Agenda

West Dunbartonshire
Health & Social Care Partnership

Special Meeting of West Dunbartonshire Health & Social Care Partnership Board

Date: Wednesday, 22 March 2017

Time: 10:00

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 special meeting of the **West Dunbartonshire Health & Social Care Partnership Board** as detailed above.

The business is shown on the attached agenda.

Yours faithfully

KEITH REDPATH

Chief Officer of the
Health & Social Care Partnership

Distribution:-

Voting Members

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

Non-Voting Members

Barbara Barnes
Kenneth Ferguson
Wilma Hepburn
Jackie Irvine
John Kerr
Neil Mackay
Diana McCrone
Anne MacDougall
Kim McNabb
Janice Miller
Peter O'Neill
Martin Perry
Keith Redpath
Selina Ross
Julie Slavin
Alison Wilding

Senior Management Team – Health & Social Care Partnership

Date of issue: 15 March 2017

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

SPECIAL MEETING - WEDNESDAY, 22 MARCH 2017

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 UNSCHEDULED CARE – COMMISSIONING INTENTIONS 2017 - 2020 — 5 - 54

Submit report by the Head of Strategy, Planning & Health Improvement seeking approval of the proposed commissioning intentions for unscheduled care.

A short presentation on proposed commissioning intentions for unscheduled care will be provided at the meeting.

4 2017/18 ANNUAL REVENUE BUDGET UPDATE — 55 - 60

Submit report by the Chief Financial Officer providing an update on the progress made with regard to the indicative funding allocation for 2017/18 from the Board's funding partner, NHS Greater Glasgow and Clyde Health Board.

5 NHS GREATER GLASGOW & CLYDE-WIDE REVIEW OF OUT OF HOURS GP SERVICES – UPDATE — 61 - 76

Submit report by the Head of Strategy, Planning & Health Improvement providing an update on the NHS Greater Glasgow & Clyde-wide Review of Out of Hours GP Services.

6 RECRUITMENT OF CHIEF OFFICER — 77 - 79

Submit report by the Head of People and Change seeking approval of the process to recruit a new Chief Officer.

7/

7 AUDIT PLAN 2016/2017 PROGRESS REPORT AND AUDIT PLAN 2017/18 — 81 - 103

Submit report by the Chief Internal Auditor providing:-

(a) an update 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;

(b) details of the planned programme of work for 2017/18; and

(c) findings of the completed Audit of the Partnership Board's Governance, Performance and Financial Management Arrangements.

8 AUDIT SCOTLAND: WEST DUNBARTONSHIRE INTEGRATED JOINT BOARD ANNUAL AUDIT PLAN 2016/17 — 105 – 120

Submit report by the Chief Financial Officer presenting the Audit Scotland Annual Audit Plan for the audit of the financial year 2016/17.

9 DATE OF NEXT MEETING OF HEALTH & SOCIAL CARE PARTNERSHIP AUDIT COMMITTEE

Members are requested to consider setting a date for the next meeting of the Audit Committee on Thursday, 22 June 2017 at 10.00 a.m. in Committee Room 3, Council Offices, Garshake Road, Dumbarton G82 3PU.

Item 3

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 22nd March 2017

Subject: Unscheduled Care - Commissioning Intentions 2017 – 2020

1. Purpose

1.1 To present the Partnership Board with proposed commissioning intentions for unscheduled care.

2. Recommendation

2.1 The Partnership Board is recommended to:

- Approve the proposed commissioning intentions for unscheduled care.
- Direct the Chief Officer to communicate the initial commissioning directions for acute services to the Chief Operating Officer of NHSGGC.

3. Background

3.1 Unscheduled care is the unplanned treatment or care of an individual usually as a result of an emergency or urgent event. This usually takes the form of presentation at Accident and Emergency services which can result in an admission to hospital.

3.2 As Members will recall, the Partnership Board is responsible for strategic planning for unscheduled care with respect to the population of West Dunbartonshire. In doing this, it is obliged to work closely with the Health Board as well the other Integration Joint Boards within the Greater Glasgow & Clyde area.

3.3 The HSCP's Strategic Plan 2016-19 highlights the importance of unscheduled care within its strategic commissioning priorities for adults and older people. As confirmed at Partnership Board's meeting on the 1st March 2017, the attached document has been prepared and is being presented to articulate how those commissioning priorities will now be taken forward (Appendix 1).

4. Main Issues

4.1 Unscheduled care is the unplanned treatment or care of an individual usually as a result of an emergency or urgent event. This usually takes the form of presentation at Accident and Emergency services which can result in an admission to hospital.

4.2 Improving unscheduled care is a shared priority for the Partnership Board, its neighbouring Integration Joint Boards, NHS Greater Glasgow & Clyde and the Scottish Government. This reflects the challenges presented by a "wicked"

combination of continuing shifts in patterns of disease to long term conditions; growing numbers of older people with multiple conditions and complex needs; and a pressurised financial environment. Critical to this is the on-going work and developments to shifting the balance of where care and support is delivered from hospital to community care settings, and to individual homes when that is the best thing to do. Good quality community care should mean less unscheduled care in hospitals, and people staying in hospitals only for as long as they need specific treatment. At the same time, waste and variation in clinical practice need to be addressed, alongside promoting the reliable implementation of effective interventions.

4.3 Following the publication of the National Clinical Strategy and the Health & Social Care Delivery Plan, NHSGGC's Acute Services Committee agreed an approach to planning the changes required to transform Acute Services in line with the direction set by these initiatives (2017). This included:

- An appreciation that while there continue to be increasing amounts of money spent on the NHS, that the growing demands from patients and the changing health needs of the population will only be met by shifting resources from acute hospitals to the community.
- A commitment that more support will be developed in the community to enable people to stay locally and out of acute hospitals unless necessary.
- An expectation that new approaches to the effective delivery of care and support for people with multiple health conditions will result from better integration and investment.
- An acknowledgement that while any redesign of acute hospital services is likely to impact on all NHSGGC acute hospital sites, the Health Board remains committed to the delivery of acute services from all of the main acute hospitals, i.e. Queen Elizabeth University Hospital, Glasgow Royal Infirmary, Gartnavel General, New Victoria Hospital, New Stobhill Hospital, Royal Alexandra Hospital, Inverclyde Royal Hospital and the Vale of Leven Hospital.

4.4 Appendix 1 then seeks to build on the body of work undertaken to-date by the HSCP and NHSGGC's Acute Division, and set out the Partnership Board's commissioning objectives to improve unscheduled care for residents of West Dunbartonshire.

4.5 At the heart of these comprehensive commissioning intentions is a commitment to invest, redesign and deliver an effective infrastructure of community services. In doing this, the document sets out initial commissioning directions for NHSGGC and its Acute Division; and a proposed improvement agenda for primary care, both of which emphasise the expectations to realise realistic medicine. With respect to the former, West Dunbartonshire HSCP took the lead in negotiating and securing a consistent set of commissioning directions across all six partnerships within the NHSGGC area.

4.6 In accordance with Scottish Government's emerging indications with regards to measuring the impact of health and social care integration (Appendix 2), this document is then setting out the commissioning objectives for the

Partnership Board in respect of acute - and particularly unscheduled - care with regards to the following inter-connected themes:

- Communication.
- Unplanned admissions.
- Occupied bed days for unscheduled care
- A&E performance.
- Delayed discharges.
- End of life care.
- Balance of spend across institutional and community services.

4.7 In response to Appendix 2, a previous draft version of Appendix 1 was submitted to Scottish Government at the end of February 2016 as requested. That submission made clear that the version shared was a work-in-progress draft; and that the final version would be subject to approval by the Partnership Board.

4.8 Subject to the Partnership Board's approval of Appendix 1, these commissioning intentions will then shape the on-going discussions and programme of work across the NHSGGC area.

5. People Implications

5.1 None.

6. Financial Implications

6.1 In the region of £70 million of the HSCP's budget – across both health and social care spend and activity – is allocated towards delivering community services that address these strategic commissioning priorities. For context, this is over half of the HSCP's direct budget and that does not include the support derived by the HSCP's Family Health Services or Prescribing budgets (in terms of funding for Primary Care); nor its share of acute "set aside" resources, which is currently estimated at £17 million.

6.2 As Members will recall from the Chief Financial Officer's 2017/18 Annual Budget Review Report (presented at the 1st March 2017 meeting), the reconfiguration of the set aside budget from an acute to community based setting is a key funding component in the delivery of the Strategic Plan priorities. It is important to recognise that if community services are to take on a greater burden of the care from acute services, they will require both on-going redesign and sustained funding; and it will only be possible to release resources from the acute services to sustain funding for community services if the number of inpatient beds is reduced. However many partnerships have experienced frustrations around being able to access timely and relevant data that can be interrogated to help in the production of realistic commissioning intentions. The Director of Health Finance for the Scottish Government will be working with Integration Authorities and Health Boards to drive forward

improvements in information available to allow partnerships to move forward with service redesign to shift the balance of care.

7. Professional Implications

7.1 These commissioning intentions are predicated on the understanding that the detailed development and then implementation of said objectives will require collaboration, engagement and professional leadership – both within West Dunbartonshire and across NHSGGC.

8. Locality Implications

8.1 These commissioning intentions reinforce support for work programmes that are being developed and led by the local practitioners within the HSCP's two localities – the ones of most relevance here being on Chronic Obstructive Pulmonary Disease (COPD) and frailty (i.e. the decreased ability to withstand illness without loss of function).

8.2 Once approved, these commissioning intentions will then provide a framework for the continued development of services and engagement with practitioners within each locality; and for increased engagement between primary care and acute clinicians in particular within the context of the overall NHSGGC Unscheduled Care Collaborative.

9. Risk Analysis

9.1 Under the terms of the Local Government in Scotland Act 2003 (or, where applicable, the Public Finance and Accountability (Scotland) Act 2000), the implementation of the duty of Best Value11 will apply to the Partnership Board. That duty is to make arrangements to secure continuous improvement in performance whilst maintaining an appropriate balance between quality and cost. In making those arrangements and securing that balance the Partnership Board will have regard to economy, efficiency, effectiveness, the equal opportunities requirements, and contribute to the achievement of sustainable development.

10. Impact Assessments

10.1 No specific implications associated with this report.

11. Consultation

11. These commissioning intentions have built on and been informed by the engagement and formal consultation undertaken in support of the Strategic Plan.

12. Strategic Assessment

12.1 These commissioning intentions reinforce key priorities within the Strategic Plan.

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

Date: 22nd March 2017

Person to Contact: Soumen Sengupta
Head of Strategy, Planning & Health Improvement
West Dunbartonshire Health & Social Care Partnership,
West Dunbartonshire HSCP HQ, West Dunbartonshire Council, Garshake Road, Dumbarton, G82 3PU.
E-mail: soumen.sengupta@ggc.scot.nhs.uk

Appendices: (1) Unscheduled Care Commissioning Intentions 2017 – 2020

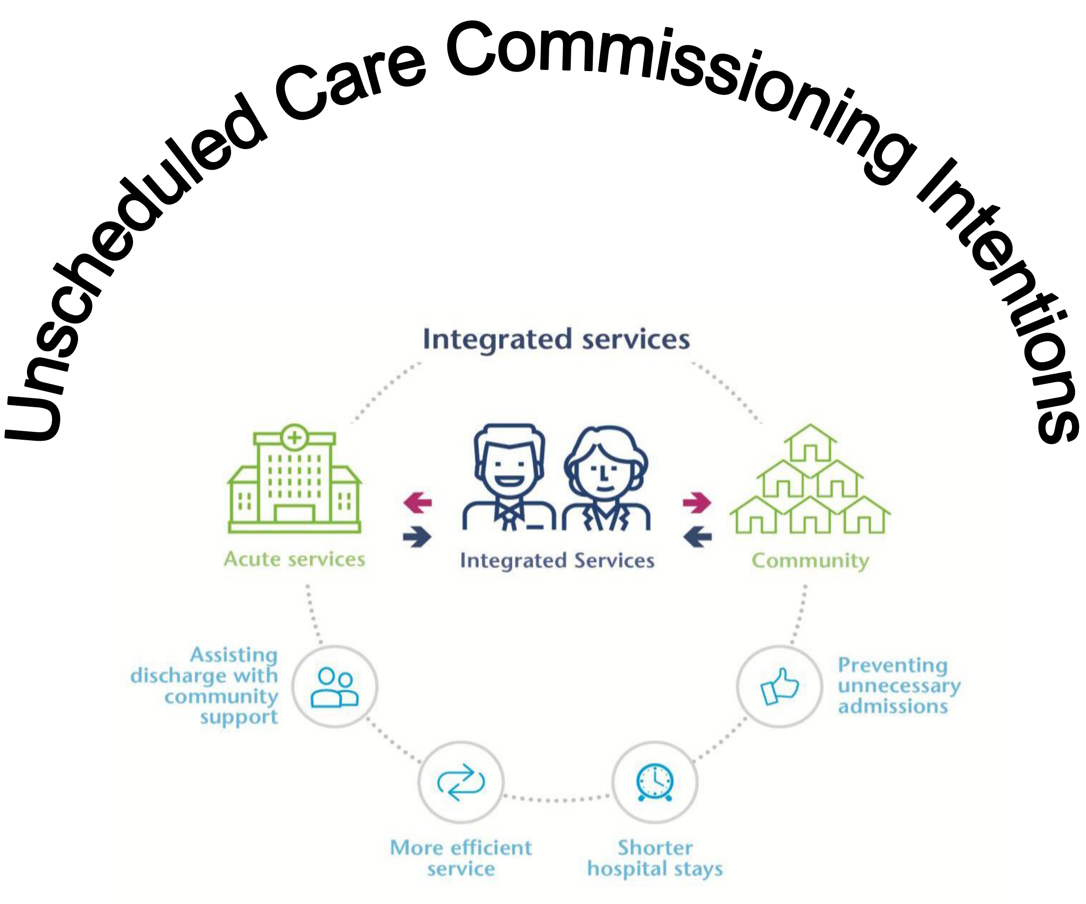
(2) Letter from Scottish Government & COSLA (19th January 2017) – Measuring Performance Under Integration

Background Papers: HSCP Board Report (1st March 2017): 2017/18 Annual Budget Review Report

Wards Affected: All

West Dunbartonshire
Health & Social Care Partnership

Unscheduled Care Commissioning Intentions



2017 - 2020

1

Contents

1. Background 2
2. Analysis of Current Performance 11
3. Commissioning Unscheduled Care 23

    Communication 24

    Unplanned admissions 25

    Occupied bed days for unscheduled care 25

    Accident and Emergency 26

    Delayed Discharges 26

    End of Life Care 27

    Balance of Spend across Institutional and Community Services 27

4. Delivering Performance under Integration 33
5. Appendix 1 – Summary of Commissioning Directions for NHSGGC Acute Services 34

Soumen Sengupta – Head of Strategy, Planning and Health Improvement
West Dunbartonshire Health and Social Care Partnership

www.wdhscp.org.uk

2

Background

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 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.

