 until January 2017.

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.

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Date: 7th December 2016

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Appendices:	West Dunbartonshire Health & Social Care Partnership Submission to National Health and Social Care Standards Consultation
Background Papers:	Audit Committee: National Care Standards – Overarching Principles (March 2016)
Wards Affected:	All

Consultation on the New National Health and Social Care Standards

October 2016

Consultation on the New National Health and Social Care Standards

The Scottish Government, Edinburgh 2016

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Ministerial Foreword

Since 2002, the National Care Standards have played an important role in ensuring people who receive care and support get the high-quality service they are entitled to. Everyone is entitled to high-quality care and support, tailored towards their particular needs and capable of being provided in any setting: be that in a hospital or clinical setting; a residential care home; a children‟s nursery; or, as many now people prefer, within their own home.

As Cabinet Secretary for Health I am committed to ensuring these services achieve positive outcomes for all. In reviewing the current Standards, we all all have a unique opportunity to contribute to how our services are planned, commissioned, delivered and improved. The Care Inspectorate and Healthcare Improvement Scotland are already inspecting and supporting our health and care services in doing this, and I am sure that the new Standards - which will now also apply to NHS health care services - will help everyone to reach higher and achieve more.

What matters most in all of this is that people feel included and respected, and can chose the kind of service which best improves their quality of life whatever their circumstances. Each and every one of us will, at some point in our lives, need to use - or know someone who needs to use – a health or care service. By introducing new Standards focusing on people‟s human rights and personal outcomes, I am confident that we can improve everyone‟s experience of using, or working in, health, care and social work services.

The new Standards have been developed by an expert group of key organisations, representative groups and individuals. Together they have done a fantastic job in getting us to this point, and now we need your help. We want to know if the new Standards are fit for purpose; if they are capable of supporting improvement in care and support services; and ultimately, if they will achieve better personal outcomes for all.

These are questions which only you can answer, and so which I, and those developing the new Standards, need to have answers to so we can achieve the goal of living longer, healthier lives.

I would ask that everyone gets involved in shaping the future of health, social care and social work services. So please, take the time to read the new Standards, consider and discuss what they mean to you and your family – both now and in the future - and let me know what you think.

Shona Robison MSP
Cabinet Secretary for Health and Sport

Responding to this Consultation

We are inviting responses to this consultation by 22 January 2017.

Please respond to this consultation using the Scottish Government‟s consultation platform, Citizen Space. You view and respond to this consultation online at https://consult.scotland.gov.uk/care-and-support/national-care-standards/ You can save and return to your responses while the consultation is still open. Please ensure that consultation responses are submitted before the closing date above.

If you are unable to respond online, please complete and return the Respondent Information Form (see “Handling your Response” below) to:

National Health and Social Care Standards Consultation
Scottish Government
Area 2-R
St. Andrew‟s House
Regent Road
Edinburgh EH1 3DG

Handling your response

If you respond using Citizen Space (http://consult.scotland.gov.uk/), you will be directed to the Respondent Information Form. Please indicate how you wish your response to be handled and, in particular, whether you are happy for your response to published.

If you are unable to respond via Citizen Space, please complete and return the Respondent Information Form included in this document. If you ask for your response not to be published, we will regard it as confidential, and we will treat it accordingly.

All respondents should be aware that the Scottish Government is subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

Next steps in the process

Where respondents have given permission for their response to be made public, and after we have checked that they contain no potentially defamatory material, responses will be made available to the public at http://consult.scotland.gov.uk. If you use Citizen Space to respond, you will receive a copy of your response via email.

Following the closing date, all responses will be analysed and considered along with any other available evidence to help us. Responses will be published where we have been given permission to do so.

Comments and complaints

If you have any comments about how this consultation exercise has been conducted, please send them to: NationalCareStandards@gov.scot

Scottish Government consultation process

Consultation is an essential part of the policy-making process. It gives us the opportunity to consider your opinion and expertise on a proposed area of work.

You can find all our consultations online: http://consult.scotland.gov.uk Each consultation details the issues under consideration, as well as a way for you to give us your views, either online, by email or by post.

Consultations may involve seeking views in a number of different ways, such as public meetings, focus groups, or other online methods such as Dialogue (https://www.ideas.gov.scot)

Responses will be analysed and used as part of the decision making process, along with a range of other available information and evidence. We will publish a report of this analysis for every consultation. Depending on the nature of the consultation exercise the responses received may:

- indicate the need for policy development or review
- inform the development of a particular policy
- help decisions to be made between alternative policy proposals
- be used to finalise legislation before it is implemented

While details of particular circumstances described in a response to a consultation exercise may usefully inform the policy process, consultation exercises cannot address individual concerns and comments, which should be directed to the relevant public body.

INTRODUCTION

Scottish Ministers have a duty to prepare and publish standards and outcomes applicable to care services and social work services under **Section 50 Public Services Reform (S) Act 2010**. Scottish Ministers also have powers under **Section 10H of the National Health Service (Scotland) Act 1978** to publish standards and outcomes for services provided under the health service; and independent health care services.

This consultation relates to draft new Standards and outcomes which Scottish Ministers propose to publish in exercise of these statutory powers. But they do not replace standards relating to healthcare that have already been produced under Section 10H of the **National Health Service (Scotland) Act 1978**.

Throughout this consultation „standards" is used as a collective term to describe both the outcomes and the descriptive statements which set out the standard of care a person can expect. For example „I experience high quality care and support that is right for me" is an outcome and „I am not discriminated against in any aspect of my care and support" is a description of the standard that can be expected.

The Care Inspectorate and Healthcare Improvement Scotland will take into account the new Standards when carrying out their inspection functions and when making decisions about care and health services which are, or are applying to be, registered.

The new Standards do not replace or remove the need to comply with legislation which sets out requirements for the provision of services (such as the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011 and the Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011). Health and care services will continue to follow existing legislative and best practice requirements applying to their particular service or sector, in addition to applying the new Standards.

There are several parts to the consultation which you should read before completing your response

1. Background
2. Overview of the new Standards
3. The Questionnaire
    a. Respondent Information Form
    b. Questions
    c. Additional Information
    d. Glossary

Annex A: National Health and Social Care Standards

1. BACKGROUND

What are National Health and Social Care Standards and how will they be used?

The purpose of the new National Health and Social Care Standards (the Standards) is to set out what we can expect when we use health and social services in Scotland. This includes a diverse range of services from childminding and daycare for children in their early years, housing support and care at home for adults, to hospitals, clinics and care homes.

From Spring 2018, the new Standards will provide a framework for registration and inspection of individually registered care and health services, but they will also be relevant to all care and health services including those not inspected by the Care Inspectorate or Healthcare Improvement Scotland. Services which are not currently required to register with or be inspected by these regulators will be encouraged to adopt and apply the Standards as a framework for high quality care.

The new Standards show what our rights to dignity, respect, compassion, being included, responsive care and support and wellbeing should actually look like across health and social care services.

They replace the 23 sets of standards produced for different types of registered care settings introduced in 2002.

Why review the Standards?

The original 2002 Standards mainly looked at technical requirements, such as written policies and health and safety procedures. The new Standards need to reflect recent changes in policy and practice and also be fit for the future. For example:

- more of us are supported and cared for in our own home and as part of the local community than ever before;
- we consider the quality of care experience to be as important as other aspects of care like safety[1]; and
- the establishment of Health and Social Care Partnerships[2] means that when people use health or care services they should get the right care and support whatever their needs, at any point in their care journey.

How we inspect health and social care services has also changed. The Care Inspectorate and Healthcare Improvement Scotland continue to regulate each individually registered health and social care service, they also now work with other regulators and scrutiny bodies to carry out strategic inspections. These inspections look at how the wider health, social work and social care system is working for children or adults in a local authority and health board area. The new Standards need to be fit for purpose for assessing how well people‟s care needs are met on both a strategic and an individual service level.

[1] https://healthier.scot/
[2] Under the Public Bodies (Joint Working) (Scotland) Act 2014

To support these changes, we need a single set of Health and Social Care Standards that apply across all care services we may use in our lifetime. These must promote flexible services and innovation.

Development of the Standards

In 2015 a public consultation confirmed widespread support for the new Standards being based on human rights and the wellbeing of people using services. The following Principles were approved by Scottish Ministers in February 2016:

- Dignity and respect
- Compassion
- Be included
- Responsive care and support
- Wellbeing

Since then draft new Standards have been developed by a Development Group made up of organisations representing people using services, unpaid carers, social care providers and commissioners of care. At an early stage there were focus groups with individuals who use care services and their carers to understand what matters most to people about their care.

Throughout the project the Scottish Government has chaired a Project Board of representatives from across the public, private and voluntary sectors. The next phase of the project is to develop an implementation plan for the final Standards.

Why are the Standards based on human rights?

Human rights are the rights and freedoms that belong to every person, at every age. These rights are set out in laws which help raise everyone‟s awareness of the need to uphold individual rights and protect people with protected characteristics from discrimination. Looking at standards of care from a human rights perspective helps us identify what individuals using care services should be entitled to, as well as ensuring providers comply with legislation when providing care.

More information on Scotland's National Action Plan for Human Rights (SNAP) is available at http://www.gov.scot/Topics/Justice/policies/human-rights/scotlandsnationalactionplanforhumanrights

The new Standards

We propose the following new Standards apply across health, care and social work services:

1. I experience high quality care and support that is right for me
2. I am at the heart of decisions about my care and support
3. I am confident in the people who support and care for me
4. I am confident in the organisation providing my care and support
5. And if the organisation also provides the premises I use
6. And if my liberty is restricted by law
7. And if I am a child or young person needing social work care and support.

The first four headings set out Standards for everyone. These are complemented by three additional headings with Standards that only apply in specific circumstances.

For example, if a young person is looked after by the local authority and living in a residential unit, then Standards 1-4 will be complemented by Standards 5 and 7. Or, if an adult is accommodated and receiving compulsory treatment under the Mental Health (Care and Treatment) (Scotland) Act 2003, then Standards 5 and 6 apply as well as Standards 1-4.

Additional Standards for people experiencing restricted liberty and for children and young people who need social work support?

People experiencing restricted liberty and some children and young people who have particular needs sometimes require specialist care and support. Standards 6 and 7 reflect these particular care and support needs, and are different from, and additional to, those covered by the other Standards that are applicable to everyone.

For example, Standard 6 („And where my liberty is restricted by law") states: "I can be with my peers, including other people who use the service, except where this has been properly assessed as unsafe" (6.7). This reflects the expectation that, for people experiencing restricted liberty, the question of whether it is safe to have contact with peers is routinely assessed. For most care and support however, this question is not routinely applicable as people have control over their own contact with peers.

Standard 6 is very specific to the relatively unusual situations where someone is subject to a formal restriction on their liberty. Standard 7, on the other hand, covers many of the same issues as in Standards 1-4, but goes into more detail of what is expected in order to meet the particular needs of children and young people who are in need of social work care and support.

How do the Standards fit with other Scottish Government priorities?

The Standards have been prepared to deliver the collective ambitions of a range of legislation and Scottish Government policy that relates to health and social care, for example:

- Scotland Performs: National Performance Framework
- Getting it Right for Every Child and the wellbeing indicators
- The Public Bodies (Joint Working) (Scotland) Act 2014 and the National Health and Wellbeing Outcomes prescribed under that Act
- The Social Care (Self-directed Support) Act 2013
- The Carers (Scotland) Act 2016
- Social Services in Scotland: a shared vision and strategy 2015-2020
- A National Clinical Strategy for Scotland
- Standards of Care for Dementia in Scotland
- My Home Life
- Expansion of funded childcare
- National Common Outcomes for Community Justice

What will happen next?

- The public consultation on the draft new Standards will run from October 2016 until January 2017
- During the consultation, we will make available personal stories to illustrate the range of people who will be impacted by the new Standards
- After the consultation, Scottish Government will review and analyse responses. The Project Board and Development Group will consider the findings and a consultation report will be published in Spring 2017
- The final Standards will be published in Spring 2017
- The new Standards will be implemented from Spring 2018
- The Scottish Government will set up a short term group to identify and advise on the detail of full implementation of the Standards
- Current inspection methodologies will be updated to ensure they align with the new Standards
- The final Standards document will explain the complementary relationship between the Standards and existing legislation, standards, guidelines and professional codes, including for example:
  - the Social Care and Social Work Improvement Scotland (Requirements for Care Services) Regulations 2011;
  - the Healthcare Improvement Scotland (Requirements as to Independent Health Care Services) Regulations 2011;
  - the Dementia Standards; and
  - the Scottish Social Services Council‟s Codes of Practice for Social Service Workers and Employers.
- The Standards will be taken into account in inspections and registration decisions in relation to health and social care services from April 2018.

2. OVERVIEW OF NEW STANDARDS

What the national care standards mean for different people.
The new Standards will extend into areas of health social care previously unaffected by the current 23 sets of standards. It is important to make clear the purpose for which the new national care standards exist; what different people can expect from them; and how they can help improve service delivery and personal outcomes.

Annex A provides a copy of the draft new Standards which you should read along with the explanations below of what these mean for different people before completing your response.

For people who use services and their carers, the national care standards set out what people should expect when using a care service. The standards help people to understand what high-quality care looks like. They will also help provide a reference point in the event that people are unhappy about their care and not sure if they should be expecting a better standard of care.

For providers of care, the Standards set out important characteristics of how they should design, deliver and improve their service. This is relevant for leaders and managers, but also for staff working in services. The standards do not attempt to

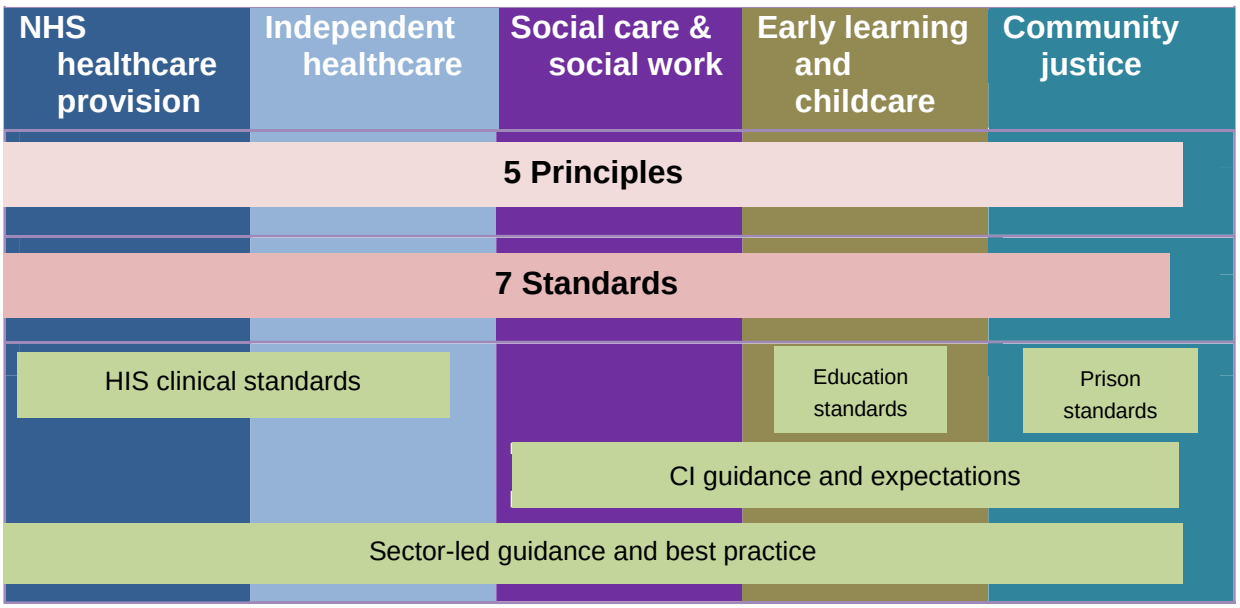
replace the professional codes of conduct for staff, but set out what people using care should expect from them. For providers of regulated social care and independent healthcare services, the standards will underpin decisions made by the Care Inspectorate and Healthcare Improvement Scotland in the course of their scrutiny and reviews of quality.

For commissioners of care services (including Integrated Joint Health and Social Care Partnerships, community planning partnerships, and other public bodies), the standards set out a framework of how high-quality care should be planned, commissioned and organised. This means that commissioners need to ensure that care is commissioned in a way which allows the standards to be achieved by the provider of the service, and that assessments of quality around commissioned services (for example, contract monitoring) should be informed by the standards.

For local authorities and NHS boards, the standards set out the broad approaches for how people should receive and experience care. The standards do not simply apply to their own care services or health services, but are relevant for the way in which people‟s needs are assessed and care packages or pathways established. The standards do not seek to replace detailed clinical standards about specific health interventions, or existing and future sector or professional guidance.

Where will the Standards fit with other guidelines?
The diagram below shows where the standards fit with other guidelines and professional codes of practice.

Note: This is for illustration only and should not be considered exhaustive.



(a): Respondent Information Form (RIF)

Please Note this form **must** be returned with your response.

Consultation on the National Health and Social Care Standards

Are you responding as an individual or an organisation?

☐ Individual (See Part (i) below) ☒ Organisation (See Part (ii) below)

Did you attend an engagement event / workshop before competing this response?

No ☒ Yes ☐ Date …… Name of Event:……..……..

West Dunbartonshire Health & Social Care Partnership

Address

West Dunbartonshire Health & Social Care Partnership Headquarters
West Dunbartonshire Council, Garshake Road, Dumbarton

Postcode

G82 3PU

Email

Phone number

The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing preference:

☒ Publish response with your name / name of organisation

☐ Publish response only (anonymous) – Individuals only

☐ Do not publish response

We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for the Scottish Government to contact you again in relation to this consultation exercise?

Yes ☒ No ☐ Date Completed: **28th November 2016**

(b): CONSULTATION QUESTIONNAIRE

Q1: To what extent do you think the Standards will be relevant and can be applied across all health, care and social work settings?

Strongly Agree	
Agree	X
Neither agree nor disagree	
Disagree	

Comments

West Dunbartonshire Health & Social Care Partnership Board is keenly aware of its responsibilities for robust clinical and care governance; and recognises the value of considers deliverable and effective national Standards for health care and social care within that "integrated" context. However, in order for any such set of Standards to be deliverable and effective – and indeed to enjoy the confidence of the staff delivering and managing services – they also need to be clear, proportionate, and reflective of a "joined-up" approach across inspection and regulatory bodies.