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 Council and the Health Board discharge the operational delivery of the services delegated to the Partnership Board - 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 (WD HSCP). The Partnership Board is responsible for the operational oversight of the HSCP.

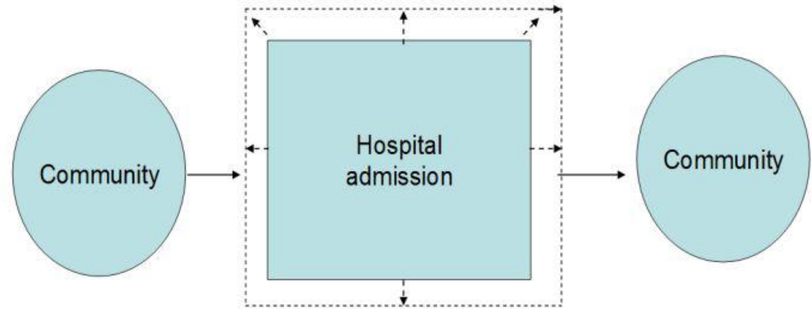
As required by legislation, the Partnership Board is responsible for strategic planning for unscheduled care with respect to the population of West Dunbartonshire. In doing this, it is obliged to work closely with the Health Board as well the other Integration Joint Boards within the Greater Glasgow & Clyde area. Unscheduled care is the unplanned treatment or care of an individual usually as a result of an emergency or urgent event. This usually takes the form of presentation at Accident and Emergency services which can result in an admission to hospital.

Improving unscheduled care is a shared priority for the Partnership Board, its neighbouring Integration Joint Boards, NHS Greater Glasgow & Clyde and the Scottish Government. This reflects the challenges presented by a "wicked" combination of continuing shifts in patterns of disease to long term conditions; growing numbers of older people with multiple conditions and complex needs; and a pressurised financial environment. Critical to this is the on-going work and developments to shifting the balance of where care and support is delivered from hospital to community care settings, and to individual homes when that is the best thing to do. Good quality community care should mean less unscheduled care in hospitals, and people staying in hospitals only for as long as they need specific treatment. At the same time, waste and variation in clinical practice need to be addressed, alongside promoting the reliable implementation of effective interventions.

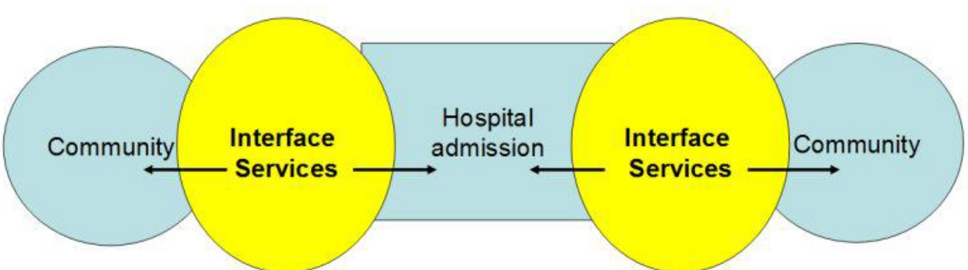
The *NHSGGC Clinical Services Strategy* (2015) aims to ensure that:

- Care is patient focused with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway.
- Services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements.
- Sustainable and affordable clinical services can be delivered across NHSGGC.
- The pressures on hospital, primary care and community services are addressed.

It describes a system under increasing pressure in which ‘hospital’ and ‘community’ services are largely seen as separate, with often poor communication and joint planning (as illustrated below).



It envisages moving to a system of care that focuses on providing care where it is most appropriate for the patient (as illustrated here).



This is based on strengthened 24/7 community services, acute services focused on assessment and management of acute episodes, and a range of services being developed at the interface including shared management of high risk patients and a range of alternatives to face to face hospital visits. Working differently at the interface (represented by the yellow circles above) may involve new services, extending existing services, creating new ways of working through in-reach, outreach and shared care, as well as changes to the way we communicate and share information across the system.

4

Similarly, the *National Clinical Services Strategy* (2016) provides a Scotland-wide framework for action, with an emphasis on:

- Taking a person centred approach
- Ensuring services are safe, sustainable, efficient and adaptable over time
- Ensuring care is provided closer to home wherever possible
- Ensuring services are integrated between primary and secondary care
- Providing affordable solutions to utilise available funding as effectively as possible.

The *National Health & Social Care Delivery Plan* (2016) emphasises that the integration of health and social care has been introduced to change the way key services are delivered, with greater emphasis on supporting people in their own homes and communities and less inappropriate use of hospitals and care homes. It argues that the people most affected by these developments, and for whom the greatest improvements can be achieved, are older people, people who have multiple, often complex care needs, and people at the end of their lives. Too often, older people, in particular, are admitted to institutional care for long periods when a package of assessment, treatment, rehabilitation and support in the community – and help for their carers – could better serve their needs.

In addition, *Realising Realistic Medicine: The Chief Medical Officer for Scotland Annual Report 2015/16* asserts that the people receiving health and care should be at the centre of clinical decision-making; and highlights the imperatives for:

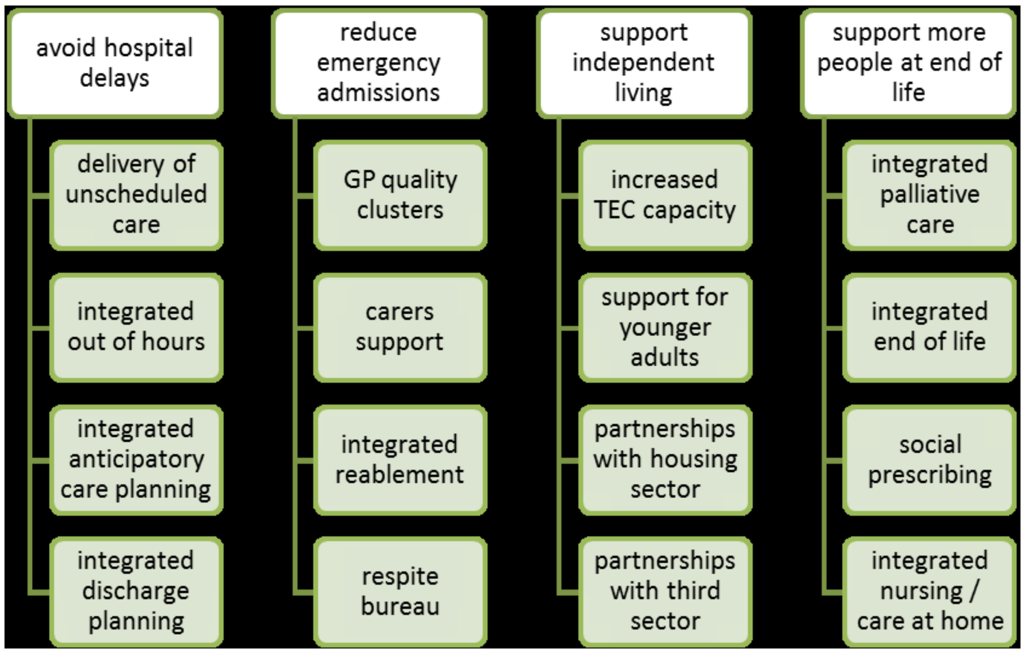
- Reducing harm and waste.
- Tackling unwarranted variation in care.
- Managing clinical risk.
- Innovating to improve.

Following the publication of the National Clinical Strategy and the Health & Social Care Delivery Plan, NHSGGC's Acute Services Committee agreed an approach to planning the changes required to transform Acute Services in line with the direction set by these initiatives - *Transforming Delivery of Acute Services Programme* (2017). This included:

- An appreciation that while there continue to be increasing amounts of money spent on the NHS, that the growing demands from patients and the changing health needs of the population will only be met by shifting resources from acute hospitals to the community.
- A commitment that more support will be developed in the community to enable people to stay locally and out of acute hospitals unless necessary.
- An expectation that new approaches to the effective delivery of care and support for people with multiple health conditions will result from better integration and investment. An acknowledgement that while any redesign of acute hospital services is likely to impact on all NHSGGC acute hospital sites, the Health Board remains committed to the delivery of acute services from all of the main acute hospitals, i.e Queen Elizabeth University Hospital, Glasgow Royal Infirmary, Gartnavel General, New Victoria Hospital, New Stobhill Hospital, Royal Alexandra Hospital, Inverclyde Royal Hospital and the Vale of Leven Hospital.

5

All of the above chimes with the Partnership Board's Strategic Plan 2016-19 and its strategic commissioning priorities for adults and older people – summarised as follows:



In the region of £70 million of the HSCP's budget – across both health and social care spend and activity – is allocated towards delivering community services that address these strategic commissioning priorities. For context, this is over half of the HSCP's direct budget and that does not include the support derived by the HSCP's Family Health Services or Prescribing budgets (in terms of funding for Primary Care); nor its share of acute "set aside" resources, which is currently estimated at £17 million.

The ScotPHO Health & Wellbeing Profile for West Dunbartonshire confirms the relatively higher levels of poor health within the area compared to Scotland as a whole, reflecting the relatively pervasive and high level of deprivation across the area. In 2015 the area has the second highest premature mortality rate per 100,000 population at 570 (Scotland 441).

West Dunbartonshire – under the auspices of the Community Health & Care Partnership – introduced integrated operational teams and arrangements for local adult services in 2014. These included:

- Single point of access staffed by senior practitioners and professionals.
- Community Older People's service, including sensory impairment.
- Community Adult Care service, including physical disability.
- Community Hospital Discharge service, including hospital ward-based early assessors and community-based nurse-led beds.
- Integrated Out-of-Hours services, including district nursing, care at home, palliative care and medicines compliance.

For 2015/16, the HSCP was the best performing in Scotland for:

- Percentage of adults supported at home who agreed that their health and social care services were well co-ordinated - 85% (Scotland 75%).
- Percentage of adults receiving any care or support who rated it as excellent or good – 88% (Scotland 81%).
- Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections – 93% (Scotland 83%).

The HSCP was also:

- The second best performing for percentage off adults supported at home who agreed that they are supported to live as independently as possible – 89% (Scotland 84%).
- The 5th lowest rate of readmissions to hospital within 28 days per 1,000 population at 78 (Scotland 95).

The HSCP has worked with primary care colleagues and other stakeholders (including Council housing and NHS acute services) to establish planning arrangements for its two locality areas: Alexandria & Dumbarton; and Clydebank. These are coterminous with the three recently confirmed GP clusters within West Dunbartonshire (as per the 2016/17 General Medical Services agreement between the Scottish GP Committee and the Scottish Government). Work programmes are being developed and led by the local practitioners involved – the ones of most relevance here being on Chronic Obstructive Pulmonary Disease (COPD) and frailty (i.e. the decreased ability to withstand illness without loss of function).

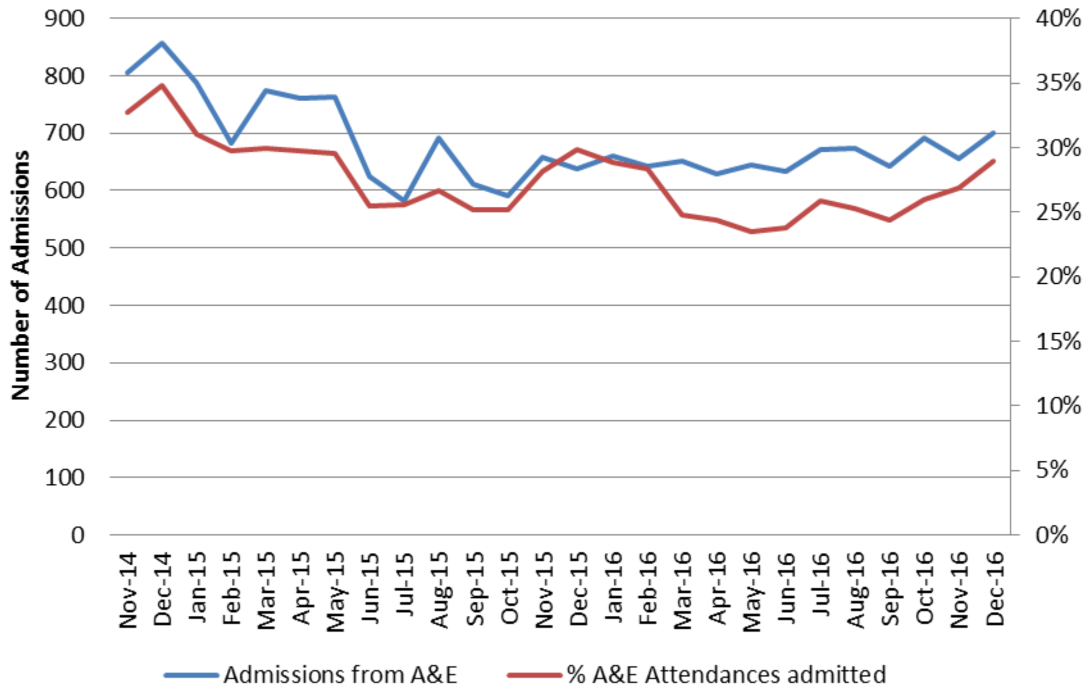
The Partnership Board has also recognised the importance of adopting a balanced approach to manage the additional unscheduled care pressures and business continuity challenges that are faced in winter (as noted within its local Strategic Risk Register). Across the six partnerships within the Health Board's area, the Chief Officers have all

agreed that each HSCP produces a winter plan. These reflect the 12 critical areas within the national *Preparing for Winter Guidance*, including the national *6 Essential Actions to Improving Unscheduled Care*:

- Clinically-focused and hospital management.
- Realignment of hospital capacity and patient flow.
- Patient rather than Bed Management - Operational Performance.
- Medical and surgical processes arranged to take patients from A&E through the acute system.
- Seven-day services targeted to increase weekend and earlier-in-the-day discharges.
- Ensuring patients are cared for in their own homes or a homely setting.

The HSCP has made use of funding provided by the Integrated Care Fund, Technology Enabled Care (TEC) Programme and support from Information Services Division (ISD) to interrogate the effectiveness of these interventions, both short and long term. The analysis of this work has demonstrated emerging evidence of early supported discharges directly from the wards and a decrease in the number of unplanned admissions as a result of investment in - for example - integrated out of hours care at home and district nursing services, out of hours availability of nurse led beds within the community and effective locality planning with GPs. These have driven and contributed to improved performance in a number of key metrics as illustrated in Figures 1, 2 and 3 below.

Figure 1: West Dunbartonshire Admissions from Accident & Emergency 2014 – 2016 (Source: ISD)



8

Figure 2: West Dunbartonshire Unscheduled Bed Days 2014 – 2016 (Source: ISD)

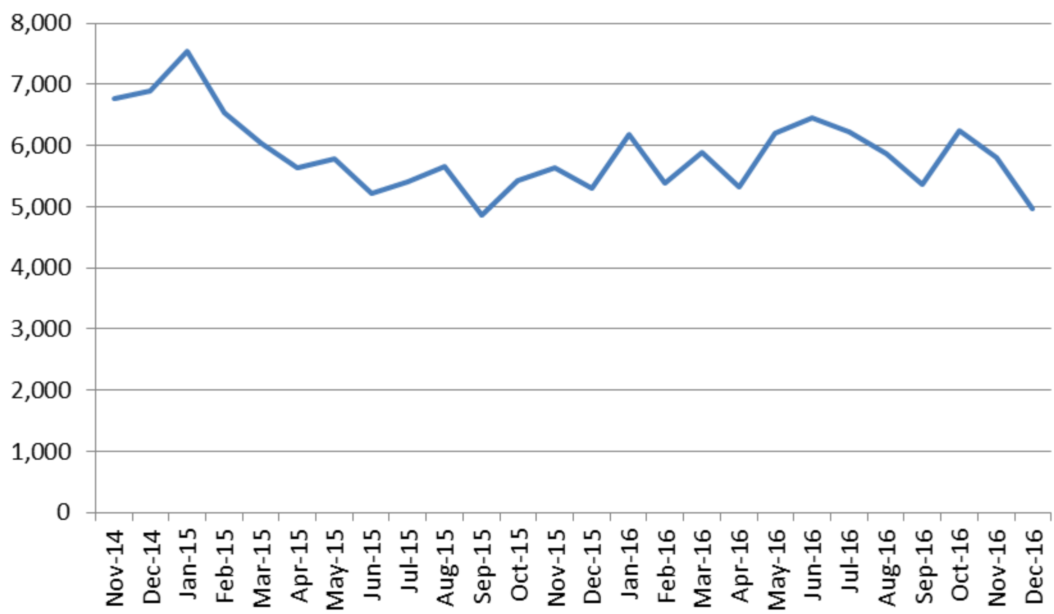
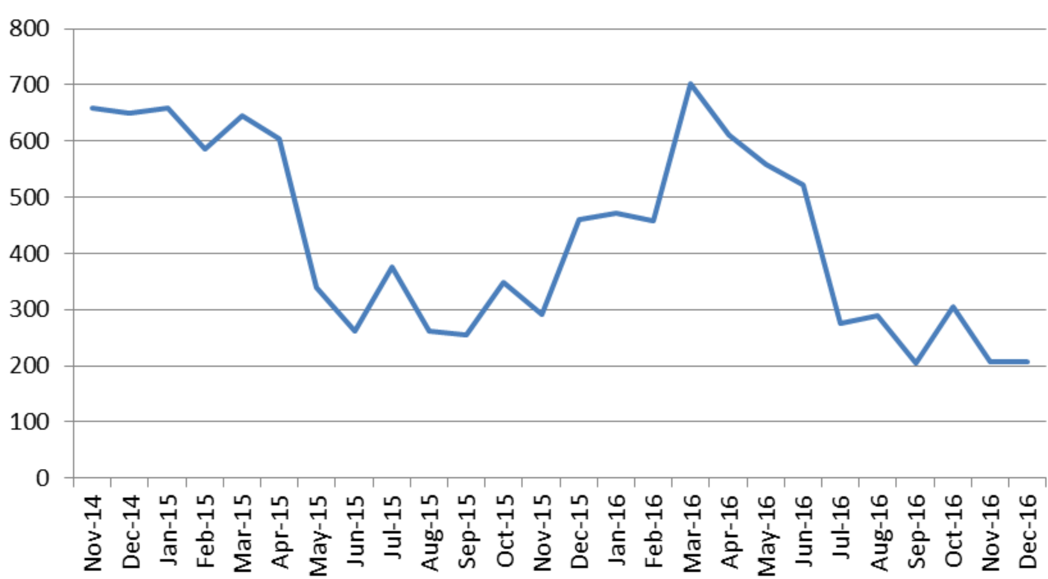
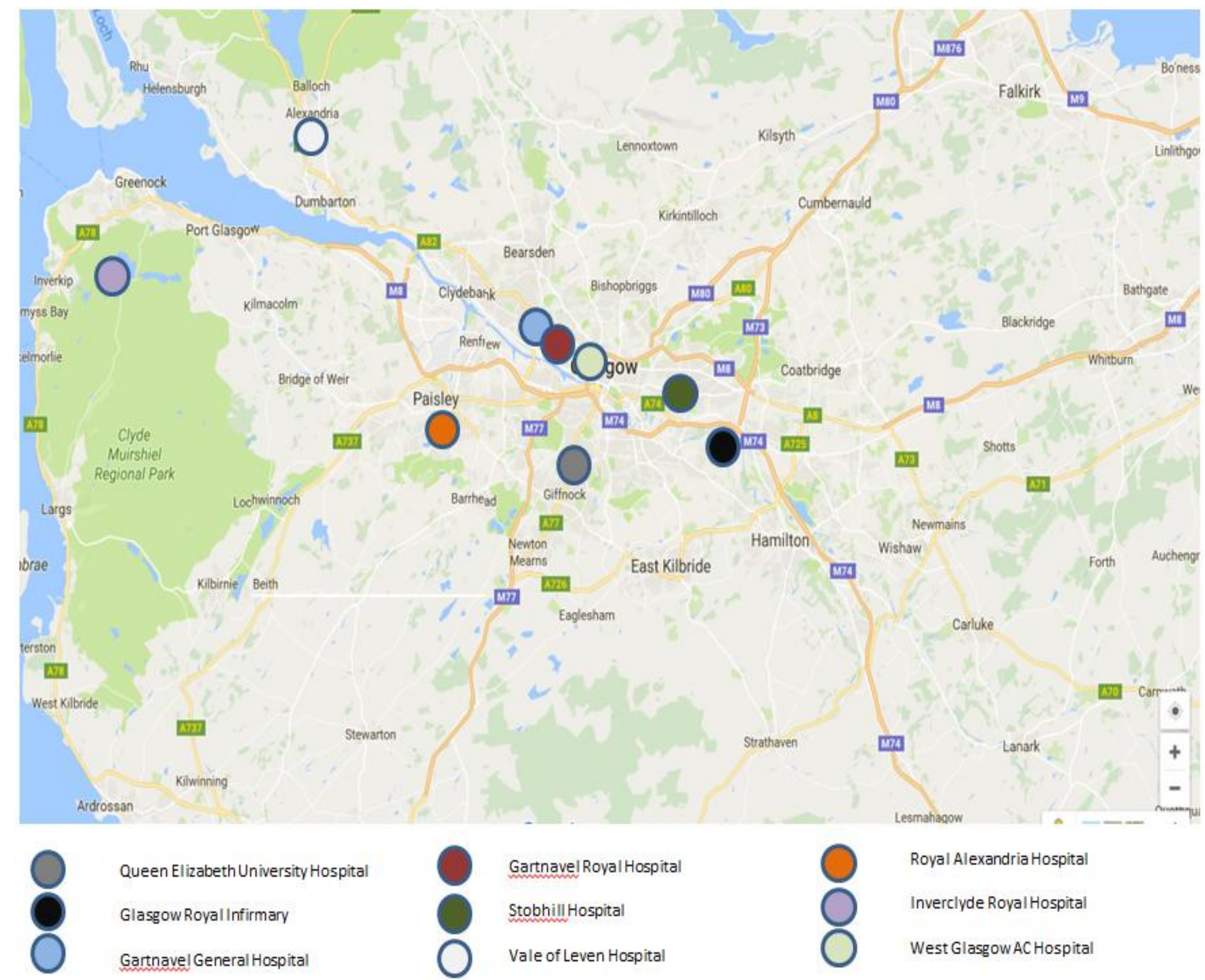


Figure 3: West Dunbartonshire Delayed Discharge Bed Days 2014 – 2016 (Source: ISD)



Each HSCP also participates in the planning work across the wider NHS system to enable the delivery of effective unscheduled care. The importance of the latter reflects the fact that residents of West Dunbartonshire are admitted to and receive acute care from nine acute sites across NHSGGC (as overleaf).

9



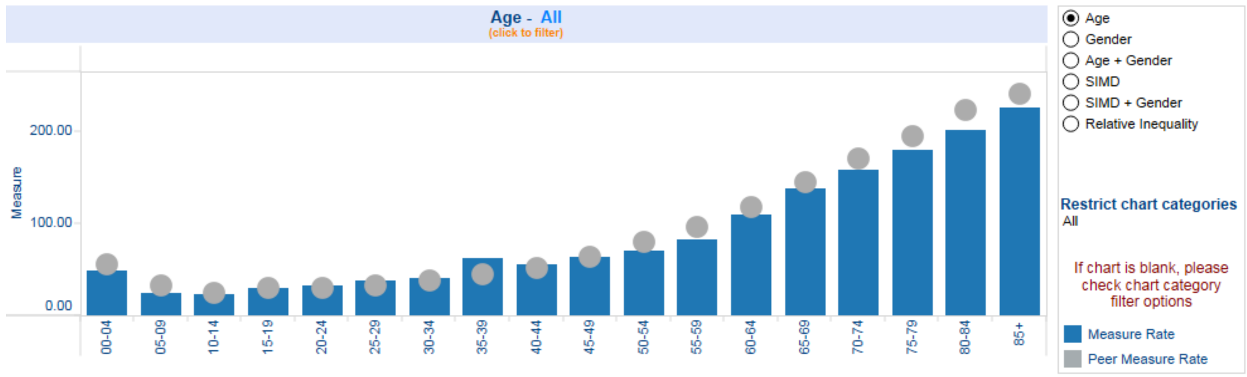
10

Analysis of Current Performance

Unplanned Admissions

Figure 4 shows the admission rate per 1,000 population resident from West Dunbartonshire HSCP (blue bar and line).

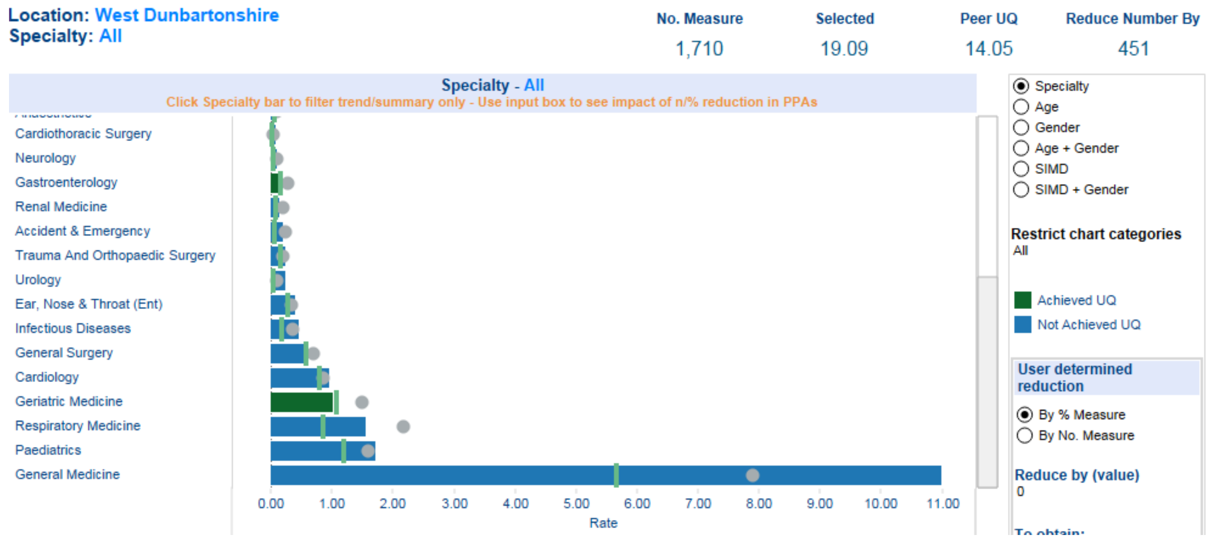
Figure 4: Admissions per 1000 Population Resident from July – September 2016 West Dunbartonshire HSCP (Source: NSS Discovery)



West Dunbartonshire's admission rate is higher compared to the admission rate per 1,000 population among our peers (gray dot and line) for those aged 20-44 years. There was a requirement to review where admissions were preventable to acute services against speciality; this supports decision making linked to community focused activities and acute specialties.

Figure 5 shows the rate of PPAs (number of potentially preventable admissions per 1,000 population) by specialty and the summary for all specialties.

Figure 5: West Dunbartonshire HSCP Potentially Preventable Admissions - All Specialties 2015 (Source: NSS Discovery)

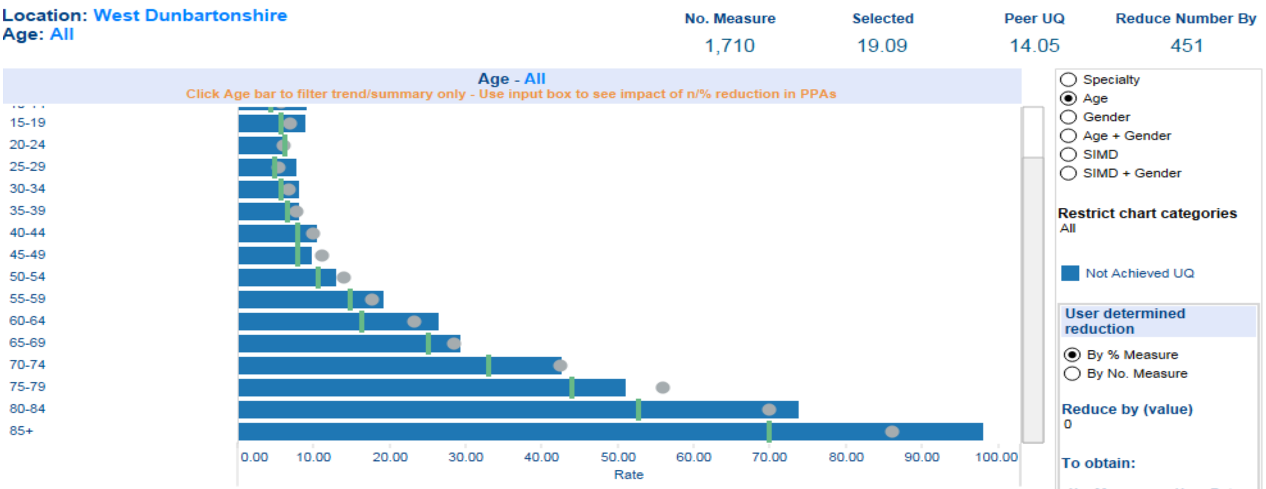


11

The blue bar and line are the rate for West Dunbartonshire HSCP; the grey dot and line are the rate for our peers and the green line represents the upper quartile (UQ) of the peer rate. We estimated that during 2015 there were 1,710 potentially preventable admissions across all specialties, giving a rate of 19.09 per 1,000 population. Had our rate been in line with our peer rate of 14.05 per 1,000, we would have had 451 fewer admissions. This calculation can be done for each specialty: so in general medicine we would have had 479 fewer admissions; and in respiratory medicine we would have had 63 fewer admissions in 2015.