Q2: To what extent do these Standards reflect the experience of people experiencing care and support?

Strongly Agree	
Agree	X
Neither agree nor disagree	
Disagree	

Comments

It is our view that these Standards broadly appear to reflect "traditionally" expressed areas of concerns with respect to quality of care. However, many are quite subjective and also repetitive in nature, which may cause confusion for those readers seeking consistent and objective indicators for what a given minimum standard of care ought to both look and feel like in practice.

Q3: (Standard 1: I experience high quality care and support that is right for me.) To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Strongly Agree	
Agree	X
Neither agree nor disagree	
Disagree	

Is there anything that is missing or should be added to this Standard?

The use of non-specific and inexact language (e.g. "proper planning") reduces the likelihood of consistent understanding and measurement across different services and care groups – and so would dampen its meaningfulness and credibility in practice.

Also, element 1.27 is the only aspect of the Standards to explicitly reference 'health care and that of any other public services' – but it is unclear why.

Throughout the Standards, we would suggest replacing reference to "health, care and social work services" or "care services" with "health and social care services".

Q4: (Standard 2: I am at the heart of decisions about my care and support.)
To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Strongly Agree	
Agree	X
Neither agree nor disagree	
Disagree	

Is there anything that is missing or should be added to this Standard?

This Standard directly links to person-centred care planning; and largely reflects current and measurable practice.

Q5: (Standard 3: I am confident in the people who support and care for me.) To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Strongly Agree	
Agree	
Neither agree nor disagree	
Disagree	X

Is there anything that is missing or should be added to this Standard?

We would suggest that while it is important that patients/service users have confidence in those individual staff who directly support and care for – <u>and with</u> - them, that these Standards should focus more on those (broadly measurable and definable) characteristics of practitioner behaviour from which such confidence should reasonably derive rather than the presence of such confidence per se.

Q6: (Standard 4: I am confident in the organisation providing my care and support.)
To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Strongly Agree	
Agree	
Neither agree nor disagree	
Disagree	X

Is there anything that is missing or should be added to this Standard?

We would suggest that while it is important that patients/service users have confidence in those services who support and care for – and with - them, that these Standards should focus more on those (broadly measurable and definable) elements of organisational good governance from which such confidence should reasonably derive rather than the presence of such confidence per se.

Q7: (Standard 5: And if the organisation also provides the premises I use.) To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Strongly Agree	
Agree	X
Neither agree nor disagree	
Disagree	

Is there anything that is missing or should be added to this Standard?

The use of subjective language such as 'attractive' is neither measurable nor helpful; and does not fit with the other expectations of 5.1, which are clear, valid and measurable.

Additionally specific requirements - such as en-suite facilities within children's houses – are arguably aspirational in nature rather than reflective of a reasonable minimum standard of provision and so would benefit from further clarity.

Q8: (Standard 6: And where my liberty is restricted by law.) To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Strongly Agree	
Agree	X
Neither agree nor disagree	
Disagree	

Is there anything that is missing or should be added to this Standard?

This Standard largely reflects current and measurable practice.

Q9: (Standard 7: And if I am a child or young person needing social work care and support.) To what extent do you think this Standard describes what people should expect to experience from health, care and social work services?

Strongly Agree	
Agree	X
Neither agree nor disagree	
Disagree	

Is there anything that is missing or should be added to this Standard?

This standard appears largely appropriate and proportionate - however as previously stated, the continued use of subjective terminology (e.g. 'as normal an up bringing as possible') is problematic.

Q10: To what extent do you agree these new Standards will help support improvement in care services?

Strongly Agree	
Agree	X
Neither agree nor disagree	
Disagree	

Comments

The degree to which these Standards support improvements across services will be heavily dependent on the extent to which national scrutiny, inspection and regulatory bodies can utilise them in a consistent and streamlined manner without adding an unproductive and costly "industry" of bureaucracy.

Q11: Is there anything else that you think needs to be included in the Standards?

Yes	
No	X

Comments

Given the continuingly evolving policy and legislative landscape, there is a need for the wording of the Standards (specifically in this case Standard 7) to be framed so as to acknowledge the realities of finite resource availability; to support local flexibility; and enable evidence-based service change.

Q12: Is there anything you think we need to be aware of in the implementation of the Standards that is not already covered?

Comments

The degree to which these Standards support improvements across services will be dependent on the extent to which the national scrutiny/inspection/regulatory and improvement support landscape is both de-cluttered and made more transparent.

Q13. What should the new Standards be called?

- ☐ National Care Standards
- X National Health and Social Care Standards
- ☐ National Healthcare and Social Care Standards
- ☐ National Care and Health Standards
- ☐ National Care and Support Standards
- □ Other - please provide details.....

Q14. Any other comments, suggestions:

In finalising the Standards, it will be important to ensure that their wording does not make the theoretical "perfect the enemy of the good", as that would undermine their broader – and much welcomed - continuous improvement ethos.

(c): Additional Information

We recognise that people may have more than one experience of / involvement with health and care services. For example; you may work in a hospital or care home and also be a registered carer for a friend or relative receiving care services. For the purposes of this consultation please indicate the main capacity in which you are responding.

(i) As an individual **service user** (including on behalf of family) ☐

As an individual who **works or volunteers** in health/social care ☐

Please tick to select the services that you have used / have experience of:

Acute health care (emergency care, hospitals etc)	
Primary health care (GP and other community health services)	
Independent health care	
Adult social care	
Early learning and childcare	
Social work (including fostering, adoption, care homes for children and young people)	
Community justice	
Other: (please state)	

(ii) As a **representative of an organisation** / service provider

Please tick to select the type of services that your organisation provides:

Acute health care (emergency care, hospitals etc)	
Primary health care (GP and other community health services)	√
Independent health care	
Adult social care	√
Early learning and childcare	
Social work (including fostering, adoption, care homes for children and young people)	√
Community justice	√
Other: (please state)	

Other Formats

Once finalised these new Standards will be made available in various formats. It would be helpful to know which format(s) may be required. Please indicate from the list below which formats you are most likely to use.

Easy Read ☐ Large Print ☐ Audio ☐ Braille ☐

Other languages (please indicate which) ……..……..

Please indicate how you are most likely to access these Standards:

online / electronic ☒ paper copy ☐ Both ☐

(d): Glossary

Every effort has been made to reduce terminology and/or jargon within the new Standards. However it is not possible to totally eliminate the use of some recognised terms and phrases. Similarly it is important that people are clear on what terms and phrases mean for the purposes of the standards and the consultation.

Term	Description
24-hour care	Where people are cared for and supported throughout the day and night. This can also apply to children‟s services.
advocacy and advocate	Advocacy means getting support from another person to help someone express their views and wishes, and to help make sure their voice is heard. Someone who helps in this way is called an advocate. In the Standards, we are referring to formal advocacy provided by an organisation to someone using care.
assessment	A health and/or social care assessment will find out what help and support a person needs, such as healthcare, medication, advocacy, equipment, care at home, housing support or a care home.
capacity	Capacity refers to an individual‟s ability to make decisions about their wellbeing. This may change over time and may refer to different aspects of their life. For people who have been medically assessed as lacking capacity there is legislation to protect their wellbeing.
care home	A care service providing 24 hour care and support with premises, usually as someone‟s permanent home.
carer	A carer is someone of any age who looks after or supports a family member, partner, friend or neighbour in need of help because they are ill, frail, have a disability or are vulnerable in some way. A carer does not have to live with the person being cared for and will commonly be unpaid.
communal areas	An area in a care service such as a living or dining room, activity room, hairdresser, library, café, garden or quiet area that everyone can use.
communication tools	These help people to communicate in a range of ways. For example, visual prompts, talking mats (system of simple picture symbols) or mobile phone apps.
confidentiality	This means that information that is kept about someone by a care provider will not be shared with anyone else unless the person gives their consent for it to be shared. Confidentiality may only be broken if it avoids or reduces the risk of harm to the person.
early years	Children aged up to 16 years.
emergency or unexpected event	This is an incident or emergency that could require immediate action, such as the premises being evacuated.
emotionally resilient	Someone‟s ability to cope with, or adapt to, stressful situations or crises.

Term	Description
evidence, guidance and best practice	Written guidelines for agreed ways to provide care, support or carry out treatment. Often these are put together by professionals based on the best available evidence at the time. These guidelines often change so that they remain up to date.
human rights	*Human rights* are based on the principle of respect for the individual and they are the rights and freedoms that belong to every person, at every age. They are enshrined in UK legislation under the Human Rights Act.
intimate personal care	This relates to activities which most people usually carry out for themselves, such as washing, going to the toilet, dressing or eating, but some people may be unable to do because of their age, an impairment or disability.
liberty is restricted by law	There are times when a person‟s choices, such as where they live, are determined by law. For instance, someone might have their liberty restricted under the Mental Health Act, as a result of a criminal conviction or decisions made by a Children‟s Hearing.
open-ended and natural play materials	Open-ended materials (also called loose parts) are play materials that can be used in numerous ways indoors and outdoors by children. They can be moved, carried, combined, and redesigned in any way the child decides.
personal plan	A plan of how care and support will be provided, agreed between the person using a service and the service provider.
physical intervention, sanctions or incentives	These are used to manage and respond to challenging behaviour. They can be constructive in reducing the risk of harm and helping people recognise that there are consequences to their actions.
planned care	The term used to describe care, support or treatment which is carried out as detailed in someone‟s personal plan (see above).
positive risks	Positive risks means making balanced decisions about risks; it is the taking of calculated and reasoned risks, which recognises that there are benefits as well as potential harm from taking risks in day to day life.
premises	When an organisation providing care and support also provides premises, such as a nursery, hospital or care home. It does not apply when someone using a service is responsible for the premises, including housing support or care at home.
pretend play	Pretend play is any game or activity where children use their imagination to create their own pretend experience.
professional codes	These codes set out professional standards of conduct and competence, as well as the personal values, which people working in health and social care are expected to follow.

Term	Description
representative	This may include someone appointed to have power of attorney, a guardian, family member, friend, neighbour or an agreed person who can speak on the individual‟s behalf. A representative may be formal or not formal.
restraint	Restraint is used to keep someone safe or to prevent them from harming others. It might involve using physical means, changing the environment or medication.
small group living	Groups of approximately 6 to 10 people provided with their own lounge and dining facilities for their own group use in a homely type environment. Small group living sometimes takes place within a larger care service such as a care home or hospital.
technology and other specialist equipment	Specialised equipment that helps people in their day to day life, such as telecare, telehealth or telemedicine, alarm call system, remote support and advice or mobility aids.
therapy	A specialised treatment or intervention, such as physiotherapy, occupational therapy, speech and language therapy, counselling and talking therapies.
transition	Used to describe a significant change for someone, such as starting to use a new care service or a change in life stage (eg becoming an adult).

October 2016

NATIONAL CARE STANDARDS

REVIEW

National Health and Social Care Standards

Principles and standards

www.newcarestandards.scot

Principles (approved February 2016)

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.

Standard 1: I experience high quality care and support that is right for me

Dignity and respect

1.1 I am accepted and valued whatever my needs, disability, gender, age, faith, spirituality, mental health status, background or sexual orientation.
1.2 I am not discriminated against in any aspect of my care and support.
1.3 I am supported and cared for using a positive and understanding approach, even if my behaviour is challenging to others.
1.4 If I require intimate personal care this is carried out in a dignified way, with my personal preferences respected.
1.5 If I need support managing my money and my personal affairs, I am able to have as much control as possible and my interests are safeguarded.
1.6 If I am being supported and cared for in the community, this is done discreetly and with respect.

Compassion

1.7 I experience encouragement and warmth and my strengths and achievements are celebrated.
1.8 I get the most out of life because the people and organisation who support and care for me have an enabling attitude and believe in my potential.
1.9 I am supported to discuss changes in my life, including death or dying, this is handled sensitively and my wishes and choices are respected.
1.10 If I experience care and support in a group, the overall size of that group is right for me.

Be included

1.11 I am recognised by people who support and care for me as an expert in my own experiences, needs and wishes.
1.12 I am encouraged to take part in everyday tasks to help the running of the service if I choose to.

Responsive care and support

Assessing my care and support needs

1.13 My emotional, psychological and physical needs are assessed by a qualified professional at an early stage, regularly and when my needs change.
1.14 My care and support is right for me because I am fully involved in my assessment.
1.15 If I have a carer, their needs are assessed and support provided.
1.16 If the care and support that I need or choose is not available or delayed, the reasons for this are explained to me and I can get help to use a suitable alternative.

Experiencing care

1.17 I am supported to live in my own home if this is possible for me.
1.18 I am supported to manage my own care and support if this is what I want.
1.19 I can access technology and other specialist equipment so I can be independent, including to call assistance and manage my own health and wellbeing.
1.20 I fully participate in developing and regularly reviewing my personal plan.
1.21 If I have particular needs, due to a health condition, age or circumstance, I am informed about the care and support I should experience. (or care plan) that clearly sets out my needs and wishes and how these will be met.
1.22 If I, or others, have concerns about my health and wellbeing, these are acted on and appropriate assessments and referrals are made.
1.23 My needs, as agreed in my personal plan, are fully met, and my wishes are respected.
1.24 I know how organisations can support my wellbeing and I am helped to contact them if I wish.
1.25 I experience proper planning and am helped when using a new service, or when I move between services.

Wellbeing

1.26 I am in the right place to experience the care and support I need and want.
1.27 I am helped to access the health care that I need and any other public services.
1.28 I am supported to make healthy lifestyle choices that are right for me.
1.29 If I need help with medication, this is done safely and effectively.

Eating and drinking

1.30 I can choose suitably presented, healthy and nutritious meals and snacks, including fresh fruit and vegetables if this is right for me.
1.31 I can enjoy unhurried snack and meal times in as relaxed an atmosphere as possible.
1.32 I can enjoy snacks and meals alongside other people using and working in the service if appropriate and I want this.
1.33 I enjoy meals and snacks which meet my cultural and dietary needs.
1.34 If I experience care and support in a group, I can choose to make my own meals, snacks and drinks, with support if I need it.
1.35 I can drink fresh water at all times.

Activities

1.36 I can have an active life and fulfil my aspirations by being supported to take part in activities that are important to me, in the way I like.
1.37 I am supported to participate in a range of recreational, social, physical and learning activities.
1.38 If I experience care and support in a group, or in my own home, I can choose to do creative and artistic activities every day, such as art, crafts, music, drama, and dance.
1.39 I am supported to participate fully as a citizen in my local community.

Protection

1.40 I am listened to and taken seriously if I have a concern about the safety and wellbeing of myself or others.
1.41 I am protected from all forms of abuse and exploitation.
1.42 I am helped to develop personal resilience and ways to keep myself safe.
1.43 If I might harm myself or others, I know that people have a duty to protect me and others, which may involve contacting relevant agencies.
1.44 The people who support and care for me are alert and responsive to any signs that I may be unhappy or at risk of harm.

For children in their early years:

1.45 I have fun as I develop my skills in understanding, thinking, language, literacy, numeracy, investigation and problem solving.
1.46 I can take part in pretend play and storytelling.
1.47 I spend time outdoors every day and this is a significant part of my day if I attend full-time, where appropriate.
1.48 I can regularly explore, and be creative in, a natural environment.
1.49 If I attend all day and I am under school age, I can if needed have a sleep on a sleeping mat or bed with my own bed linen.
1.50 I can choose to grow, cook and eat my own food, if possible.

Standard 2: I am at the heart of decisions about my care and support

Dignity and respect

2.1 I am empowered and enabled to be as independent, and as in control of my life, as I want and can be.
2.2 I receive and understand information and advice in a format or language that is right for me, including using independent advocacy if I want or need this.
2.3 I am as involved as I can be in agreeing any restrictions to my independence, control and choice and these are justified, uphold my human rights and are kept to a minimum.

Compassion

2.4 I am supported to communicate in a way that is right for me, at my own pace, by people who are sensitive to me and my needs.

Be included

2.5 I can access translation services and communication tools where necessary and I am supported to use these.
2.6 I have time and help to understand the planned care, support, therapy and intervention I will receive, including any cost, before deciding what is right for me.
2.7 If possible I can choose who will provide my care and support and how this will be provided. If possible, I can visit the service before deciding and/or meet the people who.
2.8 If there is limited choice, this is explained to me so I understand the reasons for this.
2.9 If I need or want to move on and start using another service, I will be fully involved in this decision and helped to find a suitable alternative. If I am moving from a service for children to one for adults, I am helped with this transition.
2.10 If I am unable to make my own decisions, the views of those who know my wishes, my carer, advocate or representative will be sought and taken into account to establish what my wishes would be.
2.11 If I have expressed my own views and choices, these will be respected if I lose capacity.
2.12 I am able to resolve conflict, negotiate boundaries, agree rules and build positive relationships with other people as much as I can.

Responsive care and support

2.13 I am supported to manage my relationships with my family, friends and/or partner in a way that suits my wellbeing.
2.14 If I am living in a care home, I can receive visitors in private and have a friend, family member or partner to sometimes stay over in the home.

Wellbeing

2.15 I make choices and decisions about all day to day aspects of my life, including managing my own money, how I dress, what I eat and how I spend my time.
2.16 I make informed choices and decisions about the risks I take in my daily life and am encouraged to take positive risks which enhance the quality of my life
2.17 I am helped to understand the impact and consequences of risky and unsafe behaviour and decisions.