Figure 6 details the age bands of the 1,710 PPAs - we have higher rates than the peer average for those aged 80 and over. Four hundred and ten of the PPAs were admissions where the main condition being managed was COPD and these equated to 2,687 bed days.

Figure 6: West Dunbartonshire HSCP Potentially Preventable Admissions – Age Bands 2015 (Source: NSS Discovery)



Currently there are more than 1400 anticipatory care plans (ACPs) in place across West Dunbartonshire to seek to understand and manage, in the community rather than acute, some of our most vulnerable citizens. Working with acute services, we would be seeking to establish a system whereby community staff, Scottish Ambulance Service and acute clinicians routinely use anticipatory care plans and the summary recorded on e-KIS (the electronic Key Information System) as part of the assessment process to avoid admission and to expedite discharge.

Moving forward, we will be ensuring that access to community services is enabled following an ACP and that services are comprehensive and include nursing, care at home, respite, pharmacy support and rehabilitation, palliative care and specialist disease specific nursing support. This will also include a focus on high risk individuals; and developing stronger links and pathways with acute colleagues to manage patients with long term conditions diagnosed in the community.

Occupied Bed Days for Unscheduled Care

As a rate per 1,000 population West Dunbartonshire has the 4th highest number of emergency admissions in the GGC area and the 4th highest bed days rate.

Table 1: Emergency Admissions and Bed Days April 2015 – September 2016 (Source: ISD)

	2015/16				**April - Dec 2016**			
Partnership of residence	**Emergency Admissions**	**Rate per 1,000 population**	**Bed Days**	**Rate per 1,000 population**	**Emergency Admissions**	**Rate per 1,000 population**	**Bed Days**	**Rate per 1,000 population**
East Dunbartonshire	11,734	110	82,836	774	8844	83	58,519	547
East Renfrewshire	9,077	98	59,830	644	6928	75	45,644	491
Glasgow City	77,331	128	504,983	833	59043	**97**	381,475	629
Inverclyde	10,566	**133**	72,888	**917**	7527	95	53,174	**669**
Renfrewshire	22,670	130	128,980	739	16979	**97**	94,319	540
West Dunbartonshire	10,602	118	66,395	741	8101	90	52,436	585

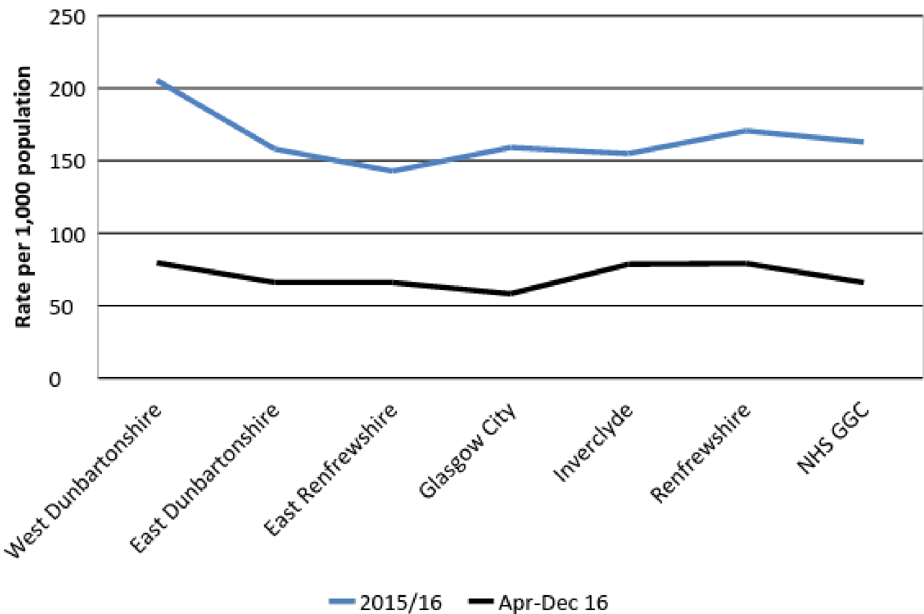
The proportion of bed days consumed by elective rather than non-elective admissions for West Dunbartonshire residents was the highest in the GGC area in 2015/16 and reduces to the second highest during April – September 2016. This equates to 18,404 bed days in 2015/16 and 7,119 in April – September 2016.

Table 2: Proportion of Non-Elective and Elective Admissions and Bed Days April 2015 – September 2016 (Source: NSS Discovery)

	2015/16				**April - Sep 2016**			
	Non-Elective		**Elective**		**Non-Elective**		**Elective**	
	Admissions	Bed Days	Admissions	Bed Days	Admissions	Bed Days	Admissions	Bed Days
West Dunbartonshire	39.6%	78.9%	60.4%	**21.1%**	40.6%	83.4%	59.4%	16.6%
East Dunbartonshire	38.7%	83.3%	61.3%	16.7%	40.0%	85.8%	60.0%	14.2%
East Renfrewshire	39.6%	82.2%	60.4%	17.8%	39.9%	84.2%	60.1%	15.8%
Glasgow City	47.1%	84.3%	52.9%	15.7%	48.1%	88.4%	51.9%	11.6%
Inverclyde	45.5%	86.0%	54.5%	14.0%	44.1%	85.6%	55.9%	14.4%
Renfrewshire	44.3%	81.4%	55.7%	18.6%	43.4%	82.8%	56.6%	**17.2%**
NHS GGC	44.6%	83.4%	55.4%	16.6%	45.1%	86.5%	54.9%	13.5%

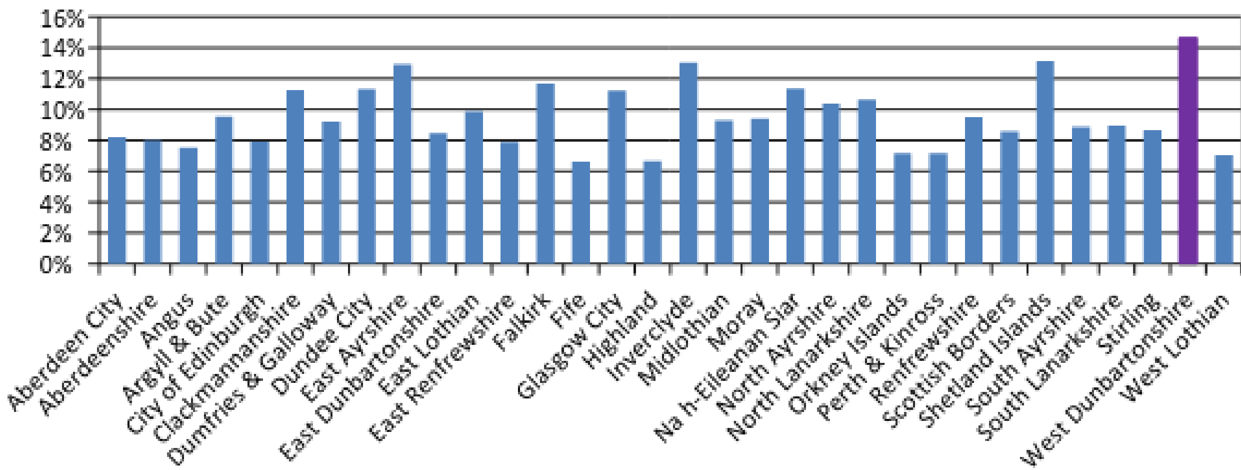
Similarly the rate of elective bed days per 1,000 population was the highest in GGC area from April 2015 to September 2016.

Figure 7: Elective Bed Days per 1,000 population 2015/16 (Source: NSS Discovery)



In 2015/16 West Dunbartonshire had the highest proportion in Scotland of people aged 75 and over living at home with support.

Figure 8: Balance of care: Percentage of population supported at home 75+ 2015/16 (Source: ISD)



Moving forward, there is need for GP Clusters and Localities to increase GP awareness of options in the community for care at home – particularly out of hours (where this is an integrated service with district nursing). Acute services will also need to demonstrate progress in working towards compliance with externally benchmarked upper quartile length of stay across all sites and specialties. This supports optimisation of discharge processes across all sites and specialties to create an earlier in the day discharge profile and increase weekend discharges, whilst the HSCP will expand hospital discharge services to enable the discharge of more complex cases.

Accident & Emergency

Table 3 details levels of attendance at Accident & Emergency (A&E) by West Dunbartonshire residents. In comparison with other partnerships within GGC we had the 3rd highest rate per 1,000 population in 2015/16 and at December 2016 had the 2nd highest rate.

Table 3: A&E Attendance Rates NHSGGC April 2015 to September 2016 (Source: ISD)

	2015/16		April - Dec 2016	
	Attendances	**Rate per 1,000 population**	**Attendances**	**Rate per 1,000 population**
East Dunbartonshire	27070	253.1	20717	193.7
East Renfrewshire	25303	272.3	19432	209.1
Glasgow City	201295	332.0	153141	252.6
Inverclyde	29387	**369.6**	22362	**281.3**
Renfrewshire	56112	321.4	43598	249.8
West Dunbartonshire	28906	322.6	23395	261.1

Figure 9 below shows improving trends for both the proportion of admissions following presentation at A&E and performance against the 4 hour target.

Figure 9: Admissions from A&E and 4 hour target West Dunbartonshire November 2014 to December 2016 (Source: ISD)

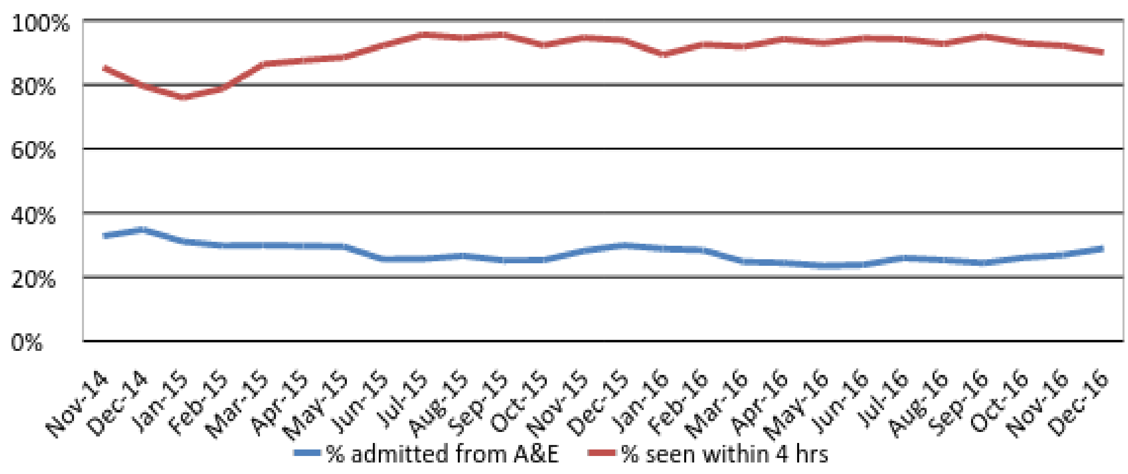
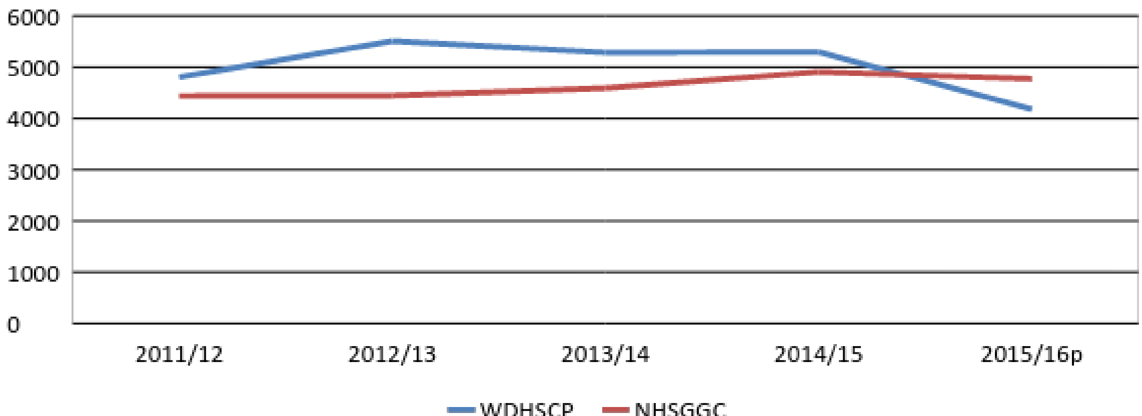


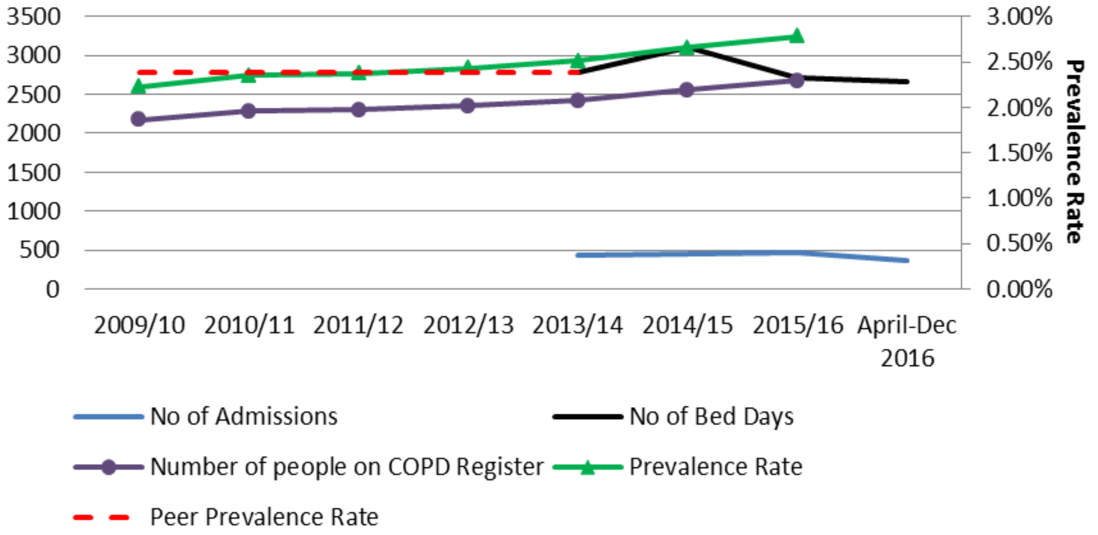
Figure 10 illustrates that there has been a steady decrease in crude rates of multiple emergency admissions among West Dunbartonshire patients aged 85 and over from 2012/13, while there has been an increase across NHS Greater Glasgow and Clyde during the same time period. This is despite the fact that the 85+ population in West Dunbartonshire has increased by 3.4% from 2012 to 2015 (National Records of Scotland Mid-Year Population Estimates). The 85+ population in NHS Greater Glasgow and Clyde has increased by 5.2% over the same period.

Figure 10: Multiple Emergency Admissions (3+) patients aged 85+ yrs: Crude rates per 100,000 (Source: ISD Scotland)



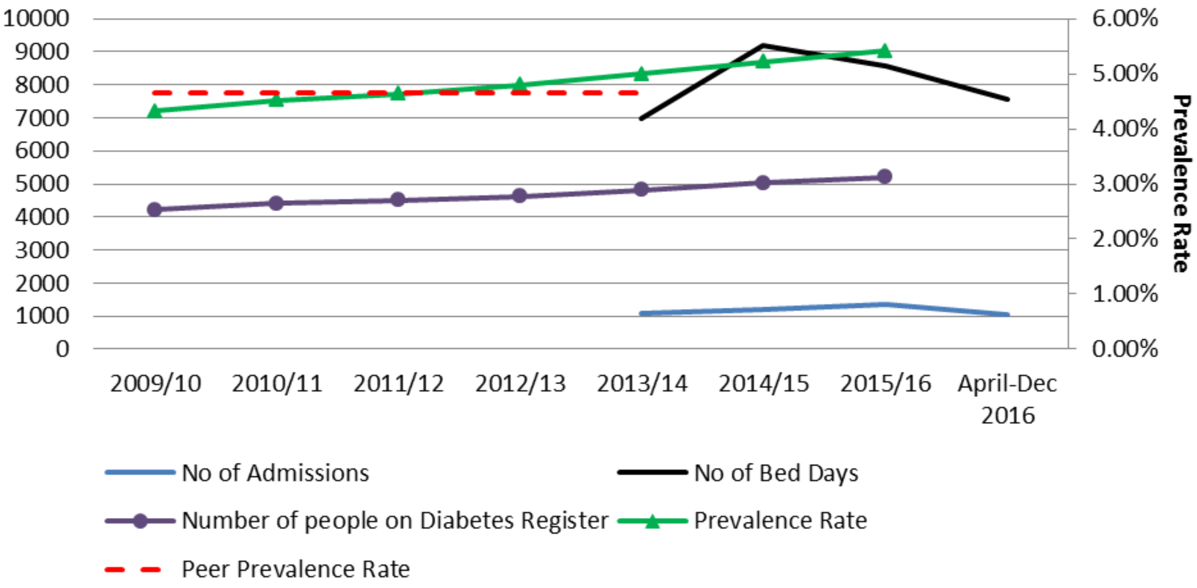
The HSCP COPD programme – which has a focus on do-not-attendees - aligns closely to the more mainstream support provided to patients in the community. A dedicated COPD nursing service is available and managed within district nursing. They provide direct patient support alongside training, advice and support to generic services within care homes and care at home services. Given that West Dunbartonshire has an increasing number of people with COPD - linked to lifestyle and previous employment - continued investment in community approaches is necessary if we are to manage performance around hospital admissions.

Figure 11: COPD Admissions and Bed Days against Prevalence (Source: NSS Discovery and QOF)



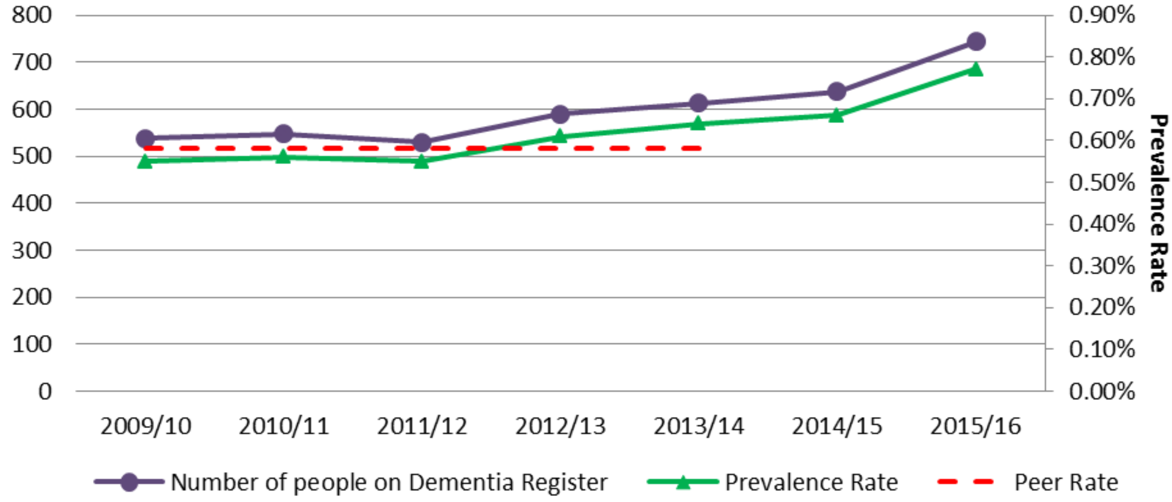
There has been a 23% increase in both the number of people on the COPD register and those on the Diabetes register between 2009/10 and 2015/16. Although we do not yet have full year 2016/17 data, the number of admissions and bed days has stayed fairly static since 2013/14 with a possible decrease particularly in diabetes admissions. This intimates the effectiveness of community interventions with regard to long term conditions, continuing to ensure innovative models of integrated care for people living with multi morbidity and complex care needs.

Figure 12: Diabetes Admissions and Bed Days against Prevalence (Source: NSS Discovery and QOF)



Working as part of the Frailty work stream in our Localities, we will be seeking to ensure that appropriate information to primary care and acute clinicians on assessed need at the point of decision is available (including the options for home based care). In partnership with acute and primary care, we will be seeking to create and implement redirection pathways back to minor injury units, primary care and other community services including community pharmacy. We will work to enable discharge of complex cases, through early identification and tailoring of services for people living with dementia, those requiring aids and adaptations and adults with incapacity (AWI).

Figure 13: Dementia Prevalence Rates (Source: QOF)



Utilising our Local Engagement Networks (which are the HSCP's mechanisms for consultation and engagement) we will continue to work with communities on appropriate use of A&E departments alongside acute colleagues.

17

Delayed Discharges

Figure 14 below details the proportion of bed days lost to delayed discharge. The significant reduction in Qtr2 2016/17 is largely due to the national change in the definition and calculation of delayed discharges

Figure 14: Bed days lost to delayed discharge as a proportion of all non-elective bed days West Dunbartonshire HSCP April 2015 – December 2016 (Source: ISD)

Q1 2015/16 Q2 2015/16 Q3 2015/16 Q4 2015/16 Q1 2016/17 Q2 2016/17 Q3 2016/17

Unscheduled bed days
Bed days lost to delayed discharge
% of non-elective bed days due to delayed discharge

Based on a matrix of community health and social care interventions in West Dunbartonshire there is a demonstrable decrease in bed days lost and in the numbers of delayed discharges as outlined in Figure 15 below.

Figure 15: Number of acute bed days lost to delayed discharges 65+ April 2014 – December 2016 including Adults with Incapacity (AWI) (Source: NHS GG&C)

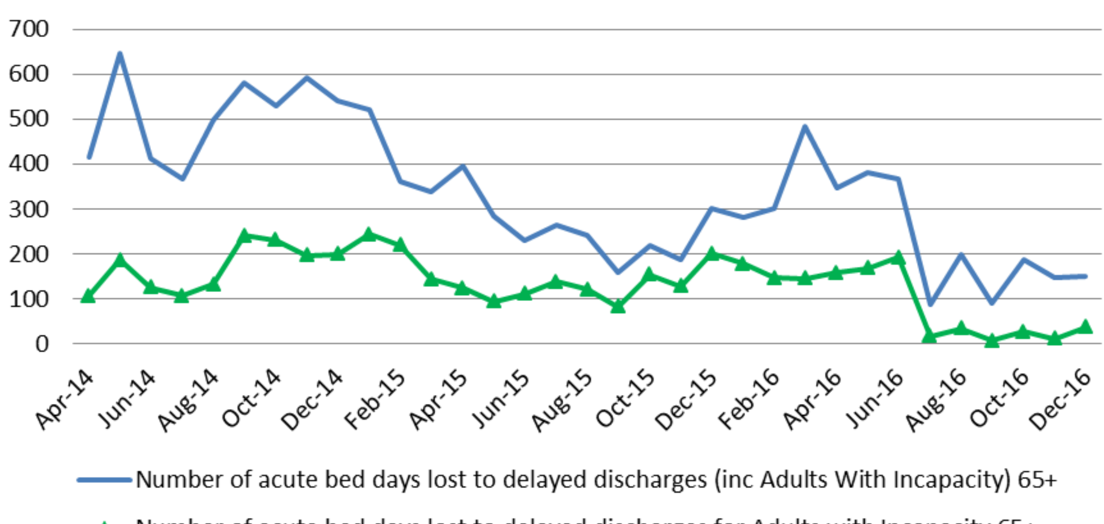
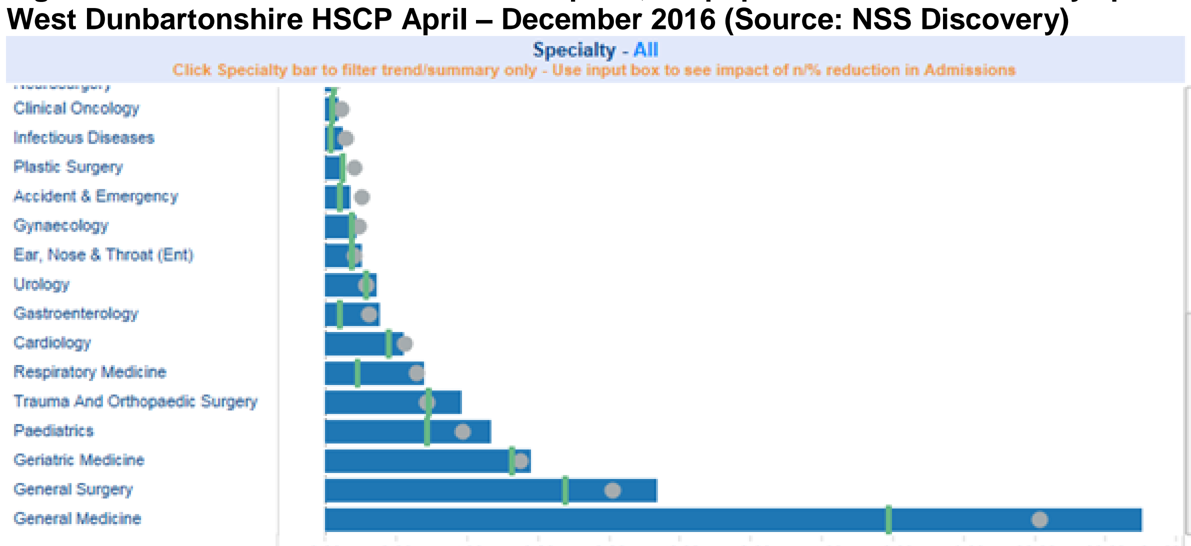


Figure 16 below gives a breakdown of the destination following admission as a rate per 1,000 population for the non-elective admissions in April – December 2016.

Figure 16: Non-elective admissions rate per 1,000 population – destination by specialty West Dunbartonshire HSCP April – December 2016 (Source: NSS Discovery)



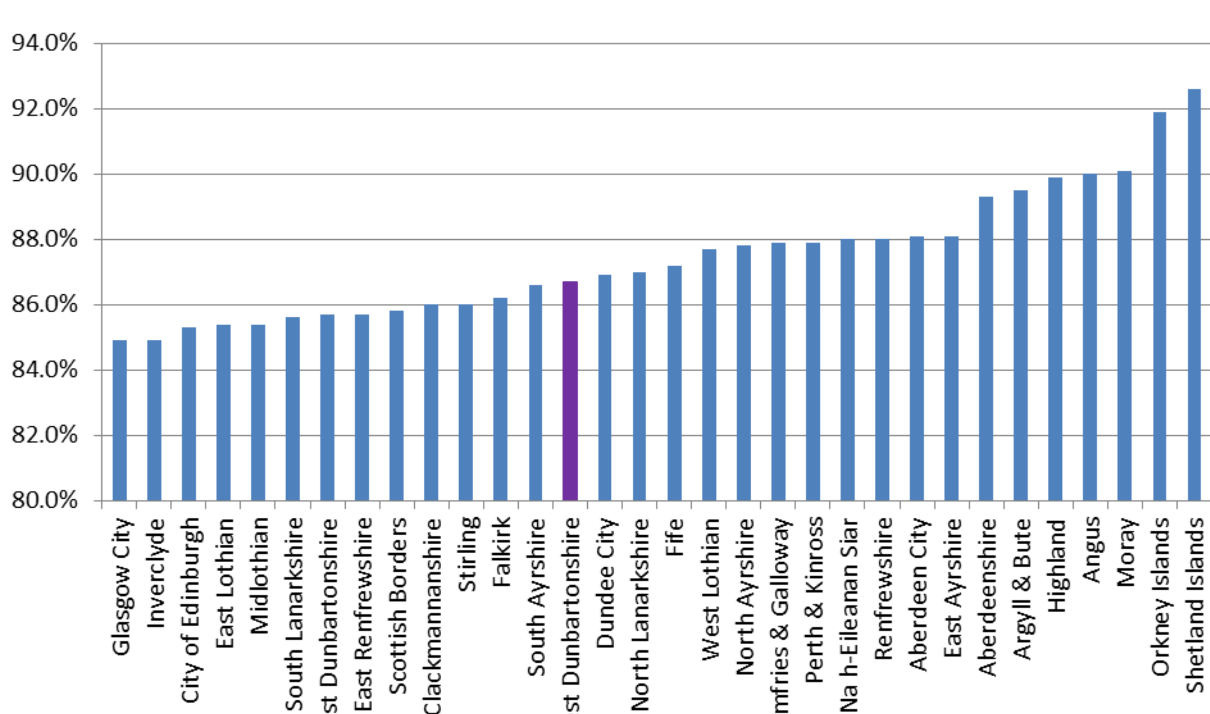
With the delivery of an Early Assessors programme where practitioners are now attached to discharging wards across GGC, we are able to begin the management of individuals' discharge at the point of admission; and as such aim to avoid unnecessary re-admission. There are no delays for care at home services for those coming out of hospital and a reorganisation of community services has supported more flexibility for timings of hospital discharges to home; as stated earlier the already integrated community services ensure a streamlined pathway for acute services supporting fewer delays for the patient. Our prescribing team, through a dedicated Care at Home Pharmacy service will continue to support improved compliance with medicines for older people, supporting discharge and reducing risk of re-admission.