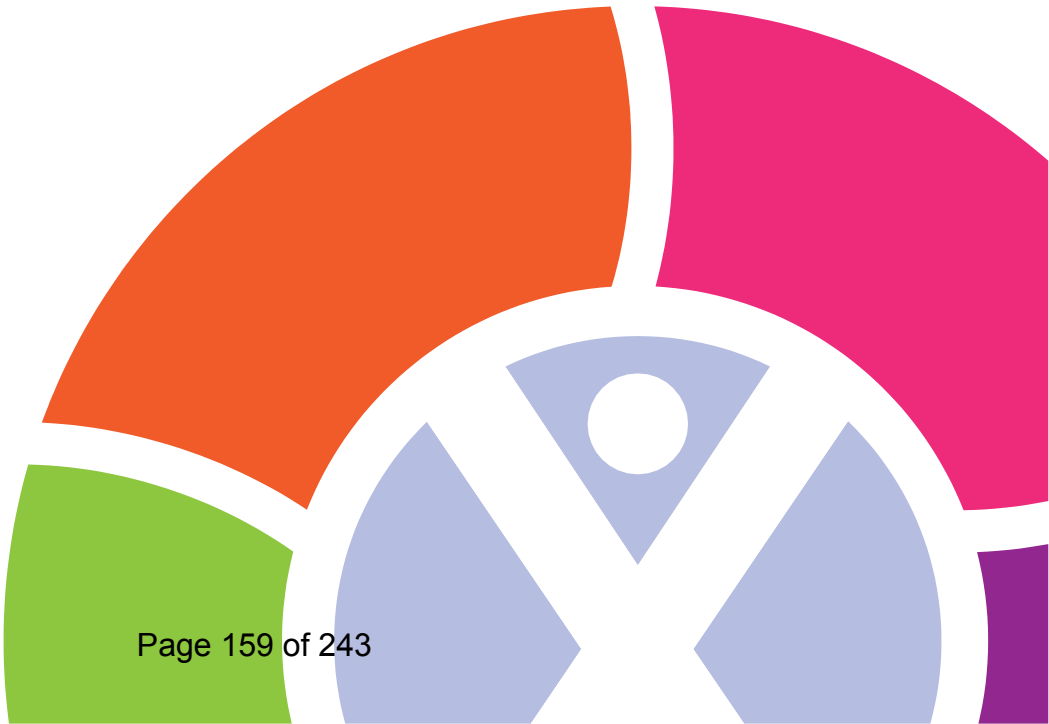
For children in their early years:

2.18 I have the right to control my own play in the way that I choose.

2.19 I can freely access a wide range of experiences and resources suitable for my age and stage, which stimulate my natural curiosity, learning and creativity.

2.20 I enjoy extended play and activities that develop my confidence, self-esteem and imagination.

2.21 I can play flexibly and creatively using open-ended and natural play materials and I experience a balance of organised and freely chosen activities.



Standard 3: I am confident in the people who support and care for me

Dignity and respect

3.1 I experience people speaking and listening to me in a way that is courteous and respectful, with my care and support being the main focus of people's attention.
3.2 If I experience care and support at home, people are respectful when they visit my home.
3.3 I am supported and cared for by people who challenge discrimination and bullying and stand up for me and my rights if I need this.
3.4 I am treated as an individual by people who get to know me and understand me, my lifestyle and choices.

Compassion

3.5 I am greeted warmly by people and, if I do not know them, they introduce themselves.
3.6 I experience a warm atmosphere because people who support and care for me have good working relationships.
3.7 I can build relationships with the people who support and care for me in a way that we all feel comfortable with.
3.8 I experience warmth, kindness and compassion in how I am supported and cared for, including physical comfort when appropriate for me and the person supporting and caring for me.
3.9 I am helped to feel content and at ease by the people who support and care for me.

Be included

3.10 I know who provides my care and support on a day to day basis and what they should do. If possible, I can have a say on who provides my care and support.
3.11 I can understand the people who support and care for me when they communicate with me.
3.12 I am supported to be part of the local community, to enjoy family life and to develop interests if this is what I want.
3.13 I experience appropriate and consistent boundaries, guidance, and care.

Responsive care and support

3.14 My needs are met by people who are trained, competent and skilled to support me, are able to reflect on how they do that, and follow their professional codes.
3.15 I am supported by people who undertand my needs, choices and wishes.
3.16 I am supported sensitively by people who anticipate issues and are aware of and plan for any known vulnerability or frailty.
3.17 My needs, wishes and choices are met because I am supported by the right number of people with the right skills and experience.
3.18 People have enough time to support and care for me and to speak with me.
3.19 I am supported by people who respond promptly when I ask for help.
3.20 My care and support is consistent and stable because people work together well.

Wellbeing

3.21 I am supported and cared for by people who have a clear understanding of their responsibilities to protect me from discrimination, neglect, abuse and avoidable harm.
3.22 I am helped to feel safe and secure in the area where I live.
3.23 The people who care for me stimulate my interests and spontaneity.
3.24 People help me to extend my learning and development, and they ask open questions and involve me in genuine dialogue.

Standard 4: I am confident in the organisation providing my care and support

Dignity and respect

4.1 I am confident and experience that my human rights are central to the organisation that supports and cares for me, and that it helps tackle inequalities.

Compassion

4.2 I receive an apology if things go wrong with my care and support or my human rights are not respected and the organisation takes responsibility for its actions.
4.3 I use a service where all people are respected and valued.

Be included

4.4 I am informed of the organisation's aims and I can be involved in decisions about how it works and develops.
4.5 I am actively encouraged to be involved in improving the service I use, in a spirit of genuine partnership.
4.6 I give feedback on how I experience my care and support and the organisation uses learning from this to improve.
4.7 I can take part in recruiting and training people who provide my care and support if possible.
4.8 I am supported to make use of relevant screening and healthcare programmes.

Responsive care and support

4.9 I experience high quality care and support based on relevant evidence, guidance and best practice.
4.10 I am involved in shaping how my service can continually improve to meet everybody's needs, choices and wishes.
4.11 I receive appropriate notice and I am involved in finding an alternative if the service I use plans to close.
4.12 I am looked after in a planned and safe way, including if there is an emergency or unexpected event affecting the premises.
4.13 I continue to experience stability in my care and support from people who know my needs, choices and wishes, if there are changes in the service or organisation.
4.14 I am supported and cared for by people I know so that I experience consistency and continuity.
4.15 If I am supported and cared for by a team or more than one organisation, this is well co-ordinated so that I experience consistency and continuity.
4.16 I know how to make a complaint or raise a concern about my care and support.
4.17 If I have a concern or complaint, I know this will be acted on without negative consequences.

Wellbeing

4.18 I am confident that the service I use and the organisation providing it are well led.
4.19 I am supported and cared for by people who have been appropriately recruited.
4.20 I am supported to reach my full potential by people who are encouraged to be innovative in the way they support and care for me.

Standard 5: And if the organisation also provides the premises I use

Dignity and respect

5.1 I experience an environment that is well looked after and attractive, with clean, tidy and well-maintained premises, furnishings and equipment.
5.2 I can use an appropriate mix of private and communal areas, including an accessible outdoor space.
5.3 I can easily access a toilet from the rooms I use and I can use a toilet when I need to.
5.4 If I live in a care home, I have ensuite facilities with a shower and can choose to have a bath if I want.
5.5 I have a secure place to keep my belongings.
5.6 If CCTV is used, I know about this and how my privacy is protected.

For children in their early years:
5.7 If I wear nappies, there is a suitable area with a sink and some privacy for me to be changed.

Compassion

5.8 I experience care and support in a homely environment.
5.9 I experience homely care and support in a service that is the right size for me.
5.10 If I live in a care home, the premises are designed and organised so that I can experience small group living and an environment that is right for me.
5.11 If I experience care and support in a group, I can use a cosy area with soft furnishings to relax.

Be included

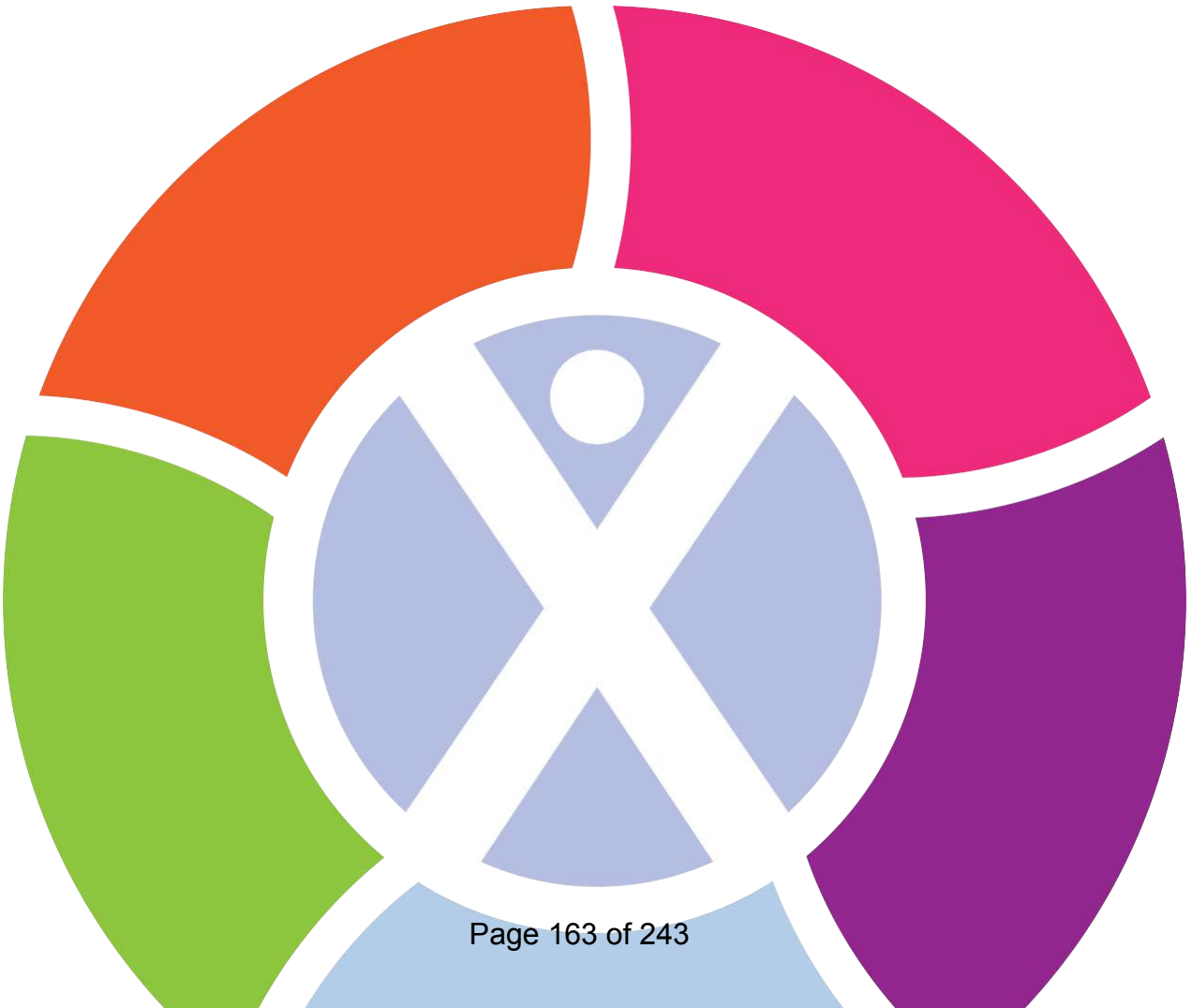
5.12 I experience a service as near as possible to people who are important to me and my home area if I want this and if it is safe.
5.13 The location and type of premises enable me to experience care and support free from isolation and for me to be an active member of the local community if this is appropriate.
5.14 If I experience 24-hour care, I have access to a telephone, radio, TV and the internet so that I am connected.
5.15 I can independently access all parts of the premises I use and the environment has been designed to promote this.
5.16 If people who support and care for me have separate facilities, these do not take away from the homeliness of the service and my feeling of being at home.
5.17 If I live in a care home, I can control the lighting, ventilation, heating and security of my bedroom.
5.18 If I live in a care home, I can decide on the decoration, furnishing and layout of my bedroom, including bringing my own furniture where possible.

Responsive care and support

5.19 The premises I use are designed, adapted, equipped and furnished with my care and support needs in mind.

Wellbeing

5.20 I experience a secure and safe environment that is suitable for me.
5.21 My environment is relaxed, welcoming, peaceful and free from avoidable and intrusive noise and smells.
5.22 I can enjoy a pleasant environment, with plenty of natural light, fresh air, space and a comfortable temperature for me.
5.23 I have enough physical space to meet my needs and wishes.
5.24 I am able to access a range of good quality equipment and furnishings to meet my assessed needs, wishes and choices.
5.25 I am able to participate in a variety of creative and physical activities, including exercise both indoors and outdoors.
5.26 If I am an adult living in a care home, I have my own bedroom that meets my needs.
5.27 If I am an adult living in a care home, I can choose to live with and share a bedroom with my partner, relative or close friend.
5.28 As a child or young person, I might need or want to share my bedroom with someone else and I am involved in deciding this.
5.29 If I experience 24-hour care, I have a bedside cabinet and light and there is enough space for me to sit comfortably with a visitor in my bedroom.
5.30 If I live in a care home and I want to keep a pet, the service will try to accommodate this request.



Standard 6: And where my liberty is restricted by law

Dignity and respect

6.1 I experience my human rights being protected when my liberty is restricted and this complies with the relevant legislation.
6.2 I am helped to understand how and why my behaviour affects my rights, including the use of any physical intervention, sanctions or incentives.
6.3 I only experience restraint as a last resort and for the minimum time necessary by people who are properly trained.
6.4 I will only be searched if there are clearly identified concerns and I am told what these are.
6.5 If I am restrained or searched, this will be carried out with sensitivity

Compassion

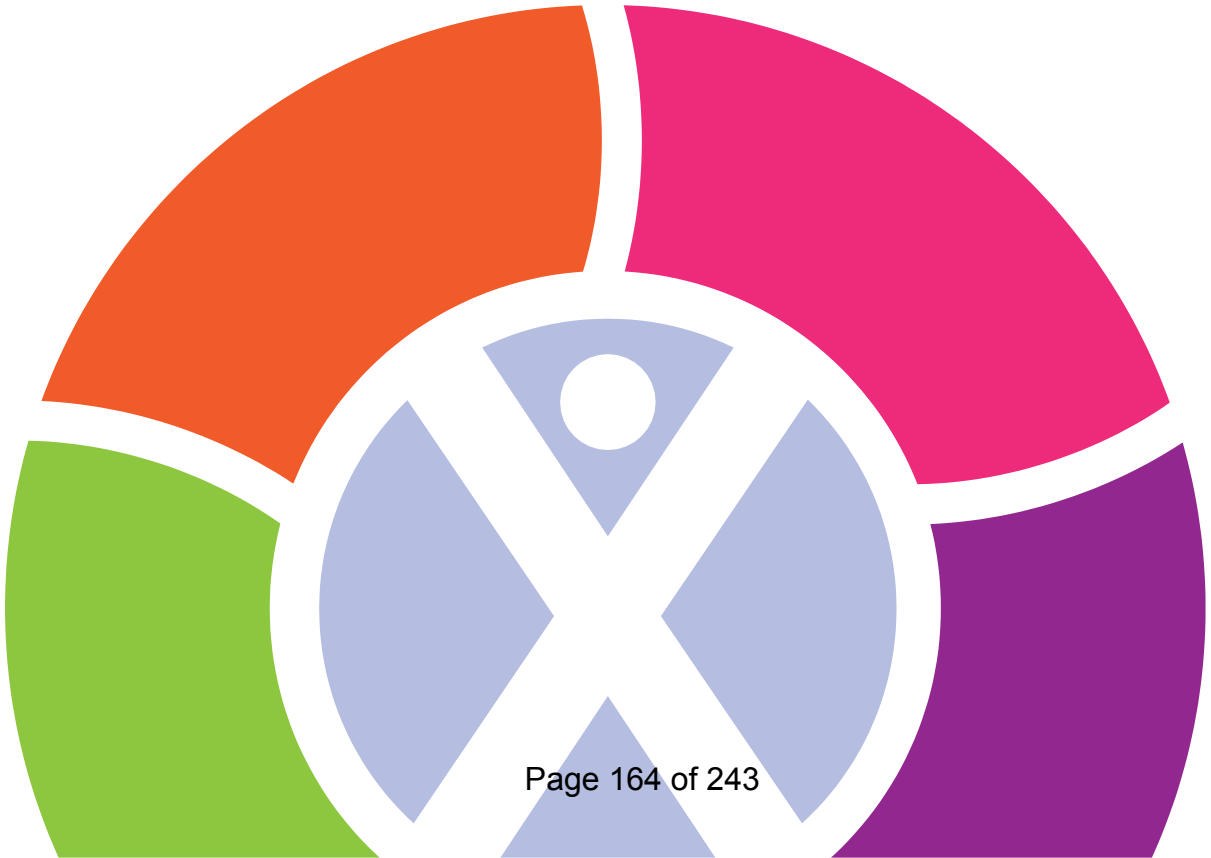
6.6 I am supported by people who anticipate challenges with my or others' behaviour and they work creatively to help manage this.

Be included

6.7 I can be with my peers, including other people who use the service, except where this has been properly assessed as unsafe.

Wellbeing

6.8 The environment is specially designed and managed to minimise the risk of me harming myself or others.



Standard 7: And if I am a child or young person needing social work care and support

Dignity and respect

7.1 I am cared for by people who are ambitious for me, champion my needs and enhance my life chances.

Compassion

7.2 I live in a place that feels like a home and I am supported and cared for by people who make me feel valued, special, loved and safe.
7.3 I am supported to develop a positive view of myself and to form and sustain trusted and secure relationships.
7.4 I am supported and cared for by people who are fully informed about my history and understand what I am communicating.
7.5 I am helped to overcome any previous experiences of trauma and neglect so I am emotionally resilient and have a strong sense of my own identity and belonging.
7.6 I am responded to with sensitivity and the people who support and care for me anticipate and reduce any conflict, with difficulties sorted out in a low-key way.
7.7 I am helped by the people who support and care for me to understand the consequences of any difficult or unsafe behaviour and I am supported to take responsibility to change this.
7.8 I have as normal an upbringing as possible and I am helped by the people who support and care for me to achieve this.

Be included

7.9 I am encouraged and supported to make friends with people my own age.
7.10 I am helped to understand decisions taken in my best interests and why sometimes it might not be possible to act on my wishes.
7.11 I am fully included in all aspects of family life if I am fostered.

Responsive care and support

7.12 My needs and wishes are assessed in good time and an assessment for a permanent placement is done within 12 weeks.
7.13 My need for permanent care and support is assessed and met.
7.14 I experience stable care and support, with minimum disruption, from people who can nurture and form strong attachments with me.
7.15 If I need and want this, I am placed with wider family members (kinship care) alongside my brothers and sisters where possible and where it is safe.
7.16 People making decisions about me, including fostering and adoption panel chairs and advisers, know me and have the right skills, training and experience to decide what's best for me.
7.17 I am supported to have safe contact and continuity of relationships with family and people who are important to me by people who understand the importance of maintaining attachments.
7.18 I continue to be supported and cared for into adulthood.
7.19 I experience different organisations working together for my benefit.

Wellbeing

7.20 I am supported to achieve my potential in education and employment.
7.21 I am supported to develop my independence while protecting myself from unsafe situations.
7.22 I am supported to become increasingly safe from neglect, abuse, grooming and sexual exploitation, self- harm, bullying, misuse of drugs or alcohol and going missing.
7.23 I am supported by people who seek to understand why I have been missing and work with me to minimise future risks.
7.24 If I go missing, people take urgent action to protect me, including looking for me and liaising with the police and other agencies, and my family.

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WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 7th December 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 three 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 As of 1st April 2015, the Care Inspectorate amended their inspection process. Where any building based service has been awarded a Grade 2 (i.e. weak) or less and/ or has requirements detailed following a full inspection, their next inspection will be a 'follow up' inspection. The follow up inspection will focus on the requirements made in the previous inspection instead of covering the four quality themes. The grades awarded at the previous inspection may change if the Inspector has evidence to support any adjustment. Follow up inspections will allow the Care Inspectorate to track improvement and gain assurance that services are making the right changes.

3.3 The independent sector support service inspections reported here are for:

- The Richmond Fellowship Scotland – East & West Dunbartonshire Supported Living Services - service is provided across West Dunbartonshire Council.
- Quarriers Homelife Glasgow Project - service is provided throughout West Dunbartonshire Council area.
- Carewatch Care Services (Inverclyde, North Ayrshire, Dunbartonshire, Argyll & Bute) - service is provided across West Dunbartonshire Council area

3.4 Some providers, who operate multiple services across Scotland, register groups of their services with the Care Inspectorate on a 'Branch' basis rather than as individual services. In this report both The Richmond Fellowship Scotland – East & West Dunbartonshire Supported Living Services and Quarriers Homelife Glasgow Project operate in this manner.

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

4. Main Issues

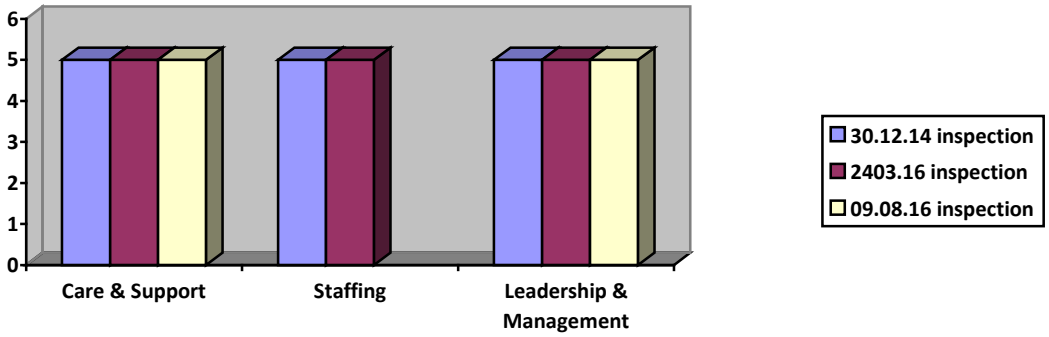
The Richmond Fellowship Scotland – East & West Dunbartonshire Supported Living Services.

4.1 The Richmond Fellowship Scotland – East & West Dunbartonshire Supported Living Services is a combined Housing Support and Care at Home service. The service is offered to individuals who have mental health issues, learning disabilities, adults with alcohol related brain damage, Autism Spectrum Disorders, people with an acquired brain injury and older people. The support is provided to people who live in their own homes or in shared accommodation. The service was inspected on 9th August 2016 and the report published on 5th September 2016. The following grades were awarded:

- For the theme of Care & Support – Grade 5/Very Good.
- For the theme of Management & 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 The Richmond Fellowship Scotland – East & West Dunbartonshire Supported Living Services from inspections over the last 3 inspections.



Quarriers' Homelife Glasgow Project

4.4 Quarriers' Homelife Glasgow Project provides housing support and care at home services to adults who have learning disabilities living in their own homes or shared tenancies. The service was inspected on 23rd June 2016 and the report published on 5th September 2016. The following grades were awarded:

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

4.5 The inspection report detailed the following two requirements to be addressed:

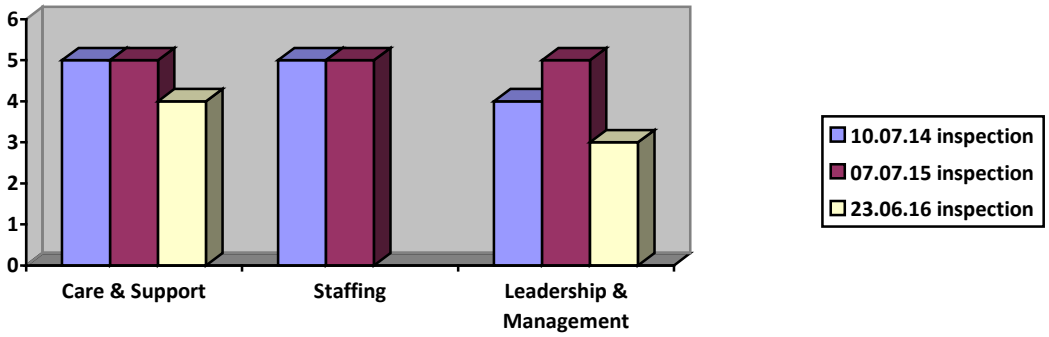
- Ensure personal plans are reviewed at intervals in keeping with required legislation and show the involvement of service users. To achieve this, personal plans must be reviewed at least every six months and when there is a significant change in a service user's health, welfare or safety needs.

Quarriers Homelife Glasgow Project was to start this upon receipt of the final report on 5th September 2016. The provider is currently working on the personal plans and key-workers are bringing together all the main components of the personal plans. Staff are meeting with service users to ensure the personal plans are updated to meet their needs and to plan for new goals and outcomes which the service user wishes to achieve.

- Ensure that Quality Assurance for the service is carried out effectively. To achieve this regular management monitoring of the quality of care & support, staffing and management & leadership is to be provided, audits undertaken and any improvements identified actioned. This was to be completed within one month upon receipt of the final inspection report.

The Homelife Glasgow Project confirmed that to achieve this Quarriers drafted a service development plan. It has been implemented by the Manager of the service and is monitored by external managers.

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



<u>Carewatch Care Services (Inverclyde, North Ayrshire, Dunbartonshire and Argyll & Bute)</u>.

4.7 Carewatch Care Services (Inverclyde, North Ayrshire, Dunbartonshire, Argyll & Bute) provide a combined Housing Support and Care at Home service. The service is offered primarily to older people who require support to live independently in their own homes. The service was inspected on 26th August 2016 and the report published on 17th October 2016. The following grades were awarded:

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

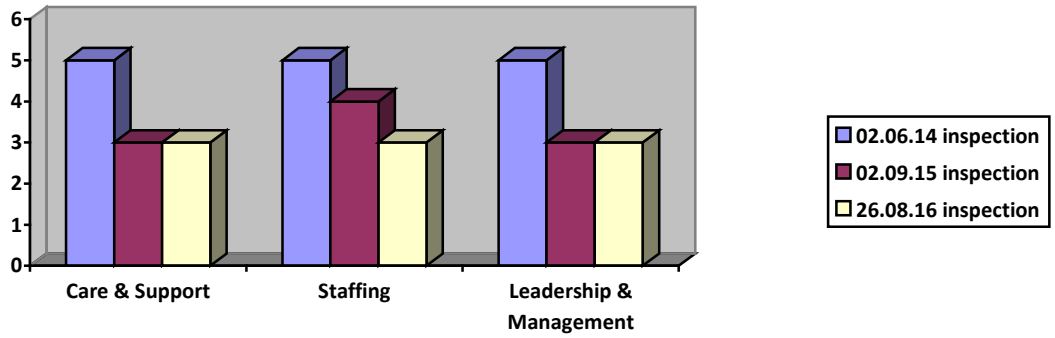
4.8 The inspection report detailed the following two requirements to be addressed:

- Ensure risk assessments are reviewed and regularly updated, staff to follow instructions in the assessments when working with service users. Staff to attend risk assessment training and know their responsibility to follow instructions. This requirement is to be completed by 31st January 2017. The provider is in the process of addressing this requirement.

- All staff to have access to regular training and when this is identified through the disciplinary process it is carried out and ensure staff are deemed competent before working on their own. All staff to have had relevant training by 28th February 2017.

The provider has confirmed that training identified through a disciplinary process was completed by 30th September 2016; all new staff have completed their induction; and that they have developed individual training plans for staff and begun to source providers to deliver the training.

4.9 The chart below summarises the movement in grades awarded to Carewatch Care Services from inspections over the last 3 inspections.



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 grades 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 2016-17 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.

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Date: 7th December 2016

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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: 7th December 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 four independent sector residential older peoples' Care Home 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 to make further requirements or revise grades 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 monitors 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:

- Clyde Court Care Home
- Balquhidder House Care Home
- Castle View Nursing Home
- Hill View Nursing Home

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

4. Main Issues

Clyde Court Care Home

4.1 Clyde Court Care Home is owned and managed by Four Seasons Health Care Limited. The home is registered with the Care Inspectorate for a maximum of 65 nursing or residential residents. As of 2nd November 2016 there were 49 West Dunbartonshire residents supported within the care home.

4.2 The care home was inspected on 14th July 2016 and the report was published on 24th August 2016, with grades awarded as follows:

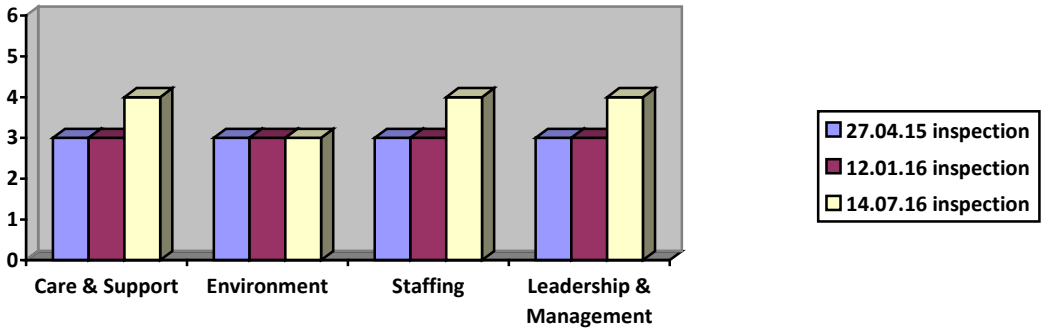
- For the theme of Care and Support – Grade 4/Good.
- For the theme of Environment – Grade 4/Good.
- For the theme of Staffing – Grade 3/Adequate.
- For the theme of Management and Leadership – Grade 4/Good.

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

- To ensure resident's needs are fully met with regards to intervention for stress/distress. This must include assessment and provision of appropriate seating equipment and staff interaction to ensure social stimulation can be achieved.

The Manager of Clyde Court Care Home has confirmed that this requirement had been completed before the end of September 2016, the timescale given by the Care Inspectorate in their inspection report.

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



Balquhidder House Care Home

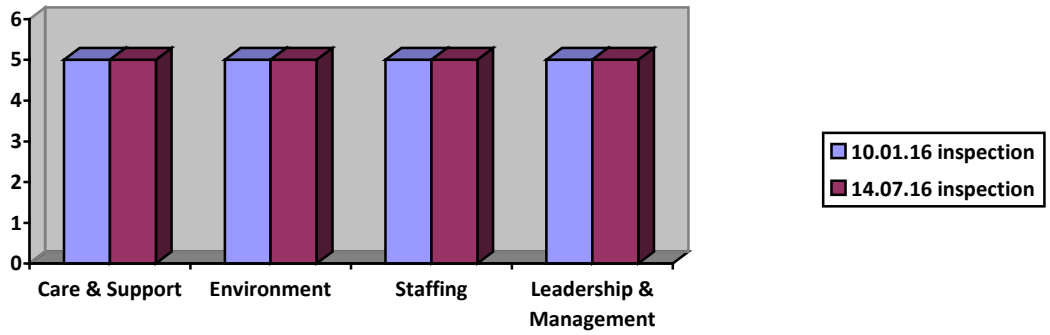
4.5 Balquhidder House Care Home is owned and managed by Balquhidder Care Limited. The home is registered with the Care Inspectorate for a maximum of 65 nursing residents. As of 2nd November 2016 there were 36 West Dunbartonshire residents supported within the care home.

4.6 The care home was inspected on 14th July 2016 and the report was published on 24th August 2016, with 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.

4.7 There were no requirements detailed in the inspection report.

4.8 This is a relatively new service that opened in July 2015. The chart below summarises any movement in grades awarded to Balquhidder House Care Home from their 2 inspections.



Castle View Nursing Home

4.9 Castle View Nursing Home is owned and managed by HC-One Limited. The home is registered with the Care Inspectorate for a maximum of 60 nursing residents only. As of 2nd November 2016 there were 52 West Dunbartonshire residents supported within the care home.

4.10 The care home was inspected on 16th August 2016 and the report was published on 23rd August 2016, with grades awarded as follows:

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

4.11 There were no requirements detailed in the inspection report.

4.12 The chart overleaf summarises the movement in grades awarded to Castle View Nursing Home from inspections over the last 3 inspections.

Hill View Nursing Home

4.11 Hill View Nursing Home is owned and managed by BUPA Healthcare Limited. The home is registered with the Care Inspectorate for a maximum of 150 residents; 120 nursing and 30 residential places. As of 2nd November 2016 there were 102 West Dunbartonshire residents supported within the care home.

4.12 The care home was inspected on 15th September 2016 and the report was published on 26th October 2016, with grades awarded as follows:

- For the theme of Care and Support – Grade 4/Good.
- For the theme of Environment - Grade 4/Good.

4.13 There were no requirements detailed in the inspection report.

4.14 The chart below summarises the movement in grades awarded to Hill View Nursing Home from inspections over the last 3 inspections.

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

a grade of 5/Very Good or 6/Excellent for the theme of Quality of Care and Support. There is a second additional quality payment if the high grade in Quality of Care and Support is coupled with a grading of 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 their Care Inspectorate Inspection report. If either of these grades are awarded it may trigger the withdrawal of the quality funding component, resulting in a reduction of £20 per resident per week from the weekly fee payable.

6.3 The Inspection Reports for Balquhidder House and Castle View Nursing Home have financial implications for the HSCP. They both again received the grade 5/Very Good for the theme of Quality of Care & Support and 5/Very Good in at least another one of the other three thematic areas in their inspection report, thereby continuing to receive the enhanced weekly rate for every resident the HSCP has placed in the homes.

6.4 As detailed at point 6.3 above Balquhidder House and Castle View Nursing Home will continue to receive the enhanced weekly rate of £3.00 per resident per week from the date of their inspection. This means the HSCP will pay Balquhidder House an additional £3,648.00 from 14/07/16 to 09/04/17 and Castle View Nursing Home an additional £4,059.00 from 16/08/16 to 09/04/17, if all residents remain in the home until the end of this financial year. The increase does not apply to residents who only receive a Free Personal and/or Nursing Care payments from the HSCP.

6.5 These additional payments will remain in place until either the National Care Home Contract terms are renegotiated or the Care Inspectorate reduces the grades awarded to Balquhidder House and Castle View Nursing Home 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 2016-19 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.

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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: 7th December 2016

Subject: Care Inspectorate Reports for Care at Home Services Operated by West Dunbartonshire Council.

1. Purpose

1.1 To provide Members with information regarding the most recent inspection reports for the Council's own Care at Home Services.

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 a combination of three thematic areas. These themes are: quality of care and support, quality of staffing, and quality of management and leadership.

3.2 The services covered in this Committee report are:

- Home Care
- Sheltered Housing

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

4. Main Issues

Home Care

4.1 Home care services were inspected from 19th to 27th January 2016, followed by additional scrutiny for clarification and evidence. The inspection was undertaken by one Care Inspectorate inspector, and supplementary work was undertaken by two lay inspectors.

The report acknowledged that the service continues to provide a high standard of care and support to people living in their own homes. All the service users and relatives who completed care standard questionnaires agreed or strongly agreed that they were happy with the quality of the service.

4.2 The inspection focused on three thematic areas, with the following grades awarded:

Quality of Care and Support	Grade 4	Good
Quality of Staffing	Grade 5	Very Good
Quality of Leadership and Management	Grade 5	Very Good

4.3 There were no requirements, and two recommendations from the inspection:

There should be a clear record in care diaries of every visit including time spent in service user's homes

Training in dementia should be provided for all staff

4.4 The tables below illustrate the sustained performance in grades for this service over the last two inspections.

Service	**Previous Grades 2015**		
Home Care	**Quality Statements Assessed**	**Grades Awarded**	**Overall Grade**
Care & Support	1 3	5 4	**4**
Staffing	1 3	5 5	**5**
Management & Leadership	1 6	4 4	**4**

Service	**Current Grades 2016**		
Home Care	**Quality Statements Assessed**	**Grades Awarded**	**Overall Grade**
Care & Support	1 3	5 4	**4**
Staffing	1 3	5 5	**5**
Management & Leadership	1 6	5 5	**5**

<u>Sheltered Housing</u>

4.5 Sheltered Housing services were inspected from 19th to 27th January 2016, followed by additional scrutiny for clarification and evidence. The inspection was undertaken by four Care Inspectorate inspectors, including the team manager, and supplementary work was undertaken by two lay inspectors.

The report acknowledged that the service continues to show a strong commitment to involving people who use the service in initiatives, and

to ensure that where possible people are supported to maintain their independence and abilities.