There is continued work with NHS primary care contractors to expand and develop their role within communities. This is alongside sustained capacity building with the third sector to provide community based supports; as well as specific and targeted support to carers; and a continuous improvement programme with the independent sector to guarantee robust quality assurance and care governance across the whole sector. An already agreed West Dunbartonshire Housing Contribution Statement provides the framework for appropriate and sustainable housing options for those at risk of unnecessary hospital admission, at the point of discharge or at risk of re-admission.

End of Life Care

Figure 17 shows data from ISD Scotland on Quality Outcome Measure 10 – the percentage of the last six months of life spent at home or in a community setting by health board. This measure is used to chart progress made by boards towards implementation of the national "Living and Dying Well action plan".

Figure 17: Quality outcome measure 10: Percentage of last six months of life spent at home or in a community setting by HSCP 2015/16 (Source: ISD)



This particular measure was chosen as a proxy for the preferred place of death as no data are recorded for the latter. It should be noted that this is a broad measure that includes people who died from causes that may not have required palliative care services (e.g. heart attacks). However, patients who died from external causes (e.g. unintentional injuries) were excluded.

The figure shows that there is variation by HSCP in this measure. West Dunbartonshire has the 19th lowest percentage of time spent at home or in a community setting in the last six months of life across Scotland but the second highest percentage when compared to HSCPs within the GGC area. This measure is crude and does not include any correction for demographic differences.

This information can be used to make an estimate of the potential reduction in bed days (Table 4 overleaf) and beds that could occur if West Dunbartonshire HSCP were to reduce inpatient hospital stays towards the end of life, for example, by increasing community palliative care services.

20

Table 4: Estimate of potential reduction in bed days: West Dunbartonshire HSCP compared with Renfrewshire (Best performing in GGC)

Number of deaths in West Dunbartonshire 2015 (Source: NRS) (Less external causes of death in line with ISD calculations)	1,056
Total bed days in hospital in the 6 months prior to death for those people who died within 2015/16	25,631
Total possible bed days (if all people who died spent all of final 6 months of life in hospital)	192,720
Average % of time spent in hospital in last 6 months of life in West Dunbartonshire 2015/16	13.3%
Average % of time spent in hospital in last 6 months of life in Renfrewshire 2015/16	12%
If % in West Dunbartonshire was the same as in Renfrewshire	
Potential reduction in bed days in hospital in the 6 months prior to death	2,505
Potential reduction in beds (adjusted for an 85% occupancy rate)	8

The calculation outlined above was carried out by multiplying the percentage of time spent in hospital seen in Renfrewshire HSCP with the total possible bed days seen in West Dunbartonshire HSCP to calculate the number of bed days that would have theoretically been used in West Dunbartonshire. This was then subtracted from the number of bed days that were actually used in West Dunbartonshire. We estimate that 2,505 bed days and 8 beds could be reduced over a year period.

As previously stated, integrated community services are supported by specialists, and end of life care is no exception. District nursing services and care at home services provide integrated services both in hours and out of hours; providing ongoing care as well as emergency care and respite care within the community, in partnership with GPs, to avoid unnecessary admissions to acute. Additionally palliative care specialists provide training, support and advice to care homes to support people with dying well at home or in a homely setting.

Table 5 shows estimated numbers of in-patient beds accounted for by admissions from Care Homes. In the year 2015, there were 3,421 emergency admissions to hospital of patients resident in care homes across NHSGGC. These patients accounted for 31,951 occupied in-patient bed-days. Assuming an average occupancy level of 85%, for West Dunbartonshire HSCP this would correspond to approximately 7.5 in-patient beds. In addition to support from palliative care specialists, our Prescribing Support Team will continue to provide medicines training, support and advice to care home and care at home services to reduce avoidable admissions to acute services.

Table 5: Estimated numbers of in-patient beds accounted for by admissions from Care Homes

Partnership	Calculated Beds
East Dunbartonshire	9.0
North East Glasgow	21.9
North West Glasgow	22.7
South Glasgow	18.3
West Dunbartonshire	7.5
East Renfrewshire	6.3
Renfrewshire	11.1
Inverclyde	6.1
Total	**103**

Acute services will be seeking to establish a consistent system in place whereby HSCPs are given early notice by Acute Services of patients who require end of life care; thus supporting improved earlier identification of patients who require end of life care within the community. This should allow community services to deliver effective palliative care in the community and ensure appropriate communication with acute and GPs. This will include access to community based rehabilitation and step up/step down services and access support from acute service geriatricians.

22

Commissioning Unscheduled Care

The King's Fund – in their report *Transforming our Health Care System* – recognised that although the impact could be highly positive, redesigning the urgent and emergency care system is likely to be highly challenging. That report then suggested that specific actions for commissioners could include:

- Providing effective signposting to help patients choose the right service.
- Ensuring that hospital and community services can adjust service levels in response to changes in demand, so that need and provision are kept in balance.
- Ensuring that A&E departments adopt best practice for handling 'majors' including early senior review.
- Ensuring that hospitals and local authority social service and housing departments work effectively together to reduce delayed discharges and shorten lengths of stay.
- Mapping and analysing patient flows around the system to identify bottlenecks and the scope for changing pathways to reduce the use of hospitals and to ensure that there is sufficient capacity across the health and social care system.

This document then seeks to build on the body of work undertaken to-date by the HSCP and NHSGGC's Acute Division, and set out the Partnership Board's commissioning objectives to improve unscheduled care for residents of West Dunbartonshire**. At its heart is a commitment to invest, redesign and deliver an effective infrastructure of community services**. In doing this, this document sets out initial commissioning directions for NHSGGC and its Acute Division; and a proposed improvement agenda for primary care, both of which emphasise the expectations to realise realistic medicine. Crucially, it is predicated on the understanding that the detailed development and then implementation of said objectives will require collaboration, engagement and professional leadership – both within West Dunbartonshire and across NHSGGC.

NHSGGC has created the Unscheduled Care Collaborative to respond to the agreed need for a 'whole system' approach, which is led by its Acute Division; and includes engagement with colleagues in Primary Care and the Scottish Ambulance Service. This programme of clinically led improvement work is being progressed but has already identified a number of interim recommendations for immediate consideration and for action during 2017, the adoption of which would be supported by this document, i.e.:

- Medical capacity should be realigned to reflect patient demand in both the receiving areas and across the hospital system.
- Options to improve Assessment Unit same day discharge efficiency should be progressed to reduce performance variation and avoid unnecessary short stay admissions.
- Improvement projects undertaken within various Sectors as 'tests of change' should be rolled out as part of a Board wide work programme over the next 12 months.

Once the work programme is completed, the expectation is that the Acute Division will engage with the GGC partnerships to consider the final findings and recommendations.

23

In accordance with Scottish Government's emerging indications with regards to measuring the impact of health and social care integration, this document is then setting out the commissioning objectives for the Partnership Board in respect of acute - and particularly unscheduled - care with regards to the following inter-connected themes:

- Communication.
- Unplanned admissions.
- Occupied bed days for unscheduled care
- A&E performance.
- Delayed discharges.
- End of life care.
- Balance of spend across institutional and community services.

(1) COMMUNICATION - Key Commissioning Objectives

HSCP Led	Primary Care Led	Acute Services Led
• Provide easy access to enhanced community services to avoid admission and encourage early discharge. • Maintain delayed discharges at a low level and ensure Adults With Incapacity (AWI) pathway enables timely and appropriate discharge from acute. • Provide robust and enhanced community services to enable higher acuity patients and those in need of Palliative Care to be managed at home or in a community setting. • Ensure e-KIS is used to provide information on available services and access.	• Create opportunities for clinical conversations pre-admission and at the point of discharge. • Ensure Anticipatory Care Plans (ACPs) are comprehensive and information is provided for Scottish Ambulance Service (SAS) and acute physicians as well as enhanced community services using e-KIS.	• Establish mechanisms whereby GPs can access advice from senior acute medical staff pre-admission relating to the need for admission and/or options other than admission. • HSCPs and acute services will identify a scoring matrix for identifying patients at risk of unnecessary admission. • Establish a consistent system whereby HSCPs are alerted by acute services, at the point of admission, of all patients already identified as at risk of unnecessary admission.

(2) UNPLANNED ADMISSIONS - Key Commissioning Objectives

HSCP Led	Primary Care Led	Acute Led
• Establish integrated and community-based Immediate Care Teams to work with GPs, managing patients for whom an admission would otherwise be needed. • To establish joint acute/community/SAS systems to monitor and audit the use of e-KIS • Ensure that access to community services is enabled following ACP and that services are comprehensive and include nursing, care at home, respite, pharmacy support and rehab, palliative care, specialist nursing support. • Offer individuals who do not attend COPD appointments to manage their condition remotely using TEC equipment.	• Establish integrated and community-based Immediate Care Teams (nursing and home care) to work with GPs. • Ensure that individuals with a frailty index have an ACP in place and recorded on e-KIS. • Continue to develop self-management programmes for patients with long term conditions such as COPD. • Primary Care works collaboratively to identify and manage frail older patients. • Work with GP Clusters to assess and address variation between GP practices.	• HSCPs and acute services will identify a joint scoring matrix for identifying patients at risk of unnecessary admission. • Establish GP access to a range of options for patients at the point of pre-admission, for example urgent next day outpatient appointment by speciality and direct access to diagnostics. • Review and optimise admissions pathways across acute sites with a view to reduce inappropriate variation.
3rd Sector Interface led		

- Delivery of Dementia Friendly West Dunbartonshire

(3) OCCUPIED BED DAYS - Key Commissioning Objectives

HSCP Led	Primary Care Led	Acute Led
• Target support to nursing homes with a focus on reducing demand on primary care, reduce admissions to acute care, deaths in hospital, and ensure demand for out of hours services is appropriate. • Expand hospital discharge services to enable the discharge of more complex cases.	• Increase GP awareness of options in the community for care at home. • Review practice arrangements for urgent and house calls which may lead to inappropriate peaks in SAS call outs and hospital attendance or admission	• Demonstrate progress in working towards delivering the externally benchmarked upper quartile length of stay across all sites and specialties. • Optimise discharge processes across all sites and specialties to create an earlier in the day discharge profile and increase weekend discharges.

25

(4) ACCIDENT AND EMERGENCY - Key Commissioning Objectives

HSCP Led	Primary Care Led	Acute Led
• Ensure appropriate information on assessed need at the point of decision is available including the options for home based care. • Continue to work with communities on appropriate use of A&E. • Work with ISD to identify those who regularly attend A&E and their profile, especially those with a care package >£50k.	• Agree a process for seeing redirected patients with GP Clusters and/or LMC [via NHSGGC Primary Care Support] • Establish a process whereby GPs are able to access agreed imaging investigations to support diagnosis and decision-making.	• Create and implement redirection pathways back to minor injury units and primary care. • Review the balance of staffing in A&E departments to ensure that frail older patients have speedy access to appropriate clinical support and imaging and investigations. • Establish a process whereby GPs are able to access agreed imaging investigations to support diagnosis and decision-making.

(5) DELAYED DISCHARGES - Key Commissioning Objectives

HSCP Led	Primary Care Led	Acute Led
• Further strengthen communication between acute and primary care/community teams to support acute consultants and families with discharge planning. • Effective medicines management at point of admission and discharge. • Offer individuals coming out of hospital the opportunity to benefit from a clearer assessment of their needs by using TEC equipment.	• Further strengthen communication between acute and primary care/community teams to support acute consultants and families with discharge planning. • Effective medicines management at point of admission and discharge	• Establish a system whereby community staff, SAS and acute clinicians routinely use anticipatory care plans and the summary recorded on e-KIS as part of assessment process to avoid admission and to expedite discharge. • Strengthen discharge planning between acute discharge planning and community hospital teams including rehabilitation communication.

3rd Sector Interface led	Housing Led
Delivery of Link Up staffed by older people volunteers.	• People with particular needs have access to suitable housing with support to optimise independence and wellbeing.

(6) END OF LIFE CARE - Key Commissioning Objectives

<u>HSCP Led</u>

- Deliver effective palliative care in the community and ensure appropriate communication with Acute and General Practice.
- Provide appropriate home based care to patients and families.
- Improving care in nursing homes and reducing referrals for assessment and enabling early discharge.

<u>Primary Care Led</u>

- Improve earlier identification of patients who require end-of-life care whilst in community

<u>Acute Led</u>

- Establish a consistent system in place whereby HSCPs are given early notice by acute services of patients who require end of life care.

<u>3rd Sector Interface led</u>

- Delivery of Palliative Care Befriending Service
- Delivery of Palliative Care Friendly West Dunbartonshire approach

(7) BALANCE OF SPEND ACROSS INSTITUTIONAL AND COMMUNITY SETTINGS

Table 6 provides the estimated expenditure in A&E Departments across all NHSGGC acute sites on attendees from West Dunbartonshire

Table 6: A&E Attendances by WD residents at NHSGGC A&E Departments and Minor Injury Units (Patients Aged 18 and over) 2014/15 (Source: ISD)

VOL	IRH	RAH	GRI	STOB	VIC	SGH	RHSC	WIG	TOTAL	Direct Cost
8511	59	4348	505	70	167	817	2	9010	23489	**£2,251,406**

Table 7 provides estimated costs for West Dunbartonshire HSCP consumed bed days per specialty in 2015/16. Since this data has been derived from the 2015/16 linked analysis file, the costs are provisional, as they have been mapped from the 2014/15 Costs Book. The actual costs may be different when the 2015/16 Costs Book has been published, and mapped to the 2015/16 activity.