4.6 The inspection focused on four thematic areas, with the following grades awarded:

Quality of Care and Support	Grade 5	Very Good
Quality of Staffing	Grade 5	Very Good
Quality of Leadership and Management	Grade 5	Very Good

4.7 There were no requirements, and two recommendations from the inspection:

There should be a clear record in care diaries of every visit including time spent in service users' homes

Training in dementia should be provided for all staff

4.8 The tables below illustrate the sustained performance in grades for this service over the last two inspections

Service	**Previous Grades 2015**		
Sheltered Housing	**Quality Statements Assessed**	**Grades Awarded**	**Overall Grade**
Care & Support	1 3	5 5	**5**
Staffing	1 3	5 5	**5**
Management & Leadership	1 6	5 5	**5**

Service	**Current Grades 2016**		
Sheltered Housing	**Quality Statements Assessed**	**Grades Awarded**	**Overall Grade**
Care & Support	1 3	5 5	**5**
Staffing	1 3	5 5	**5**
Management & Leadership	1 6	5 5	**5**

5. People Implications

5.1 There were no people implications.

6. Financial Implications

6.1 There were no financial implications.

7. Risk Analysis

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

8. Equalities Impact Assessment (EIA)

8.1 Not required for this report.

9. Consultation

9.1 Not required for this report.

10. Strategic Assessment.

The Council's Strategic Plan 2012-17 identifies "improve care for and promote independence with older people" as one of the authority's five strategic priorities.

Improve care for and promote independence for older people.
Improve the wellbeing of communities and protect the wellbeing of vulnerable people.

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Date: 28th November 2016

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01389 737356

Appendices: None

Background Papers: The information provided in Care Inspectorate inspection reports website on -
Home Care :

http://www.careinspectorate.com/index.php/care-services?detail=CS2004077076&q=west%20dunbartonshire%20council&fq=&message=

Sheltered Housing :

http://www.careinspectorate.com/index.php/index.php/care-services?detail=CS2004077074&q=west+dunbartonshire+council&fq=&sort=&start=10&message=%3Cb%3EResults%20for%20west%20dunbartonshire%20council:%3C/b%3E

Wards Affected: All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 7 December 2016

Subject: Final Audit Plan 2016/17 and Progress Report

1. Purpose

1.1 The purpose of this report is to provide:

- An update to members on the planned programme of audit work for the year 2016/17 in terms of the internal audit work undertaken at West Dunbartonshire Council and NHS Greater Glasgow and Clyde that may have an impact upon the West Dunbartonshire Health & Social Care Partnership Board;
- Confirmation of the cost implications of the provision of audit services to the IJB; and
- Information on the recommendations of the Audit Scotland report entitled "Health and Social Care Integration" (December 2015).

2. Recommendations

2.1 It is recommended that the Audit Committee approve the final 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. The draft Audit Plan was approved by the Audit Committee at its meeting on 15 June 2016.

3.3 The provision of Internal Audit services, for Social Care, 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, for Health Services, to Price Waterhouse Coopers (PWC). Audit work is carried out across each organisation with findings being reported to the respective audit committees within each organisation. It should be noted that there is currently no cost implication at this time to either organisation as a result of this arrangement, in particular the 35 allocated audit days for the IJB referred to at paragraph 4.17 below are absorbed into the cost of the Council's Internal Audit Team.

3.4 The Audit Plan was compiled using a risk based approach through a review of Audit Universes (i.e. both Council and Health Board) which includes all significant activities and systems that contribute to the achievement of strategic priorities and objectives.

3.5 West Dunbartonshire Council's Audit and Risk Manager, Colin McDougall, has been appointed as the Chief Internal Auditor for the Health & Social Care Partnership and report to the members of the Audit Committee on internal control and audit matters. The Chief Internal Auditor of the Health & Social Care Partnership places reliance on both the work of the Council and Health Board Internal Audit teams. The Audit Plan incorporates not only audits on Health & Social care services, but also allocates time to review the performance, governance and financial management of the Health & Social Care Partnership.

3.6 An Audit Scotland report published a report in December 2015 entitled "Health & Social Care Integration". This report, which is discussed further in Section 4, refers to the need for integration authorities to work with Councils and Health Board to establish effective scrutiny arrangements. This is to ensure that Elected Members and NHS non-executives, who are not members of the IJB board, are kept fully informed of the impact of integration for users of local health and care services. The existence of this committee provides the opportunity for such scrutiny to take place.

3.7 This report provides a summary to the West Dunbartonshire Council Integration Joint Board's Audit Committee of recent the Internal Audit activity at these organisations which may have an impact upon the delivery of the strategic plan.

4. Main Issues

General

4.1 The Chief Internal Auditor met with the Chief Officer and Chief Financial Officer to discuss and agree a programme of work for the financial year 2016/17.

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

WDC Internal Audit element

- A risk based audit needs assessment identifying all potential audit areas methodology (this is aligned to PSIAS);
- Consultations with senior management;
- The plans of Audit Scotland (as External Auditor) and other inspection agencies;
- The HSCP Board's Strategic Plan and Strategic Risk Register;
- Current issues and changes in computer systems; and
- Resources available.

PWC element

- PWC's Internal Audit methodology (this is aligned to PSIAS);
- Audit Scotland (external audit); and
- Healthcare Improvement Scotland.

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

4.4 The Chief Internal Auditor will continually review the risks and operating environment of the Health & Social Care Partnership during the course of the year and may tailor this planned work accordingly. Consideration will also be given to the Internal Audit work undertaken by PWC within NHS Greater Glasgow and Clyde in order to identify any matters arising relevant to the Health & Social Care Partnership Board's Audit Committee.

West Dunbartonshire Council

4.5 WDC's audit plan for 2016/17 includes a number of audit reviews which cover Health & Social Care Partnership service areas, namely:

Audit	Days Allocated
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**

These audits, together with other Council wide system reviews, help to inform an opinion on the control environment within the Health & Social Care Partnership.

4.6 Since 1st April 2016, the following Internal Audit reports have been issued to the Council, which are relevant to the Integration Joint Board:

Audit Title	Number and Priority of Recommendations		
	High	Medium	Low
Social Care Services reports:			
Child Protection (2015/16 Audit Plan)	0	1	0
Home Care	0	3	1
Corporate Reports:			
Overtime and Additional Working (2015/16 Audit Plan)	0	1	0
Attendance Management (2015/16 Audit Plan)	0	3	2
Employee Licences/Vehicle Documentation Checks 2016/17	0	2	0
ICT Risk Register Controls	0	3	0

4.7 Recommendations have timescales for completion in line with the following categories:

Category	Expected implementation timescale
High Risk: 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
Medium risk: Significant observations requiring reasonably urgent action.	Generally, complete implementation of recommendations within six months of action plan being agreed
Low risk: 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

4.8 The agreed action plans prepared as a result of these reports as attached at Appendices A.

4.9 Internal Audit will undertake follow up work to confirm the implementation of the recommendations.

NHS Greater Glasgow and Clyde

4.10 For the overall internal audit plan for NHS Greater Glasgow and Clyde, a total of 665 indicative audit days has been allocated for all audit activity.

4.11 Much of the audit work which is carried out within NHS Greater Glasgow and Clyde by PWC covers services which are delegated to the Health & Social Care Partnership Board and the findings of these reviews also contribute to an opinion of the control environment

4.12 In the period, the following Internal Audit reports have been issued to the NHS Greater Glasgow & Clyde, which are relevant to the Integration Joint Board:

Audit Title	Opinion	Number and Priority of Recommendations		
		High	Medium	Low
Delayed Discharge: Use of additional funding	Low risk	0	2	0
Health & Social Care Partnerships: Governance Arrangements	Low risk	0	0	4
Risk Management Arrangements	Medium risk Note (iv)	0	3	1
Clinical Governance	High risk Note (v)	0	6	1

4.13 High risk indicates findings that could have a:

- Significant impact on operational performance; or
- Significant monetary or financial statement impact or
- Significant breach in laws and regulations resulting in significant fines and consequences; or
- Significant impact on the reputation or brand of the organisation.

Medium risk indicates findings that could have a:

- Moderate impact on operational performance; or
- Moderate monetary or financial statement impact; or
- Moderate breach in laws and regulations resulting in fines and consequences; or
- Moderate impact on the reputation or brand of the organisation.

Low risk indicates findings that could have a:

- Minor impact on the organisation's operational performance; or
- Minor monetary or financial statement impact; or

- Minor breach in laws and regulations with limited consequences; or
- Minor impact on the reputation of the organisation

4.14 Internal Audit undertake follow up work to confirm the implementation of high risk and a sample of medium risk recommendations. The results of this follow up work are reported to the Audit Committee with any matters of concern being drawn to the attention of this Committee.

Integration Joint Board

4.15 Audit Scotland published a report in December 2015 entitled "Health & Social Care Integration" which made recommendations to help organisations address potential risks to the success of health and social care integration.

4.16 The key recommendations of the report for integration authorities to address are:

- Provide clear and strategic leadership to take forward the integration agenda;
- Set out how governance arrangements will work effectively;
- Develop strategic plans that document how key priorities will be delivered;
- Develop financial plans that clearly show how integration authorities will use resources such as money and staff to provide more community-based and preventative services; and
- Integration authorities should work with Councils and NHS Boards to:
  - Recognise and address the risks associated with complex accountability arrangements
  - Review clinical and care governance arrangements
  - Agree budgets
  - Establish effective scrutiny arrangements
  - Put in place data sharing arrangements.

4.17 In addition to the reviews referred to above, the Health & Social Care Partnership Board has a draft audit plan which includes 35 days drawn from the Internal Audit service of West Dunbartonshire Council. The Health & Social Care Partnership Board Internal Audit plan is summarised below.

Review	**Proposed number of days**
Governance	10
Performance	15
Financial Management	10
TOTAL	**35**

Governance – a review of the governance arrangements and documentation in place for the Health & Social Care Partnership Board. This will also include a post-implementation review.

Performance – a review of the performance management and reporting arrangements in place which monitor delivery of the Strategic Plan.

Financial Management – a review of the arrangements in place to monitor and manage the financial performance of the Health & Social Care Partnership Board.

The recommendations contained within the Audit Scotland report referred to at paragraphs 4.15 and 4.16 will assist in completing this work.

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 prepared in consultation between the IJB's Chief Internal Auditor, James Hobson, Assistant Director of Finance (NHS Greater Glasgow and Clyde), Julie Slavin (Chief Financial Officer, West Dunbartonshire Health and Social Care Partnership) and Stephen West (Strategic Lead – Resources, West Dunbartonshire Council.

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: **Colin McDougall**
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Date: **28 November 2016**

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Appendices: Appendix A: Internal Audit Reports – WDC Internal Audit Team

Background Papers: None

Appendix A
Internal Audit Reports – WDC Internal Audit Team

Generated on: 28 November 2016

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

Project 95. Overtime and Additional Working 2015 -16 (Report Issued April 2016)

Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
1. Actions to Reduce Overtime It is recommended that the Head of Finance and Resources reminds departments that they should continue to explore opportunities to reduce overtime. Areas that could be explored include: - Where supply lists of staff are kept, departments should ensure these are large enough to cope with demands - Explore areas where flexible work patterns could reduce the need for out of	The recommendation is agreed and all departments will be reminded of the actions required.		100%	31-May-2016	31-May-2016	Stephen West	Strategic Directors and Strategic Leads have been reminded on the actions required.

Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
hours overtime - Care at Home and Residential Care supply lists should be further developed so that staff in either list can be used in either section - If they are not already in place, links should be developed with Working4U, which could further enhance the supply lists. (Medium Risk)							

Project 100. Child Protection (Report Issued July 2016)

Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
1. Promote staff awareness of privacy to the sensitive data There is no regular review in place of users' access to the sensitive and confidential data for vulnerable children. This is due to large volume of cases, approx. 200,000 both old and new, that they have to hold in CareFirst system. A review is carried out if it is suspected that someone has accessed a record that they should not have. A recent review was carried out following a media release. This poses a risk that unauthorised access will not always be detected and no actions will	This direction and contractual commitment about Data Protection is emphasised at both the CareFirst Training Sessions and also the Data Protection Awareness Sessions but not just in relation to CP information as we consider all information in the system to be sensitive. We carry out DP Awareness Sessions with HSCP staff and this is tailored to the type of information practitioners collate in their everyday work within the HSCP. All staff who access the		100%	30-Jun-2016	30-Jun-2016	Jacqueline Pender	Complete.

Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
be taken leading to sensitive information being disclosed and putting the Council at risk. It is recommended that the Children and Families Management team (not all the work relates to child protection) ensures the users of the CareFirst system are reminded of their responsibility under the Data Protection Act when accessing sensitive and confidential information. (Medium Risk)	system regardless of whether they have a WDC or NHS contract must sign that they agree to the Corporate Information and Communication Technology Acceptable Use & Security Policy. An additional line has been added to the current narrative in our Terms of Access screen on CareFirst advising staff that they must adhere to the above policy.						

Project 101. Attendance Management (Report Issued August 2016)

Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
<u>1. Following of attendance management policy</u> Managers should be reminded when the trigger report is issued to verify if any of their staff are on the report and the subsequent actions that they are required to take. In addition managers should be reminded of the importance of involving HR when an employee has reached a second trigger. (Medium Risk)	Agreed.		100%	31-Aug-2016	31-Aug-2016	Darren Paterson	With WMS developments, managers now have access to run their own real time trigger report. This facility will be reiterated to managers, including reminder of HR21 guidance, via the HR Monthly manager's report. The HR teams now run these reports on a regular basis and follow up with managers to monitor application of policy, and adherence to triggers – effectively a perpetual monitoring and audit process. Persistent non adherence to triggers will be discussed with the relevant Strategic Lead. The opportunity to

Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
							incorporate this into Masterclasses will be explored.
2. Illness Category Managers need to be informed of the importance of categorising illness correctly, with further guidance provided if requested. (Low Risk)	This has already been identified through regular reporting. Guidance is available on intranet; specific action already agreed with HRBPs to re-communicate to Leads and Mgt teams Action agreed to incorporate into training.		80%	31-Aug-2016	31-Aug-2016	Darren Paterson	Illness Categories have been reviewed and updated and can now be found on the Council's Intranet under Attendance Management pages, HR21 pages and Occupational Health pages. Reminders on this matter have been issued via ELG and HRBP monthly reports. Cases where no reason is recorded are reported to ELG and PMRG. HR teams have adopted a monitoring role and will remind managers where reasons are not recorded or are incorrectly recorded. Persistent non adherence will be reported to the relevant Strategic Lead. The opportunity to incorporate this into Masterclasses will be explored.
3. Management Contact Managers should be aware of the importance of contacting employees who are off work at regular intervals dependent on the situation and specific circumstances, and a record should be made. (Medium Risk)	Agreed: refresher to managers re contact. Consider how to extend manager permissions to record contact in HR21.		100%	30-Sep-2016	30-Sep-2016	Darren Paterson	New developments in absence email notification have been implemented in order to address this matter. If an employee has not returned when a fit note is due, an email is generated to the manager. Managers also receive emails when an employee reports sick with MSK or Stress. This will be incorporate into the next Masterclasses topic – 'having difficult conversations'. HR teams will continue to monitor manager contact in

Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
							respect of long term absence. Persistent lack of contact will be reported to the relevant Strategic Lead.
4. Individual Stress Risk Assessments and OH referrals Ensure Managers and employees are aware of the Stress Management Policy and the importance of adhering to it. (Medium Risk)	Ensure Managers and employees are aware of the Stress Management Policy and the importance of adhering to it.		80%	31-Jan-2017	31-Jan-2017	Darren Paterson	This will be managed at a local level by the HR teams. HR teams are notified of stress absences and will support managers to apply the Stress Management Policy while taking on a monitoring role.
5. Consistency of information recorded Thought should be given to how a consistent approach can be adopted. (Low Risk)	Agreed. Recording via WMS is under review in respect of input by managers and/or HR to ensure consistency.		50%	31-Mar-2017	31-Mar-2017	Darren Paterson	A review of WMS HR case management pages is currently underway to ensure ease of use and to improve consistency. Further developments in respect of manager self service is being developed within HR21.

Project 103. Employee Licences/Vehicle Documentation Checks 2016/17 (Report Issued November 2016)

Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
1. Non Compliance With Scheme 1) It is recommended that the Travel & Subsistence Scheme be updated to include the following: a) Vehicle Documentation checks be carried out across the Authority during the month of November.	Agreed Draft to be completed by 30th November 2016 and submitted for approval at earliest possible opportunity thereafter. Agreed Message included within November Workforce Update to Strategic Leadership Group (for		50%	30-Nov-2016	30-Nov-2016	Darren Paterson	The post-audit action plan was agreed on 9/11/16. Whilst the required changes to the Scheme, highlighted by the audit, will be produced by 30th November 2016, a communication has already been made to all managers (via the monthly Workforce Update to Strategic Leads) to ensure that required checks to address any current risk to

Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
b) Vehicle Documentation checks for new employees should be carried out within one month upon starting and should not be left until November. c) The Scheme should make reference to the Check Form and that this form should be used when carrying out the annual checking process. d) The Check Form should be updated to include 'Documents Checked By'. 2) Strategic Leads should ensure that all line managers are aware of their responsibilities and that they are carrying out the appropriate annual checking of vehicle documentation for all staff who use their car for business. (Medium Risk)	wider cascade to all managers). Further communication will be issued upon approval of revised scheme. Suggest Internal Audit revisit again during 2017/18 to check on compliance						the organisation are addressed in the interim.
2. Non Claiming of Reimbursement a) To avoid any vicarious liability for the Authority, the Travel & Subsistence Scheme should be updated to reflect that: Vehicle documentation should be checked annually for all staff who choose not to claim reimbursement and that business use is documented on the insurance policy (Medium Risk)	Agreed Draft to be completed by 30th November 2016 and submitted or approval at earliest possible opportunity thereafter.		0%	30-Nov-2016	30-Nov-2016	Darren Paterson	The post-audit action plan was agreed on 9/11/16. Whilst the required changes to the Scheme, highlighted by the audit, will be produced by 30th November 2016, a communication has already been made to all managers (via the monthly Workforce Update to Strategic Leads) to ensure that required checks to address any current risk to the organisation are addressed in the interim.

Project 104. ICT Risk Register Controls (Report Issued November 2016)

Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
1. Out of Date Information Management should ensure ICT Risk register is reviewed and updated regularly. (Medium Risk)	The Risk register will be reviewed by 31st October 2016 and on a regular basis thereafter.		100%	25-Nov-2016	25-Nov-2016	Brian Miller	Nov 2016. ICT Risks are reviewed annually as part of ICT Controls audit.
2. Risks Around Significant Office Moves Must be Recorded Management should include an itemised Risk in the register to reflect the complexity of the decant and move to the new Dumbarton Office (Medium Risk)	A new risk will be created and linked to existing ICT actions.		100%	31-Dec-2016	31-Dec-2016	Patricia Kerr	Nov 2016. New risks added and linked to the current actions and projects.
3. Data Centre Move Management should include an itemised Risk in the register to reflect the complexity of moving a key data centre and associated communications equipment (Medium Risk)	A new risk will be created and linked to existing ICT actions.		100%	31-Dec-2016	31-Dec-2016	Brian Miller	Nov 2016. Risk added for Data centre relocation and linked to current ICT actions

Project 107. Home Care (Report Issued November 2016)

Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
1(b). CM2000 missed clock ins and clock outs It is recommended that home carers are reminded of their responsibility and duty to always clock in and clock out when they are visiting the clients at their home in order to ensure all visits are correctly recorded and monitored within CM2000. (Medium Risk)	This is a new system and we had made provision to complete successful roll-out over some time. Performance continues to improve as staff becomes more familiar with technology. The ongoing aim is to achieve 95% compliance.		0%	31-Mar-2017	31-Mar-2017	Lynne McKnight	Action on track.
1(b). CM2000 missed clock ins and clock outs It is recommended that Home Care management put in place an action plan in order to ensure the compliance with clock in and clock out increases within CM2000. (Medium Risk)	There is already a significant reduction in administration of timesheets for Home Help organisers allowing more time for care planning, client and family liaison and staff supervision. An action plan will be prepared to drive improvements in clock in / clock out compliance.		0%	31-Mar-2017	31-Mar-2017	Lynne McKnight	Action on track.
2. Policy and procedures It is recommended that procedures for CM2000 and Home Care in general are reviewed and finalised as soon as possible. Once completed these should be available to all Organisers, Admin staff and Home Carer via the shared drive.	Processes for CM2000 will be reviewed by end of March 2017. Procedures such as medication policy have recently been reviewed, however all policies and standard operation policies will be updated by June 2017.		0%	30-Jun-2017	30-Jun-2017	Lynne McKnight	Action on track.

Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
(Medium Risk)							
3. Mobile phones capped at £50 a month It is recommended that the £50 monthly monetary cap is reviewed to manage the risk of WDC incurring excessive costs from the inappropriate use of phones allocated to home carers. This can be reviewed with ICT when assessing potential opportunities from the new Vodafone contract. (Low Risk)	The standard operation policy for the use of phones will be reviewed by the end of March 2017.		0%	31-Mar-2017	31-Mar-2017	Lynne McKnight	Action on track.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 7th December 2016

Subject: Model Publication Scheme and Guide to Information

1. Purpose

1.1 To present to the Scottish Information Commissioner's Model Publication Scheme and the drafted Guide to Information for the Health and Social Care Partnership Board.

2. Recommendation

2.1 The Audit Committee is asked to:

- Adopt the Scottish Information Commissioner's Model Publication Scheme for use by the Health and Social Care Partnership Board.
- Approve the Guide to Information for publication.

3. Background

3.1 The Freedom of Information (Scotland) Act 2002 (FOISA) places a duty on Scottish public authorities to publish information proactively. Authorities must have regard to the public interest in the information they hold and make information available to the public so it can be accessed without having to make a request for it.

3.2 Scottish public authorities are required to adopt and maintain a publication scheme that has the approval of the Scottish Information Commissioner. Publication schemes describe the information that the authority makes available to the public without them having to ask for it.

3.3 Publication schemes must:

- Contain the classes (or types) of information that the authority publishes or will publish.
- Explain the manner in which the information is published or will be published.
- State whether there is a charge for the information.

3.4 When formulating a scheme, an authority must consider the public interest in the information that it holds, particularly in allowing public access to:

- Information about services, the cost of services and the standards attained.
- Facts or analysis which informed decisions of importance to the public
- The reasons for decisions taken.

3.5 Authorities must publish their publication schemes and review them from time to time.

3.6 The Commissioner has developed a Model Publication Scheme to support authorities to meet their publication scheme duties (appended).

3.7 The Model Publication Scheme is a pre-approved framework for Scottish public authorities to publish the information they hold. By adopting the Model Publication Scheme, authorities commit to:

- Publishing, as a minimum, specified types of information, through their own Guide to Information.
- Ensuring all their published information meets six accessibility principles.

3.8 An authority which formally adopts the Model Publication Scheme and then publishes information in accordance with the it will meet its publication scheme duties.

3.9 The Partnership Board became subject to the Freedom of Information (Scotland) Act 2002 when it was established on the 1st July 2015. Consequently, a Guide to Information has been drafted for the Health and Social Care Partnership Board in accordance with the Model Publication Scheme (appended).

4. Main Issues

4.1 The Model Publication Scheme:

- Provides the most efficient and effective way to secure the Commissioner's approval for a publication scheme.
- Focuses authorities' resources on making as much information available as possible.
- Improves accessibility of information for the public and increases consistency in the range of information available.
- Gives access to specific guidance and advice.

4.2 The Model Publication Scheme imposes six principles which govern the way authorities must make their information available through their Guides to Information:

- Principle 1 - Availability and formats.
- Principle 2 - Exempt information.
- Principle 3 - Copyright and re-use
- Principle 4 - Charges.
- Principle 5 - Advice and assistance.
- Principle 6 - Duration.

4.3 There are six steps to adopting the Model Publication Scheme for the first time:

- Make a corporate decision to adopt the Model Publication Scheme without amendment.
- Identify the information held by the authority that is covered by the Model Publication Scheme classes and any additional information in which there is a public interest in publication.
- Produce and publish a Guide to Information, ensuring that the arrangements for publication meet the six principles in the Model Publication Scheme.
- Notify the Commissioner of the adoption of the Model Publication Scheme (which only has be done once).
- Make arrangements to maintain and update the Guide to Information. This includes adjusting the Guide in response to any future changes to the Model Publication Scheme.

4.4 Subject to the Audit Committee's agreement to adopt the Model Publication Scheme and approve the drafted Guide for Information for publication, officers will then notify the Commissioner as above; and publish the Guide for Information on the Health and Social Care Partnership's website.

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 financial 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 The Scottish Information Commissioner's approval depends on authorities complying with all the above steps set out in 4.3. If an authority does not satisfy all the requirements, it can neither claim to have adopted a publication scheme nor to be maintaining one. The authority would therefore not be compliant with the publication scheme duty under section 23 of FOISA.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

12. Strategic Assessment

12.1 The Strategic Plan already affirms the Partnership Board's commitment to openness and accountability as per the National Clinical and Care Governance Framework.

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Date: 7th December 2016

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Appendices: Scottish Information Commissioner's Model Publication Scheme

WDHSCP Board – Guide to Information

Background Papers: None

Wards Affected: All

Model Publication Scheme

Guide for Scottish Public Authorities

Scottish Information Commissioner

Contents

Glossary and abbreviations

Term used	Explanation
FOISA/ The Act	Freedom of Information (Scotland) Act 2002
EIRs	Environmental Information (Scotland) Regulations 2004
MPS	Scottish Information Commissioner's Model Publication Scheme
Guide/ GTI	Guide to Information
Re-use regulations	The Re-use of Public Sector Information Regulations 2015
Copyright law	The Copyright, Designs and Patents Act 1988
TNA	The National Archives
OGL	Open Government Licence

Cross-referenced VC documents (for internal use)

VC No	VC name
69809	Model Publication Scheme
69815	Self-assessment checklist
69676	Notification form

Section 1: Overview

Introduction

1. The Freedom of Information (Scotland) Act 2002 (FOISA) places a duty[1] on Scottish public authorities to publish information proactively. Authorities must have regard to the public interest in the information they hold and make information available to the public so it can be accessed without having to make a request for it. The duty to publish is in addition to the obligation to respond to requests for information (see Appendix 2: Publication Schemes: the legal requirements for more information).

2. Even if it were not a specific duty, there are benefits to authorities from publishing information, including:

   - reducing the work and resources associated with information requests. Where the public can already access some of the information they want to see, their requests will focus only on unpublished information. Some requests may be avoided altogether.
   - developing better relationships with stakeholders by responding proactively to their information needs
   - demonstrating openness and transparency in actions as well as intentions.

3. The Commissioner has developed a Model Publication Scheme (the MPS) to support authorities to meet their publication scheme duties.

4. This guidance takes you through what your authority needs to do to adopt the Scottish Information Commissioner's MPS. It provides information about the MPS, the actions you will need to take and good practice tips. There is a section of answers to frequently asked questions.

5. If you don't find here what you need, we provide an enquiries service, from Monday to Friday 9:00 am to 5:00 pm. Our contact details are on the back cover of this Guide.

About the Model Publication Scheme

What is the MPS?

6. The MPS is a pre-approved framework for Scottish public authorities to publish the information they hold.

7. By adopting the MPS, authorities commit to:

   (i) publishing, as a minimum, specified types of information, through their own Guide to Information.

   (ii) ensuring all their published information meets six accessibility principles.

8. **An authority which formally adopts the MPS and then publishes information in accordance with the MPS will meet its publication scheme duties.**

[1] Section 23 of FOISA

9. The Commissioner regularly updates the MPS and alerts authorities to any changes. All the documents you need are available to download at www.itspublicknowledge.info/MPS.

Who can adopt the MPS?

10. The MPS can be adopted by any Scottish public authority subject to FOISA.

What are the benefits of the MPS to an authority?

11. The MPS:

    (i) Provides the most efficient and effective way to secure the Commissioner's approval for a publication scheme.

    (ii) Focuses authorities' resources on making as much information available as possible.

    (iii) Improves accessibility of information for the public and increases consistency in the range of information available.

    (iv) Gives access to specific guidance and advice.

How does an authority adopt the MPS?

12. There are six steps to adopting the MPS for the first time (each is explained in more detail in later sections):

    (i) Make a corporate decision to adopt the MPS **without amendment**

    (ii) Identify the information held by your authority that is covered by the MPS classes and any additional information in which there is a public interest in publication.

    (iii) Produce and publish a Guide to Information, ensuring that the arrangements for publication meet the six principles in the MPS

    (iv) Notify us that you have adopted the MPS. **You need do this only once**.

    (v) Make arrangements to maintain and update your Guide to Information. This includes adjusting your Guide in response to any future changes to the MPS.

13. **The Commissioner's approval depends on authorities complying with all the above steps. If your authority does not satisfy all the requirements, it can neither claim to have adopted a publication scheme nor to be maintaining one. The authority will therefore not be compliant with the publication scheme duty under section 23 of FOISA.**

When do we have to adopt the MPS?

14. New authorities must adopt the MPS in advance of the date they become subject to FOI.

15. As soon as you know your authority's founding or commencement date, you must start planning to adopt the MPS. Please let us know the date you will submit a notification form. We are pleased to help you prepare for publication schemes. Do contact us if you would like support.

The MPS principles

16. The MPS imposes six principles which govern the way authorities must make their information available through their Guides to Information:

    - Principle 1: Availability and formats
    - Principle 2: Exempt information
    - Principle 3: Copyright and re-use
    - Principle 4: Charges
    - Principle 5: Advice and assistance
    - Principle 6: Duration

17. Each principle is explained in detail in The MPS principles.

Section 2: Preparing for Adoption

Making the decision to adopt the MPS

18. Your authority needs to take a formal decision to adopt the MPS. In practice, many authorities take the decision at committee or board level, but it can be taken on behalf of the authority by any person or group with delegated approval.

19. When you are recommending your authority adopts the MPS, it may be helpful to point colleagues to the introductory section of this Guide to remind them why the authority must adopt a publication scheme. See Appendix 2: Publication Schemes: the legal requirements. It is important to reach a common understanding in the authority about the commitment it is making and to ensure there is management support for the work you have to do.

20. Once the decision has been taken to adopt the MPS, you need to communicate the decision as widely as possible. Many of the steps will require support from colleagues in other business areas and they need to know that your authority plans to adopt the MPS. In due course, *everyone* in your authority will need to know about your Guide to Information when it is published so that they can respond to enquiries about it and contribute to keeping it up to date.

Deciding what information to publish

21. When deciding what to publish, authorities have a **statutory duty** to have regard to the public interest in the information they hold. That is, we must think about the **audience** for our published information, and identify what information we *ought* to make available to them. As section 23(3) of FOISA explains, there is a specific public interest in information about:

    - Authority decisions, and the facts and analysis that inform them
    - The functions and services provided by authorities, including the cost of services and their performance

22. Investing time and effort to decide what to publish brings benefits beyond simple compliance with publication scheme duties. As mentioned earlier, the more information your authority makes available as a matter of course, the easier you and your colleagues will find responding to information requests.

23. The MPS sets out nine classes (or types) of information that authorities **must publish if they hold that information**. In Appendix 1: Types of information under the MPS classes we provide detailed lists of the information the Commissioner expects authorities to publish under each class. The Commissioner's lists focus on where there is a clear public interest in making information available e.g., where:

    (i) FOISA says there is a public interest (see para 24)

    (ii) there is a statutory requirement to publish

    (iii) it is recognised good practice to publish

    (iv) the type of information is often requested and generally disclosed under FOI law.

24. We provide a Self-assessment checklist to help you assess your information holding against the Commissioner's lists.

25. If your authority does not hold information under any of the classes, don't delete the class in your Guide to Information. Add a statement "No information held under this class".

26. The Commissioner's lists are not exhaustive or restrictive. They set out the **minimum** for all authorities. Authorities have different functions, so **you will still need to consider whether there is additional information that your authority holds and ought to publish in the public interest.**

Research and information services

27. Research and information services are not "publications". They involve creating new information (including "certificates"), from other information the authority holds and may publish. The new information is not actually available until it has been commissioned. The information is not already prepared and available to anyone to access easily and quickly. So it cannot be considered to be "published".

28. Examples of research and information services include:

    (i) certified extracts from registers

    (ii) family history searches

    (iii) property enquiry certificates

29. If your authority offers such services, you can *advertise* them through your Guide to Information as it may help the reader to know that you offer the service. But do **not** include them in the lists of information your authority publishes through the MPS.

Guides to information for new authorities

30. If you work for an authority new to FOI, we recommend that you carry out a full "information audit", using the classes of information to guide you through. For example, ask business areas to list the types of information they hold relating to each class and indicate for each category whether it should or should not be published.

31. If your authority is starting from scratch, you may find that you have very little information under each of the classes. This is acceptable. You must, however, make plans to update your Guide to Information as your information holding grows. This is a great opportunity to set up procedures for updating the Guide (see Page 23 for more information).

32. If your new authority is as the result of a merger with, or replacement of, existing authorities, you'll be able to bring together previous Guides to Information. You'll still need to look at the public interest in the new authority's information. This may have changed.

Section 3: Guides to Information

What is a guide to information?

33. Your Guide to Information is effectively an "index" of the information you publish and a "how to" guide to access it. The format it takes, e.g. a document, webpages or an A-Z, is dependent on what suits your audience (and organisation) best.

34. Whatever format it is presented in, your guide **must** set out:

    (i) What information your authority publishes under each class

    (ii) How to access the information

    (iii) Whether you charge for the information (if you do, you must say both what the charges are and when they apply)

    (iv) Contact details for advice and assistance to access information

35. You should maintain a record of what information was published and when it was available. You will need this record in the event of a dispute.

36. The Guide to Information **must** be published on your authority's website and it must be possible to find it through a simple search of the website. You should test whether it actually comes up in search results for e.g. "Guide to Information", or "Publication Scheme".

37. Many authority websites link their Guides to Information to "freedom of information" or "publications" links on their home pages.

Meeting the MPS principles

The 6 MPS Principles

1: Availability and formats	**4:** Charges
2: Exempt information	**5:** Advice and assistance
3: Copyright and re-use	**6:** Duration

38. **The access arrangements for all the information in your authority's Guide to Information must meet the MPS principles.**

39. The principles are explained in more detail below.

Principle 1: Availability and formats

Definition:
• Information published through this model scheme should, wherever possible, be made available on the authority's website. • There must be an alternative arrangement for people who do not wish to, or who cannot, access the information either online or by inspection at the authority's premises. An authority may e.g., arrange to send out information in paper copy on request (although there may be a charge for doing so).

40. Guides to Information must clearly state how to access the published information.

41. The term "publication" has a specific meaning in FOI law. "Published" information is available to anyone to access easily. This definition depends on the Section 25(3) absolute exemption for information which is available through a publication scheme.

42. As our Briefing on Section 25 (Information otherwise obtainable) explains,

    - "This is one of the few exemptions in FOISA where the identity of the requester is relevant. This is because the exemption applies to information which the requester can reasonably obtain. Information may be generally accessible to the public at large, but not to an individual requester, if their personal circumstances prevent them from obtaining it. For example, a person with a visual impairment might not be able to access information provided only on a website, while it might not be reasonable to expect someone who lives a long way from the public authority's offices to travel to see the information."

    For this reason, authorities cannot claim to "publish" information if it is available only by inspection or online.

43. It is for your authority to decide how to meet this MPS principle. Most authorities meet it by providing a combination of access opportunities, including:

    (i) Making the information available online, allowing people to access the information for themselves without contacting the authority. It is good practice to provide direct web links in the Guide to Information. It's not enough to merely point to the home page, or ask people to use the website search engine.

    (ii) Offering a telephone or email service for the public to ask for paper copies to be printed out and posted to them. It is acceptable to ask the requester to meet the costs of providing the information in this way (see principle 4).

44. Authorities must also be prepared to meet requests for information in alternative formats. FOISA makes explicit the link with obligations under Equality Act 2010.

45. Information published through Class 9 (Open Data) is exempt from this principle. By its nature, open data is generally available in only electronic format and cannot easily be provided in other formats. (See the Scottish Government's Open Data Resource Pack for the accessibility requirements for this class of information).

Principle 2: Exempt information

Definition:
If information described by the classes cannot be published and is exempt under Scotland's freedom of information laws e.g., sensitive personal data or a trade secret, the authority may withhold the information or provide a redacted version for publication, but it must explain why it has done so.

46. Authorities adopting the MPS must publish all the information they hold that falls within the classes of information.

47. The exempt information principle allows authorities to decide to not publish information, but only if that information would be exempt under FOISA or the EIRs.

48. For example, there is a strong public interest in the decisions authorities take at board or committee meetings, so as a general rule, minutes should be published. But there may be times when they cannot be published. Board or committee meetings may contain: personal information where disclosure would contravene the data protection principles, or; information about contracts where disclosure would damage someone's commercial interests.

49. In such cases, you should consider whether a redacted version could be published or whether the information must be withheld in full.