Table 7: Cost per bed day by specialty – West Dunbartonshire HSCP 2015/16 (Source: ISD IRF)

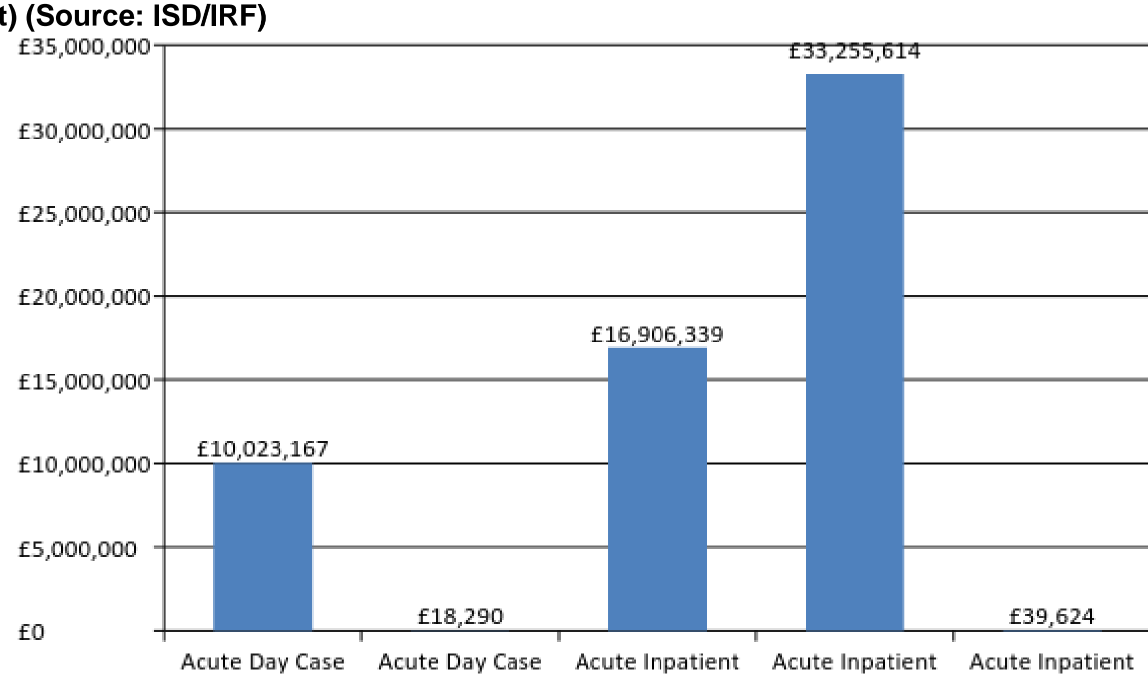
Speciality	Cost per bed day
Learning Disability	£3,143.61
Diabetes	£1,911.91
Ear, Nose & Throat	£1,507.68
Plastic Surgery	£1,358.70
Neurology	£1,160.63
Orthopaedics	£888.89
Urology	£705.79
General Surgery	£659.77
General Surgery (ex. Vascular)	£638.02
Gastroenterology	£624.14
Endocrinology	£505.50
General Medicine	£422.09
Dermatology	£419.62
Nephrology	£405.50
Rehabilitation Medicine	£330.80
Geriatric Medicine	£288.55
Psychiatry of Old Age	£254.49
General Psychiatry	£247.91

West Dunbartonshire's current performance suggests that whilst progress is being made there continue to be challenges for partnerships and acute services alike to continue to decrease presentations at A&E departments and unnecessary admissions to hospital. The approach moving forward will be to continue to develop local and GGC wide initiatives based on performance and evidence from across the system including the "small tests of change" being undertaken by the Unscheduled Care Collaborative.

In order to provide more timely activity and costs information to support capacity planning, information available has been expanded to also include activity and estimated costs for 2015/16. It should be noted these costs are purely an estimate and it is therefore important the methodology and caveats below are considered when using this information.

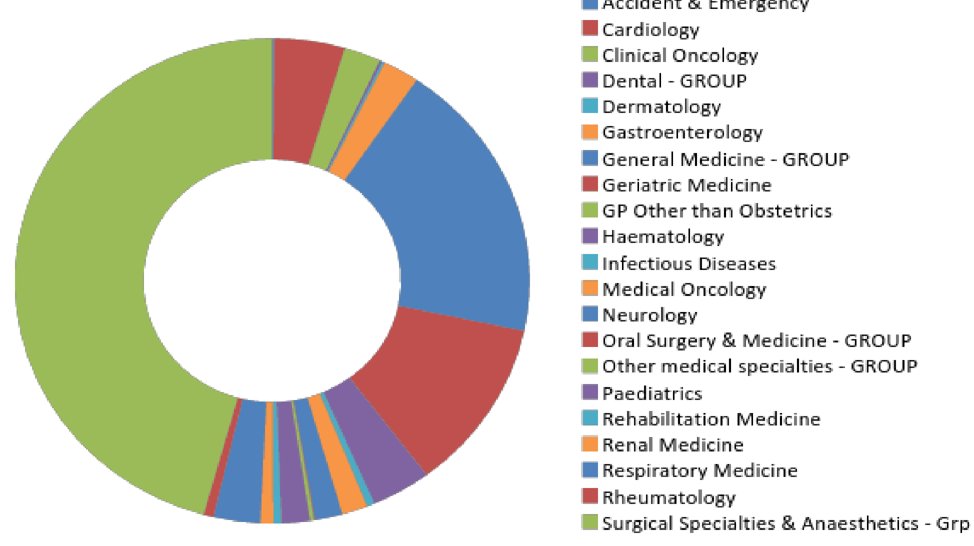
28

Figure 18: 2015/16 West Dunbartonshire HSCP Acute Activity - Estimated 'Live' Costs (Net) (Source: ISD/IRF)



Derived costs have been estimated for 2015/16 by applying inflated (by 1%) 2014/15 site and line number specific unit costs (e.g. nursing cost per day; overheads proportion) to the more recent activity.

Figure 19: 2015/16 West Dunbartonshire HSCP Acute Activity - Estimated 'Live' Costs by Specialty (Net) (Source: IRF/ISD)



Using available estimated information, and within the current commissioning parameters, following indicative attributable costs have been estimated based on current service modelling; current levels of activities and current levels of spend attributed to West Dunbartonshire; and existing data (reflected earlier within this paper). However, it should be noted that these figures continue to be estimates based on the

current cost book; and, importantly, do not account for variations in demographic profile. As such, they are included here for illustrative purposes.

Table 8: Bed Days Lost to Delayed Discharge (Source: ISD)

Bed Days Lost to Delayed Discharge 2015/16 - Standard Delays	Bed Days Lost	18+ pop	Bed Days Lost Rate per 1,000 pop(18+)	Reduction in Bed Days Lost	Cost per Bed Day	Annual Cost	Beds released	Equivalent cost
West Dunbartonshire	2236	71878	31.1					
East Renfrewshire	1682	72062	23.3					
If West Dunbartonshire reduced to East Renfrewshire's rate	1675	71878	23.3	561	£422.09	£236,792	1	£130,848
Best performing in Scotland: Renfrewshire	2216	140747	15.7					
If West Dunbartonshire reduced to Renfrewshire's rate	1128	71878	15.7	1108	£422.09	£467,676	3	£392,544
Bed Days Lost to Delayed Discharge 2015/16 - Code 9s	Bed Days Lost	18+ pop	Bed Days Lost Rate per 1,000 pop(18+)	Reduction in Bed Days Lost	Cost per Bed Day	Annual Cost	Beds released	Equivalent Cost
West Dunbartonshire	2596	71878	36.1					
Renfrewshire	3883	140747	27.6					
If West Dunbartonshire reduced to Renfrewshire's rate	1984	71878	27.6	612	£422.09	£258,319	1	£130,848
East Dunbartonshire	868	85740	10.1					
If West Dunbartonshire reduced to East Dunbartonshire's rate	726	71878	10.1	1870	£422.09	£789,308	6	£785,087
East Renfrewshire	684	72062	9.5					
If West Dunbartonshire reduced to East Renfrewshire's rate	683	71878	9.5	1913	£422.09	£807,458	6	£785,087
Best performing in Scotland: Inverclyde	506	64741	7.8					
If West Dunbartonshire reduced to Inverclyde's rate	561	71878	7.8	2035	£422.09	£858,953	6	£785,087

- Cost per Bed Day - IRF 2015/16 General Medicine bed West Dunbartonshire HSCP based on 2014/15 Cost Book
- Annual Cost - Based on Actual Bed Day reduction
- Beds released - Based on 85% occupancy (310 bed days annually)
- Equivalent Cost - Based on 85% occupancy

Again it must be noted that these are estimated costs and may vary from actual costs - as more detailed budgetary information becomes available these figures can be reviewed and refreshed. However the variance is likely to be greatest where:

- There is a material difference between Costs Book unit costs in the later years and those for 2014/15.
- Misalignments exist between Scottish Morbidity Records (SMR) activity data and the Costs Book activity (e.g. for mental health specialties for some sites).

Delays are classed as Code 9s in those circumstances:

- Where the patient lacks capacity, is going through a Guardianship process, and for whom the use of S13za of the Social Work (Scotland) Act 1968 is not possible.
- Where the patient is delayed awaiting availability of a place in a specialist facility, where no facilities exist and an interim move would not be appropriate (i.e. no other suitable facility available).
- For those patients for whom an interim move is not possible or reasonable.

Table 9 details emergency admissions and the conditions being managed within an acute setting for West Dunbartonshire residents during 2015/16 with estimated costs based on the 2014/15 cost book. These admissions equate to almost £8.5 million and 19,629 bed days.

Table 9: Emergency Admissions West Dunbartonshire residents 2015/16 (Source: ISD)

Main diagnosis being managed	Occupied Bed Days	Cost per Bed Day	Total Cost
Pneumonia	3,076	£437.43	£1,345,545.52
Cerebrovascular diseases	3,096	£370.86	£1,148,191.55
Other diseases of the urinary system	2,798	£379.40	£1,061,558.66
Chronic obstructive pulmonary disease	2,684	£382.70	£1,027,166.91
Other acute lower respiratory infections	2,016	£448.40	£903,968.45
Other diseases of the nervous system	1,521	£573.00	£871,527.79
Acute myocardial infarction	1,290	£592.68	£764,551.52
Other diseases of the respiratory system	1,704	£421.82	£718,786.34
Heart failure	1,444	£426.96	£616,526.67

There is a small amount of variation in costs per bed day across sites detailed overleaf for the three disease groups of particular interest to this process.

Table 10: Emergency Admissions West Dunbartonshire residents by site 2015/16 (Source: ISD)

Main diagnosis being managed	Vale of Leven	Royal Alexandra	Glasgow Royal	Queen Elizabeth University	West Glasgow
Diseases of the respiratory system	£428.46	£470.37	£357.65	£444.25	£299.35
Diseases of the circulatory system	£396.87	£426.37	£454.66	£463.91	£327.18
Diseases of the nervous system	£428.46	£456.06	£410.69	£636.83	£353.51

We are exploring a percentage target of reduction in the overall set aside budget in 2017/18, thereby delivering significant savings and potential redirection to the HSCP. It is likely that this will require a reduction in acute inpatient beds across a number of hospital sites – as articulated within the NHSGGC Transforming Delivery of Acute Services Programme and as the programme's impacts are realised. The bed calculations in the section above are HSCP planning assumptions that require testing and modelling as part of the wider NHSGGC whole system approach.

Key Commissioning Objectives

HSCP Led	Primary Care Led	Acute Led
• Agree a way of working between acute sites and all six HSCP community services, using a proportion of set aside budget to support development of interface services out-with acute sites. • To appropriately invest, develop and redesign community based services.	• Provide support to community based services to optimise the management of patients in the community.	• Agree a way of working between acute sites and all six HSCP community services through which a proportion of set aside budgets is used to support development of interface services out-with acute sites. • Acute services to review and ensure effective medicines management at point of admission and discharge. • Demonstrate progress in working towards delivering the externally benchmarked upper quartile length of stay across all sites and specialties.

3rd Sector Interface led

- Seek to maximise monies to community third sector organisations by levering in external funding sources.

Delivering Performance under Integration

There is a need for each of the partnerships within Greater Glasgow and Clyde to develop joint commissioning intentions across the system; this approach will require effective joint planning with the Acute Services Division. Proposals will need to be agreed before subsequent presentation and agreement by each HSCP Integrated Joint Board. As has been stated previously in this paper, there is a commitment and an appetite for more joined up initiatives. Emerging areas for a collective across all the partnerships and acute services are:

- Management of frailty and associated conditions including falls management.
- Management of COPD and response to exacerbations.
- Management of nursing homes beds.
- Delivery of step up/step down supports and intermediate care.
- Delivery of integrated ACP processes.

The development of this approach will require collaboration between the Acute Division and each of the local partnerships; whilst acknowledging the range of delivery models within each partnership area and the organisation of local services and agreed Locality priorities. Moreover, shared and agreed outcomes will need to reflect the financial planning in each partnership as well as across the system; including shifts in resources between shared parts of the system and identifiable needs and demands with specific partnership areas.

There is a requirement for a clear and transparent reporting system linked to performance; to ensure that impacts and results can be appropriately reported, measured and delivered to meet the priorities of the Scottish Government as described earlier. Work is on-going across NHSGGC to confirm differential targets for different partnerships with respect to the following indicators:

- Reduction in the number of unplanned admissions (percentage).
- Reduction in the number of occupied bed days for unscheduled care (percentage).
- Reduction in the rates of attendance at A&E (percentage).
- Reduction in the number of delayed discharges delayed more than 3 days to 0 for non-complex[1] codes.
- Reduction in the number of delayed discharges (all codes).
- Increase the proportion of people dying at home or in a homely setting (percentage).

Once that work has been completed, the proposed targets in relation to this commissioning document will be presented to the Partnership Board for approval. Thereafter, the Partnership Board will be kept appraised of progress and developments; and those targets will be explicit within the routine public performance reporting presented to and scrutinised by the Partnership Board.

---

[1] Standard delays (excluding Code 9s).

Appendix 1 – Summary of Commissioning Directions for NHSGGC Acute Services

- Implement initial recommendations of Unscheduled Care Collaborative clinically led improvement work; and engage with Partnership Board on final findings and recommendations.
- Establish mechanisms whereby GPs can access advice from senior acute medical staff pre-admission relating to the need for admission and/or options other than admission (e.g. potential hot clinics).
- Establish a consistent system whereby HSCPs are alerted by acute services, at the point of admission, of all patients already identified as at risk of unnecessary admission.
- HSCPs and acute services will identify a joint scoring matrix for identifying patients at risk of unnecessary admission.
- Establish GP access to a range of options for patients at the point of pre-admission, for example urgent next day outpatient appointment by speciality and direct access to diagnostics.
- Review and optimise admissions pathways across acute sites with a view to reduce inappropriate variation.
- Acute Services to demonstrate progress in working towards delivering the externally benchmarked upper quartile length of stay across all sites and specialties.
- Optimise discharge processes across all sites and specialties to create an earlier in the day discharge profile and increase weekend discharges.
- Create and implement redirection pathway back to minor injury units and primary care.
- Review the balance of staffing in A&E departments to ensure that frail older patients have speedy access to appropriate clinical support and imaging and investigations.
- Establish a process whereby GPs are able to access agreed imaging investigations to support diagnosis and decision-making.
- Establish a system whereby community staff, Scottish Ambulance Service and acute clinicians routinely use anticipatory care plans and the summary recorded on e-KIS as part of assessment process to avoid admission and to expedite discharge.
- Strengthen discharge planning between acute discharge planning and community hospital teams including rehabilitation communication.
- Establish a consistent system in place whereby HSCPs are given early notice by acute services of patients who require end of life care.
- Acute services to review and ensure effective medicines management at point of admission and discharge.
- Agree a way of working between acute sites and all six HSCP community services through which a proportion of set aside budgets is used to support development of interface services out-with acute sites.