50. Your Guide should also explain that the authority does hold the particular type of information but that it is not published. You do not need to provide a full description of the exemption or exception relied on e.g., "contains personal information" is widely understood to mean that an exemption in s38 of FOISA would apply. It is good practice to consider whether you could provide other information about the function or service to help the public understand your work. For example, if your authority carries out investigations, you may not be able to reveal details of individual investigations, but you could provide a statement or case study which would explain how you conduct investigations in general terms.

Principle 3: Copyright and re-use

Definition:
• The authority's Guide to Information must include a copyright statement which is consistent with the fair dealing provisions of the Copyright, Designs and Patents Act 1988. Where the authority does not hold the copyright in information it publishes, this should be made clear. • Any conditions applied to the re-use of published information must be consistent with the Re-Use of Public Sector Information Regulations 2015.

51. You must include a statement on both copyright and re-use of information in your Guide. This is important because the public need to know exactly what they can (and cannot) do with the information you make available. There have been substantial legislative changes to both

copyright and re-use[2], so you need to review and may need to revise statements you have used in past editions of your Guide.

52. In particular, the new re-use regulations impose new statutory requirements to what used to be a voluntary framework. The UK Information Commissioner has produced a helpful Guide to RPSI for public sector bodies to explain the duties and what authorities need to do.

53. The National Archives (TNA) has produced substantial guidance on copyright and re-use.

54. The Commissioner continues to recommend that authorities adopt the TNA's Open Government Licence (OGL) for all their published information. The OGL sets out clear terms and conditions for both copyright and re-use. TNA provides additional information licences which may be more suitable for particular types of information. If an authority has adopted one of TNA's licences, it can use TNA's sample wording for Copyright Notices (see TNA's Links between access and re-use guidance) as its copyright and re-use statement.

55. Alternatively, your authority can produce its own copyright and re-use statement, as long as it is compliant with the legislative provisions governing copyright and re-use.

56. In most cases, your authority will hold the copyright in the information you make available. Where you publish third party copyright information you must make that clear e.g., where local authority planning registers provide access to plans created by third parties, they should explain who owns the copyright where it applies.

Principle 4: Charges

Definition:

- The Guide to Information must contain a charging schedule, explaining any charges and how they will be calculated.
- No charge may be made to view information on the authority's website or at its premises, except where there is a statutory fee e.g., for access to some registers.
- The authority may charge for computer discs, photocopying, postage and packing and other costs associated with supplying information. The charge must be no more than these elements actually cost the authority e.g. cost per photocopy or postage. There may be no further charges for information in Classes 1 – 7. An exception is made for commercial publications (see **Class 8: Our commercial publications**) where pricing may be based on market value.

57. Your Guide must state any charges that apply. If an authority intends to charge, it must publish a charging schedule in its Guide to Information. **If there is no schedule, the authority cannot impose a charge.**

58. You do not *have* to charge for published information. Most authorities have decided to make their information available free of charge. It is rare that any authority would charge for information available only online or only by inspection. Sometimes fees are set by statute e.g., some of the information published by the Registers of Scotland.

[2] The Copyright, Designs and Patents Act 1988 and The Re-use of Public Sector Information Regulations 2015.

59. Any charges must be consistent with the following **charging criteria**:

    (i) Any charges must be "reasonable". That is, the charge must not be more than it costs the authority to provide the information e.g., the actual postage cost. Photocopying charges should reflect only the cost per copy and a relevant proportion of the cost of any consumables. As a general guide, it is expected that a photocopying charge will be significantly less than a commercial copying service. Where printed materials are published, an authority can derive a cost per copy from the total printing price, divided by the number of copies.

    (ii) Authorities cannot try to recoup the cost of creating the information in the first place. So staff time for researching or drafting information cannot be charged.

60. The MPS charging provision applies to information made available through Class 8: Our commercial publications, but the charging *criteria* do not. This class describes information sold at market value through a retail outlet such as a bookshop, museum or research journal. That market value can include the cost of creating the information. The authority can charge the market value for access to such information.

61. Your authority must specify any charges it makes for re-use of information. We recommend you consider adding these to your charging schedule. Under the Re-Use of Public Sector Information Regulations 2015, in most cases authorities should make their information available for re-use under an open licence and at "marginal cost". There are links to helpful guidance on re-use in Principle 3: Copyright and re-use above.

Principle 5: Advice and assistance

Definition:
• The authority must provide contact details for enquiries about any aspect of the adoption of the model scheme, the authority's Guide to Information and to ask for copies of the authority's published information. • The authority's Guide to Information must provide contact details to access advice and assistance to request unpublished information.

62. Your authority is already under a duty to provide reasonable advice and assistance to anyone who wants to request information which is not published under section 15 of the Freedom of Information (Scotland) Act 2002 and regulation 9 of the Environmental Information (Scotland) Regulations 2004.

63. The MPS requires authorities to provide a similar level of service for their published information.

64. Your Guide must provide contact information so the public can ask for help with finding any information your authority publishes. It is, of course, essential that the help is available when it is asked for. Many authorities provide the FOI team contact details for support, others train customer care staff to respond to enquiries about their publications.

65. Your Guide must also explain how to access information which is not published. Most authorities do this by publishing guidance on making information requests.

Principle 6: Duration

Definition:
Once published through the Guide to Information, the information should be available for the current and previous two financial years. Where information has been updated or superseded, only the current version need be available (previous versions may be requested from the authority under section 1(1) of the Act).

66. Information must be available for at least two years following publication. Authorities can decide to continue to publish information for a longer period.

67. Where information is continually updated e.g., lists of current applications, it may be confusing to the public to provide outdated information. In this case, the authorities should provide only the current version. If someone wants to see older versions of the information, they can make a request to the authority for it.

Section 4: Notifying the Commissioner

68. Authorities must notify the Commissioner when they adopt the MPS for the first time. Notification is a required step in adopting the MPS.

69. After all the hard work that you have done, it is surprisingly simple to complete. You need to download, complete and return the Notification Form available on the Commissioner's website and send it to publicationschemes@itspublicknowledge.info

70. Please note that we cannot accept incomplete Notification Forms. We do require the URL of the publication of your authority's Guide so we can check compliance. If you are working to a deadline, you must factor in the time to publish the Guide online. If you depend on someone else to do the web publishing, it's a good idea to alert them to your timescales.

71. The Notification Form indicates the information that we will publish about your adoption of the MPS.

72. When you submit the form to us you'll receive an auto reply to acknowledge your form. We aim to issue you with a formal response within two weeks of submission.

73. **Once you have submitted a notification form to us, you will not have to do it again unless your authority's legal status changes e.g., it merges with another authority, or there is a change of legal name.**

Section 5: Reviewing and maintaining your Guide

74. The final step is to make sure you have arrangements in place to regularly and routinely update your Guide. This is a statutory duty. You must also update your Guide to reflect any changes to the MPS (the Commissioner will alert you to any such changes).Some of the documents in your authority's Guide will already be produced as part of routine business processes e.g., minutes of committee or board meetings. It is relatively easy in these circumstances to agree who is responsible for adding new documents to the Guide.

75. It's a little harder, but just as important, to make sure new types of information are added to the Guide as the work of your authority changes over time. There are many ways to do this and you'll need to find the way that works for your authority. Some common approaches taken by authorities include:

    (i) Setting review dates as part of the approval process

    (ii) Maintaining a schedule of information due for publication

    (iii) Training staff to think about publication as they prepare information ("thinking FOI" as they write, marking information for redaction at publication)

    (iv) Making the decision to publish information a deliberate step when new information is approved

(v) Including checking and updating the Guide as part of the procedures for updating and reviewing documents and records management procedures and systems.

76. If you don't have such internal processes, you can still look proactively for new information that your authority ought to publish. The following sources will often help you spot new information:

- In-house newsletters and committee / board minutes
- Press cuttings and external news releases about your authority's activities
- Information requests to your authority.

77. It is good practice to establish regular intervals for reviewing your Guide. In the Commissioner's office we convene a group of staff across the organisation at least twice a year to discuss our own Guide. We complete the self-assessment checklist annually and report internally on our performance against it. We have a performance target for the amount of information we publish.

FAQs

These are the questions we are most often asked about publication schemes. If you have a question that is not included, please contact us. We'll answer your question and consider whether it should be added here.

Adopting the MPS

Do we have to use the MPS? Can't we produce our own publication scheme?

You do not have to adopt the MPS. You are entitled to produce your own bespoke scheme. **But the Commissioner does not recommend it**.

Experience and feedback shows that bespoke schemes are not efficient and can be burdensome for both the authority and the Commissioner. They also lead to delays in approval.

100% of Scottish public authorities have adopted the MPS
97% of authorities surveyed would recommend the MPS to others

Not only is adoption of the MPS easier and more efficient for an authority (than a bespoke scheme), it helps requesters too. It gives greater consistency for the public about how the Scottish public sector publishes information and therefore makes it easier for them to find information.

If you want to explore a bespoke scheme, contact us as soon as possible. We will ask you to specify the issues you have with the MPS and we will first attempt to resolve those issues before we will consider approving a bespoke scheme. If we are asked to approve a bespoke scheme, we will test it against the standard of the MPS.

Can a group of authorities produce their own model publication scheme?

Section 24 of FOISA allows for the development of model schemes that can be adopted by more than one authority. The Commissioner used this provision when developing the MPS.

We do not encourage the development of more model schemes because the MPS provides a consistent framework for the public. If you feel that the MPS is not suitable for your authority, please tell us about the problems you are having so that we can look for a solution.

Several groups of authorities have worked together to produce template Guides to Information. This approach has helped authorities in those sectors identify other information they ought to publish, over and above the MPS.

Deciding what information to publish

What is "publication"?

Publication has a slightly different meaning under FOI than in everyday usage. In terms of FOI it simply means making available information that is already prepared. The information must be available to anyone and easy to access quickly without having to make a request for it.

Can we delete a class if we don't hold any information that would be covered by it?

No. But the MPS does not ask you to publish information that you do not hold! But even if some of the classes in your Guide are empty, do not delete them (it is an important principle of the MPS that it is adopted without amendment). You can add notes to your Guide to explain why your authority does not hold particular types of information.

Do we have to create information for a class?

No, if the authority does not hold information, there is no requirement to create or publish it. Of course, if you think that your authority ought to have a particular type of information, then you can decide to produce it in the future.

Some of the information we hold falls within the classes of information, but we can't publish it because it is sensitive. What do we do?

See Principle 2: Exempt information. If information is exempt under the Act or the EIRs e.g., sensitive personal information or a trade secret, you should remove or redact the information before publication and explain why you have done so.

It is more open to publish a redacted document with an explanation, than to not publish it at all. But if you do publish redacted information do remember that some redactions might be time-sensitive, so will need to make sure redactions are reviewed periodically.

My authority has a lot of information not captured by the classes of information, can we publish it in our Guide?

Yes. The MPS is the *minimum* information we expect authorities to publish. You can add more information to the Guide. And if you think that the MPS could be improved, please do share your suggestions with us.

Should we publish environmental information in our Guide?

Yes. Your Guide should contain environmental information relevant to the classes of information. The publication scheme duty applies equally to environmental and non-environmental information. Section 73 of FOISA (Interpretation) does not make a distinction between environmental and non-environmental information. In any case, regulation 4 of the Environmental Information (Scotland) Regulations 2004 (the EIRs) requires authorities to actively disseminate to the public the environmental information (relevant to its functions) that it holds. So the publication scheme will help you meet your EIRs duty too.

We provide a research / information service. Can we publish it in our Guide?

No. See Research and information services. The service itself does not offer something that is pre-prepared and therefore you cannot claim that it is a "publication". For example, certified extracts from registers, family history searches and property enquiry certificates involve creating new information from other information which may already be published. The new information, or certificate, does not actually exist until someone asks you to create it. So it is not already prepared and available to anyone to access easily and quickly without having to make a request for it. Therefore it is not a "publication" in terms of FOISA.

Availability and formats

We have added new information to our Guide, but it isn't yet available online. Is it acceptable to provide a telephone number to ask for the information in the meantime?

Yes, but…! Such an arrangement should only be a temporary solution. You should have a firm plan to publish the information in the near future and where possible include the intended date in your Guide. Not only is this good practice, but it will actually help you if you want to apply Section 27 (Information intended for future publication) to an information request as it demonstrates clear and planned intention to publish.

Charging for information

My authority has already set charges for publications and they are not the same as the MPS, is this OK?

No. All charges for publications in the Guide must comply with the MPS principles. If an authority's agreed charges are not consistently applied, then the authority is not complying with the MPS and the authority does not have an approved publication scheme. This would be a breach of section 23 of FOISA.

We recommend that you raise the issue within your authority as soon as possible. It may help you to explain that the MPS charging principles were informed by case precedent under FOISA, the EIRs, and European Directive 2013/37/EU on the Re-Use of Public Sector Information which has been incorporated into UK law by the Re-Use of Public Sector Information Regulations 2015.

My authority produces a range of printed publications, e.g. strategic and regional plans – will these fall within Class 8?

It is unlikely. The test for Class 8 publications is whether the information could be sold through a commercial retailer. If, and only if, a commercial bookseller could stock and sell the information, can it be published through Class 8.

Do we have to move all the Open Data we publish to Class 9 even though it falls within the description of other classes?

No, you can continue to publish Open Data throughout your authority's Guide to Information. You need to make sure that Class 9 sets out your authority's open data strategy and signposts people to the open data published.

Duration

How long must we publish information for?

The MPS requires you to publish information for the current and last two financial years. You can publish it for longer if it suits your business needs or you feel that there is a public interest in older information.

We're adding a new type of information. The MPS says we must publish information for the current + 2 years. How could we publish information we don't have?

You don't have to – you're only expected to publish information you have.

Legal requirements

Is my organisation subject to the publication scheme duty?

If your organisation is subject to FOISA, it is subject to the publication scheme duty. If your organisation is a Scottish public authority listed in Schedule 1 of FOISA, a publicly owned company as defined by section 6 of FOISA or has been designated by Scottish Ministers as a Scottish public authority for the purposes of FOISA, it is subject to the publication scheme duty. You can read more about who is subject to the legislation on our website at www.itspublicknowledge.info/WhoCanIAsk.

If your organisation is subject only to the EIRs (and not to FOISA), then it is not subject to the publication scheme duty. But do please be aware that the EIRs require proactive publication of environmental information.

Even if you are not covered, there is nothing to stop you following the MPS approach (although you will not have the Commissioner's formal approval and the public will not be able to complain to us about any compliance issues).

What happens if an authority doesn't adopt a publication scheme?

Failing to adopt a publication scheme is a breach of a statutory duty. The Commissioner will invoke her Enforcement Policy if an authority fails to adopt a scheme. We will give your authority notice that it has failed to comply with a provision of FOISA and we will enforce the notice as required.

Appendices

Appendix 1: Types of information under the MPS classes

The classes of information are set out, with a list of the types of information that the Commissioner would expect to provide through the MPS, **where the authority holds that information**.

Class 1: About the authority
Description Information about the authority, who we are, where to find us, how to contact us, how we are managed and our external relations The Commissioner expects authorities to publish the following information, **as a minimum:**
General information about the authority
• Authority name, address and contact details for headquarters and principal offices • Organisational structure, roles and responsibilities of senior officers • Business opening hours • Contact details for customer care and complaints functions • Customer codes or charters • Publication scheme and Guide to Information • Charging schedule for published information • Contact details and advice about how to request information from the authority • Charging schedule for environmental information provided in response to requests under the EIRs (if the authority charges for environmental information) • Legal framework for the authority, including constitution, articles of association or charter
How the authority is run
• Description of governance structure, Board, committees and other decision making structures • Names, responsibilities and (work-related) biographical details of the people who make strategic and operational decisions about the performance of function and/or delivery of services by the authority e.g. Board members, chief officers • Governance policies, including standing orders, code of conduct and register of interests
Corporate planning
• Mission statement • Corporate plan • Corporate strategies e.g., for economic development, etc. • Corporate policies, e.g., health and safety, equality, sustainability • Strategic planning processes
External relations
• Accountability relationships, including reports to regulators • Internal and external audit arrangements • Subsidiary companies (wholly and part owned) and other significant financial interests • Strategic agreements with other bodies

Class 2: How we deliver our functions and services

Description

Information about our work, our strategy and policies for delivering functions and services and information for our service users.

The Commissioner expects authorities to publish the following information, **as a minimum:**

Functions

- Description of functions, including statutory basis for them, where applicable
- Statement of public task required by the Re-use of Public Sector Information Regulations 2015 (if applicable)
- Strategies, policies and internal staff procedures for performing statutory functions
- How to apply for a licence, warrant, grant, etc. where it is a function of the authority to approve it
- How to report a concern to the authority
- Reports of the authority's exercise of its statutory functions
- Statutory registers (NB not if inspection-only)
- Fees and charges for performance of the authority's function e.g., fee for making a planning application, etc.

Services

- List of services, including statutory basis for them, where applicable
- Service policies and internal staff procedures, including allocation, quality and standards
- Service schedules and delivery plans
- Information for service users, including how to access the services
- Service fees and charges, including bursaries

Class 3: How we take decisions and what we have decided

Description

Information about the decisions we take, how we make decisions and how we involve others.

The Commissioner expects authorities to publish the following information, **as a minimum:**

- Decisions taken by the organisation: agendas, reports and papers provided for consideration and minutes of Board (or equivalent) meetings
- Public consultation and engagement strategies
- Reports of regulatory inspections, audits and investigations carried out by the authority

Class 4: What we spend and how we spend it

Description

Information about our strategy for, and management of, financial resources (in sufficient detail to explain how we plan to spend public money and what has actually been spent).

The Commissioner expects authorities to publish the following information, **as a minimum:**

- Financial statements, including annual accounts, any regular statements e.g. quarterly budget statements.
- Financial statements required by statute e.g., sections 31 and 33 of the Public Service Reform (Scotland) Act 2010, if applicable to the authority
- Financial policies and procedures for budget allocation
- Budget allocation to key policy / function / service areas
- Purchasing plans and capital funding plans
- Financial administration manual / internal financial regulations
- Expenses policies and procedures
- Senior staff / board member expenses at category level e.g., travel, subsistence and accommodation
- Board member remuneration other than expenses
- Pay and grading structure (levels of pay rather than individual salaries)
- Investments, summary information about endowments, investments and authority pension fund
- Funding awards available from the authority, how to apply for them and funding awards made by the authority

Class 5: How we manage our human, physical and information resources

Description

Information about how we manage the human, physical and information resources of the authority

The Commissioner expects authorities to publish the following information, **as a minimum:**

Human resources

- Strategy and management of human resources
- Staffing structure
- Human resources policies, procedures and guidelines, including e.g., recruitment, performance management, salary and grading, promotion, pensions, discipline, grievance, staff development, staff records
- Employee relations structures and agreements reached with recognised trade unions and professional organisations

Physical resources

- Management of the authority's land and property assets, including environmental / sustainability reports
- Description of the authority's land and property holdings
- Estate development plans
- Maintenance arrangements

Information resources

- Records management policy and records management plan, including records retention schedule
- Information governance / asset management policies and procedures, information asset list
- Knowledge management policies and procedures
- List of statistical information published by the authority
- Freedom of information policies and procedures
- Data protection or privacy policy

Class 6: How we procure goods and services from external providers

Description

Information about how we procure goods and services, and our contracts with external providers

The Commissioner expects authorities to publish the following information, **as a minimum:**

- Procurement policies and procedures
- Invitations to tender
- List of contracts which have gone through formal tendering, including name of supplier, period of contract and value

Class 7: How we are performing

Description

Information about how we perform as an organisation, and how well we deliver our functions and services.

The Commissioner expects authorities to publish the following information, **as a minimum:**

- External reports e.g., annual report, performance statements required by statute (e.g., section 32 of the Public Service Reform (Scotland) Act 2010 if applicable.
- Performance indicators and performance against them.

Class 8: Our commercial publications

Description

Information packaged and made available for sale on a commercial basis and sold at market value through a retail outlet e.g., bookshop, museum or research journal.

Class 9: Our open data

Description

Open data made available by the authority as described by the Scottish Government's Open Data Resource Pack and available under an open licence.

The Commissioner expects authorities to publish the following information, **as a minimum:**

- The authority's open data publication plan
- Open data sets and their metadata, or links to where they are accessible

Appendix 2: Publication Schemes: the legal requirements

1. Scottish public authorities are required to adopt and maintain a publication scheme that has the approval of the Scottish Information Commissioner. Publication schemes describe the information that the authority makes available to the public without them having to ask for it.

2. Publication schemes must:

   (i) Contain the classes (or types) of information that the authority publishes or will publish

   (ii) Explain the manner in which the information is published or will be published.

   (iii) State whether there is a charge for the information.

3. When formulating a scheme, an authority must consider the public interest in the information that it holds, particularly in allowing public access to:

   (i) Information about services, the cost of services and the standards attained.

   (ii) Facts or analysis which informed decisions of importance to the public

   (iii) The reasons for decisions taken.

4. Authorities must publish their publication schemes and review them from time to time.

Document control sheet

Document Information	
Full name of current version: Class, Title, Version No and Status. *E.g. C5 Key Documents Handbook v01 CURRENT ISSUE*	C2 Model Publication Scheme: Guide for Scottish Public Authorities v01 CURRENT ISSUE
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Type	Briefing
Approver	SMT
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Corrections / Unplanned or Ad hoc reviews (see Summary of changes below for details)	
Date of last update	

Summary of changes to document				
Date	**Action by** *(initials)*	**Version updated** *(e.g. v01.25-36)*	**New version number** *(e.g. v01.27, or 02.03)*	**Brief description** (*e.g. updated paras 1-8, updated HOPI to HOOM, reviewed whole section on PI test, whole document updated, corrected typos, reformatted to new branding*)
05/04/16	JAW	01.00	01.01	Creation of new document
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West Dunbartonshire
Health & Social Care Partnership

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

Publication Scheme: Guide to Information

Document Title:	WDHSCP Publication Scheme: Guide to Information	Owner:	Head of Strategy, Planning & Health Improvement
Version No.	Submission Version to Scottish Information Commissioner (December 2016)	Superseded Version:	N/A
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1. PURPOSE

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 to 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 (HSCP).

1.2 The 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 its Integration Scheme (as per the Public Bodies [Joint Working] Act 2014). The Partnership Board regards its publications and records as major assets, with its records an essential resource for the the efficient and effective fulfilment of its governance, business and legal responsibilities.

1.4 The Partnership Board became subject to the Freedom of Information (Scotland) Act 2002 when it was established on the 1st July 2015. Freedom of Information (Scotland) Act 2002 (the Act) requires Scottish public authorities to adopt and maintain a publication scheme as part of their legal obligation to:

- Publish the classes of information that they make routinely available.
- Tell the public how to access the information they publish and whether information is available free of charge or on payment.

1.5 We have adopted the Model Publication scheme produced by the Scottish Information Commissioner: www.itspublicknowledge.info/PublicationSchemeGuidance.
Our aim in adopting the Commissioner's Model Publication Scheme and in maintaining this Guide to Information is to be as open as possible.

1.6 The Model Publication Scheme is underpinned by six principles:

1.6.1 Principle One: Availability and formats

- Information published through this model scheme should, wherever possible, be made available on the authority's website.
- There must be an alternative arrangement for people who do not wish to, or who cannot, access the information either online or by inspection at the authority's premises. An authority may e.g., arrange to send out information in paper copy on request (although there may be a charge for doing so).

1.6.2 Principle Two: Exempt Information

- If information described by the classes cannot be published and is exempt under Scotland's freedom of information laws e.g., sensitive personal data or a trade secret, the authority may withhold the information or provide a redacted version for publication, but it must explain why it has done so.

1.6.3 Principle Three: Copyright and Re-use

- The authority's Guide to Information must include a copyright statement which is consistent with the fair dealing provisions of the Copyright, Designs and Patents Act 1988. Where the authority does not hold the copyright in information it publishes, this should be made clear.
- Any conditions applied to the re-use of published information must be consistent with the Re-Use of Public Sector Information Regulations 2015.
- The Commissioner recommends that authorities adopt the Open Government Licence and/or the non-commercial Government Licence, produced by The National Archives for their published information.

1.6.4 Principle Four: Charges

- The Guide to Information must contain a charging schedule, explaining any charges and how they will be calculated.
- No charge may be made to view information on the authority's website or at its premises, except where there is a fee set by other legislation e.g., for access to some registers.
- The authority may charge for computer discs, photocopying, postage and packing and other costs associated with supplying information. The charge must be no more than these elements actually cost the authority e.g. cost per photocopy or postage. There may be no further charges for information in Classes 1 – 7. An exception is made for commercial publications (Class 8) where pricing may be based on market value.

1.6.5 Principle Five: Contact details

- The authority must provide contact details for enquiries about any aspect of the adoption of the model scheme, the authority's Guide to Information and to ask for copies of the authority's published information.
- The Act requires authorities to provide reasonable advice and assistance to anyone who wants to request information which is not published. The authority's Guide to Information must provide contact details to access this help.

1.6.6 Principle Six: Duration

- Once published through the Guide to Information, the information should be available for the current and previous two financial years. Where information has been updated or superseded, only the current version need be available (previous versions may be requested from the authority).

1.7 Our aim is to make our Guide to Information as user-friendly as possible, and we hope that you can access all the information we publish with ease.

Contact Details

1.8 All enquiries, feedback and complaints relating to this Guide to Information, or any other aspect of Freedom of Information or Data Protection should be sent to:

Information Manager - West Dunbartonshire HSCP
West Dunbartonshire Health & Social Care Partnership HQ,
West Dunbartonshire Council Offices, Garshake Road, Dumbarton, G82 3PU
Tel: 01389 737000; E-mail: wdhscp@west-dunbarton.gov.uk

1.10 You have legal rights to access information under the Model Publication Scheme (as described in this Guide to Information) and a right of appeal to the Scottish Information Commissioner if you are dissatisfied with our response. These rights apply only to information requests made in writing or another recordable format. If you are unhappy with our responses to your request you can ask us to review it and if you are still unhappy, you can make an appeal to:

Scottish Information Commissioner
Kinburn Castle, Doubledykes Road, St Andrews, Fife, KY16 9DS
Tel: 01334 464610; Email: enquiries@itspublicknowledge.info
Website: www.itspublicknowledge.info/YourRights

The Commissioner's website has a guide to this three step process, and operates an enquiry service on Monday to Friday from 9:00am to 5:00pm.

2. ACCESSING INFORMATION UNDER THIS SCHEME

Availability and Formats

2.1 The information published through this Guide to Information is, wherever possible, available on our website: www.wdhscp.org.uk (see Section 3: Classes of Information). If the information you seek is listed in our Guide to Information but is not published on our webpage, we can send it to you by email, wherever possible. If you have any difficulty identifying the information you want to access, then please contact us to help you as above.

2.2 All information in the guide can be made available in hard copy form (i.e. paper copies). Hard copies of information can be requested from us over the telephone or in writing. When writing to us to request information, please include your name and address; full details of the information or documents you would like to receive; and ideally a telephone number so we can telephone you to clarify any details if necessary. If you prefer to visit us to inspect the information, please contact us to make an appointment to view the information.

Copyright and Re-use

2.3 Where the Partnership Board holds the copyright to published information, the information may be copied or reproduced without formal permission, provided that it is copied or reproduced accurately; it is not used in a misleading context; and the source of the material is identified.

2.4 Where the Partnership Board does not hold copyright in information it publishes, we will cite the source/copyright holder appropriately within those publications.

Exempt Information

2.5 Our aim in adopting the Commissioner's Model Publication Scheme and in maintaining this Guide to Information is to be as open as possible. However, there may be limited circumstances where information will be withheld from one of the classes of information listed in Section 3: Classes of Information. Information will only be withheld, however, where the Act expressly permits it. For example, information may be withheld where its disclosure would breach the law of confidentiality; harm an organisation's commercial interests; or if it is another person's personal information, and its release would breach the Data Protection Act.

2.6 Whenever information is withheld we will inform you of this, and will set out why that information cannot be released. Even where information is withheld it will, in many cases, be possible to provide copies with the withheld information edited out. You can complain to us, if you so wish, about any information which has been withheld from you.

Charges

2.7 Unless otherwise stated in Section 3: Classes of Information, all information contained within our scheme is available from us free of charge where it can be viewed online or where it can be sent to you electronically by email. There is no charge to view information online or at our offices.

2.8 However, we reserve the right to impose charges for providing information in paper copy or on computer disc. In the event that a charge is to be levied, you will be advised of the charge and how it has been calculated. Information will not be provided to you until payment has been received. Charges reflect the actual costs of supplying the information (e.g. photocopying and postage), as set out below.

Black & White Photocopying	
A4	10p
A3	20p
Colour Photocoping	
A4	20p
A3	40p
Alternative Formats	
CD-ROM / DVD	£1.00 per copy

Duration

2.9 Once information is published under a class as a minimum we will continue to make it available for the current and previous two financial years.

2.10 Where information has been updated or superseded, only the current version will be available. If you would like to see previous versions, you are welcome to make a request to do so.

3. CLASSES OF INFORMATION

3.1 We publish information that we hold within the following classes as specified by the Scottish Information Commissioner:

Class	Publication Descriptor
1	About West Dunbartonshire Health & Social Care Partnership Board.
2	How West Dunbartonshire Health & Social Care Partnership Board delivers its functions and services.
3	How West Dunbartonshire Health & Social Care Partnership Board takes decisions and what it has decided.
4	What West Dunbartonshire Health & Social Care Partnership Board spends and how it spends it.
5	How West Dunbartonshire Health & Social Care Partnership Board manages human, physical and information resources.
6	How West Dunbartonshire Health & Social Care Partnership Board procures goods and services from external providers.
7	How West Dunbartonshire Health & Social Care Partnership Board is performing.
8	Commercial publications.
9	Open data.

Class 1: About West Dunbartonshire Health & Social Care Partnership Board.	
Class Description: Information about West Dunbartonshire Health and Social Care Partnership Board, who we are and where to find us, how to contact us, how we are managed and our external relations.	
The information we publish under this class	**How to access it/details of any changes**
As per the Public Bodies (Joint Working) Act 2014, West Dunbartonshire Health & Social Partnership Board was established on 1st July 2015 as the "body corporate" arrangement to which Greater Glasgow & Clyde Health Board and West Dunbartonshire Council had agreed to formally delegate health and social care services for adults and children to (i.e. as the Integration Joint Board for West Dunbartonshire). Further background information about the Health & Social Care Partnership Board is available at: http://wdhscp.org.uk/about-us/ General enquiries should be sent to: wdhscp@west-dunbarton.gov.uk	

Class 2: How West Dunbartonshire Health & Social Care Partnership Board delivers its functions and services.	
Class Description: Information about our work, our strategy and policies for delivering functions and services and information for our service users.	
The information we publish under this class	**How to access it/details of any changes**
West Dunbartonshire Health & Social Partnership Board is responsible for the strategic planning and reporting of a range of health and social care services delegated to it by NHS Greater Glasgow & Clyde Health Board and West Dunbartonshire Council. 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 (HSCP). Integration Scheme for West Dunbartonshire is available at: http://wdhscp.org.uk/media/1215/wdhscp-integration-scheme-may-2015.pdf West Dunbartonshire Health & Social Partnership Board's Strategic Plan is available at: http://wdhscp.org.uk/about-us/health-and-social-partnership-board/strategic-plan/	
Class 3: How West Dunbartonshire Health & Social Care Partnership Board takes decisions and what it has decided.	
Class description: Information about the decisions we take, and how we make decisions and how we involve others.	
The information we publish under this class	**How to access it/details of any changes**
Information about those decisions made by the West Dunbartonshire Health & Social Partnership Board and its supportive arrangements are detailed at :http://wdhscp.org.uk/about-us/health-and-social-partnership-board/health-and-social-care-partnership-board-meeting-papers/ The procedure and business of the Partnership Board require to be compliant with its Standing Orders: http://wdhscp.org.uk/about-us/health-and-social-partnership-board/health-and-social-care-partnership-standing-orders/ The Partnership Board's approach to involving others is set out within its Participation & Engagement Strategy: http://wdhscp.org.uk/about-us/health-and-social-partnership-board/strategic-plan/	
Class 4: How West Dunbartonshire Health & Social Care Partnership Board takes decisions and what it has decided.	
Class Description: Information about our strategy for, and management of, financial resources.	
The information we publish under this class	**How to access it/details of any changes**
Details of arrangements for the governance and management of financial resources by West Dunbartonshire Health & Social Partnership Board are provided at: http://wdhscp.org.uk/about-us/health-and-social-partnership-board/financial-governance/ The Partnership Board's strategy for the use of financial resources is integrated within its Strategic Plan: http://wdhscp.org.uk/about-us/health-and-social-partnership-board/strategic-plan/ Regular financial reports are considered at meetings of the Partnership Board: http://wdhscp.org.uk/about-us/health-and-social-partnership-board/health-and-social-care-partnership-board-meeting-papers/ The arrangements for and minutes of the Partnership Board's Audit Committee are available at: http://wdhscp.org.uk/about-us/health-and-social-partnership-board/financial-governance/audit-committee-section/	
Class 5: How West Dunbartonshire Health & Social Care Partnership Board manages human, physical and information resources.	
Class Description: Information about how we manage the human, physical and information resources.	
The information we publish under this class	**How to access it/details of any changes**
West Dunbartonshire Health & Social Partnership Board does not directly employ	

staff, with the exception of an element of the contracted time of the Chief Officer and the Chief Financial Officer – see the Annual Accounts for details: http://wdhscp.org.uk/about-us/health-and-social-partnership-board/financial-governance/
Staff who work within the management of the HSCP continue to be employed by either the Health Board or the Council (retaining their respective terms and conditions) as described within the HSCP's Workforce & Organisational Development Strategy: http://wdhscp.org.uk/about-us/senior-management-team/workforce-and-organisational-development/
The Partnership Board does not own physical assets – the capital and assets (with their associated running costs) used by the HSCP belong to and are the responsibility of either the Health Board or the Council as per the Integration Scheme: http://wdhscp.org.uk/media/1215/wdhscp-integration-scheme-may-2015.pdf
The Council, the Health Board and the other local authorities within the Health Board area develop, review and maintain an Information Sharing Protocol, which has been extended to include the Partnership Board.

Class 6: How West Dunbartonshire Health & Social Care Partnership Board procures goods and services from external providers.

Class Description**:** Information about how we procure goods and services, and our contracts with external providers.

The information we publish under this class	**How to access it/details of any changes**

It is not the practice of West Dunbartonshire Health & Social Care Partnership Board to directly procure goods or services, and so it does not hold information in this area. Any procurement related to the operations of the HSCP is undertaken through either the Council or the Health Board (and so those organisations hold that information).

Class 7: How West Dunbartonshire Health & Social Care Partnership Board is performing.

Class Description: Information about how we perform as an organisation, and how well we deliver our functions and services

The information we publish under this class	**How to access it/details of any changes**

Performance information is routinely published: http://wdhscp.org.uk/about-us/public-reporting/
This includes the Partnership Board's Annual Performance Report: http://wdhscp.org.uk/about-us/public-reporting/performance-reports/
Regular reports on performance are considered at meetings of the Partnership Board: http://wdhscp.org.uk/about-us/health-and-social-partnership-board/health-and-social-care-partnership-board-meeting-papers/

Class 8: Commercial publications.

Class Description: Information packaged and made available for sale on a commercial basis and sold at market value through a retail outlet (e.g. bookshop, museum or research journal).

The information we publish under this class	**How to access it/details of any changes**

West Dunbartonshire Health & Social Care Partnership Board does not publish any material that is packaged and made available for sale on a commercial basis; and so we do not hold any such information.

Class 9: Open data.	
Class Description: Open data made available by the authority as described by the Scottish Government's Open Data Resource Pack and available under an open licence.	
The information we publish under this class:	**How to access it/details of any changes**
While West Dunbartonshire Health & Social Care Partnership Board does not itself hold open data sets and their metadata (as these are held by the Council and the Health Board) performance information is routinely published: http://wdhscp.org.uk/about-us/public-reporting/ This includes the Partnership Board's Annual Performance Report: http://wdhscp.org.uk/about-us/public-reporting/performance-reports/ Regular reports on performance and finance are also considered at meetings of the Partnership Board: http://wdhscp.org.uk/about-us/health-and-social-partnership-board/health-and-social-care-partnership-board-meeting-papers/	