Appendix 2

Scottish Government
Riaghaltas na h-Alba
gov.scot

Health and Social Care Integration Directorate
Geoff Huggins, Director
T: 0131-244 3210
E: geoff.huggins@gov.scot

COSLA
Paula McLeay, Chief Officer Health and Social Care
T: 0131-474 9257
E: paula@cosla.gov.uk

To: Chief Officers – Integration Authorities

19 January 2017

Dear Colleagues

MEASURING PERFORMANCE UNDER INTEGRATION

The Ministerial Strategic Group for Health and Community Care (MSG) discussed how to measure progress under integration at its meetings on 16 November and 21 December.

At the meeting on 21 December MSG agreed that for 2017/18 we will track across Integration Authorities:

(1) unplanned admissions;
(2) occupied bed days for unscheduled care;
(3) A&E performance;
(4) delayed discharges;
(5) end of life care; and
(6) the balance of spend across institutional and community services.

You are each invited to set out your local objectives for each of the indicators for 2017/18 by the end of February. MSG has agreed that it will receive a quarterly overview on progress across the whole system and you are asked to produce your objectives on that basis. We are meeting with the Executive Group of Chief Officers on Friday and will discuss what national support you would want us to offer for this process. Our objective will be to adapt and use existing data collection methodologies where possible and to establish a clear process for the work.

When we met on 16 December we had indicated that as a minimum we would provide data for each partnership covering each of the indicators. The data would show the position for all partnerships to enable individual Integration Authorities to understand the shape and

nature of their service relative to others. We are still working on the structure and format of that data. For now, we attach high level data covering a number of the areas (**Annex A**). Again we would intend to use the conversation on Friday to discuss the structure and format of the data with the intention of writing shortly after to all Chief Officers with the necessary material.

MSG noted that the approach for future years may change as a consequence of the Review into Targets and Indicators being undertaken by Sir Harry Burns and also as data sources for particular areas of service delivery improvement. It also noted that most key service delivery areas under integration have a direct impact on these higher level system indicators. In particular, it is important that we are able to understand both the contribution of social care and primary care services to these higher level system indicators, but also how they support important outcomes in respect of independent living and the protection and maintenance of health.

Local partnerships are already using a wide range of data to support their commissioning and delivery activity and will continue to operate under the duties in the 2014 Act in respect of public reporting. This process is not intended to duplicate or substitute for that process.

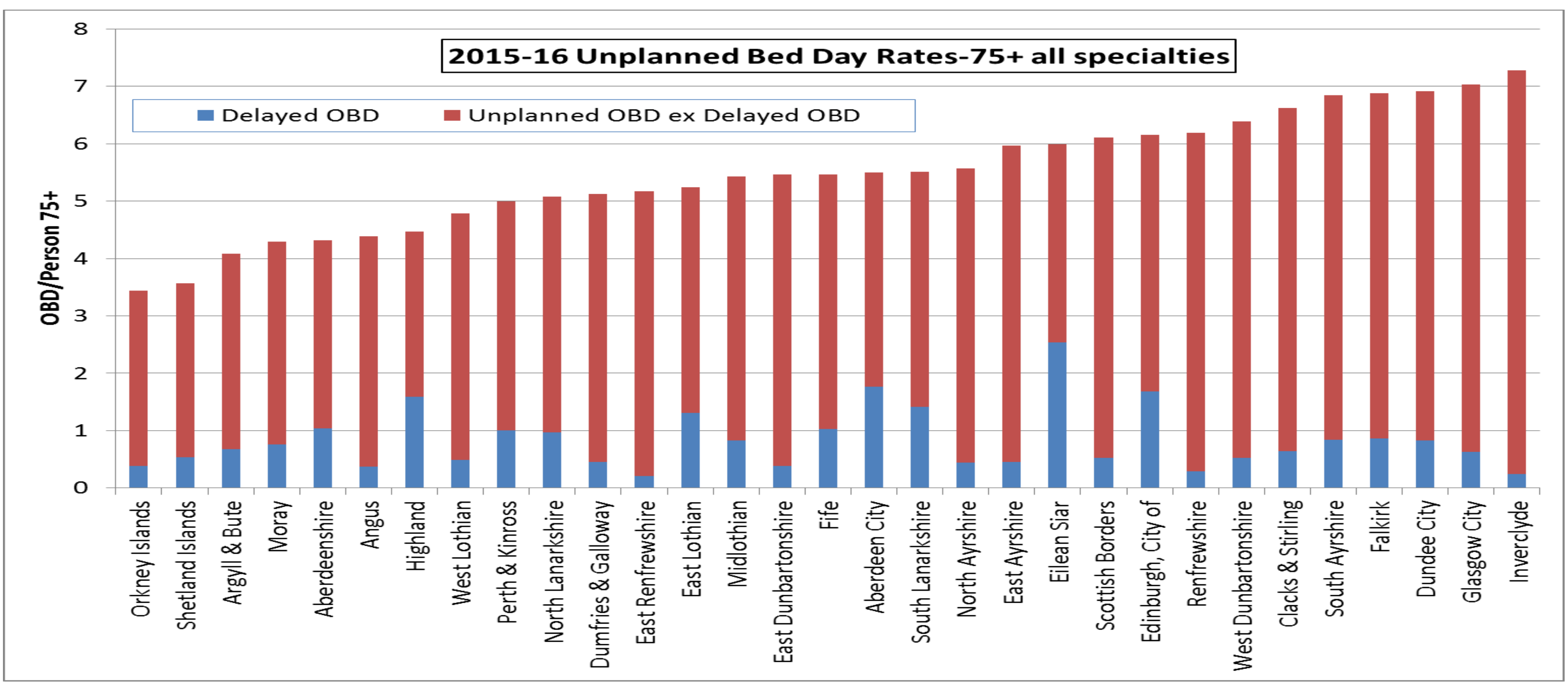
The Local Delivery Plan (LDP) Guidance for 2017/18 has been issued to NHS Chief Executives and sets the expectation that Boards and regional planning partnerships ensure that their objectives and plans are consistent with Integration Authority plans. Similarly, given the interaction with the hospital system you will need to ensure that your objectives and plans are consistent with NHS Board and regional plans for 2017/18.

Yours sincerely

GEOFF HUGGINS
Scottish Government

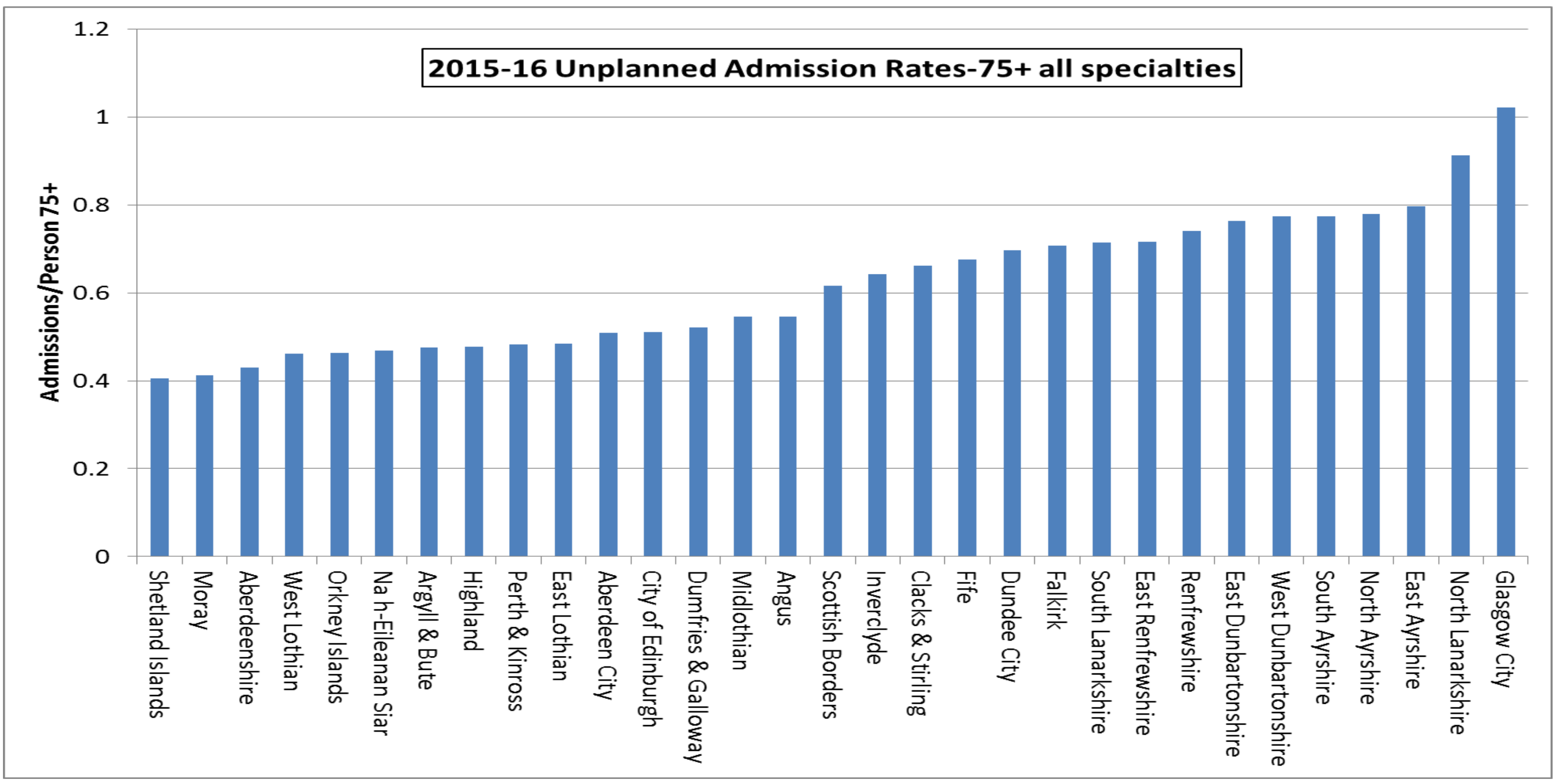
PAULA McLEAY
COSLA

Unplanned Bed Days



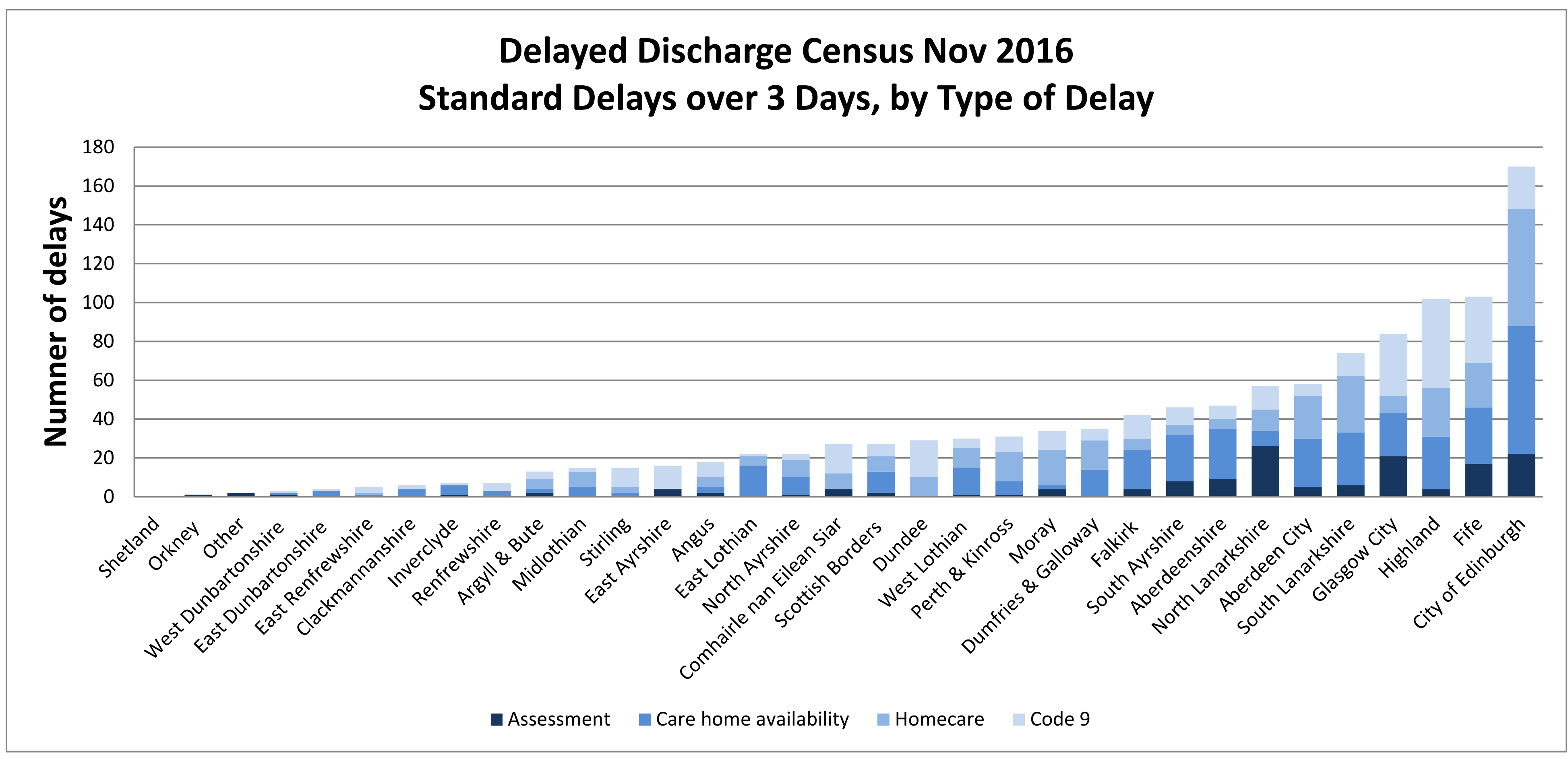
Notes: This chart shows the unplanned bed days per capita for people aged 75+ for each partnership (in 2015/16). It is for unplanned bed days in all specialties and differentiates between the bed days used by delayed patients and other non-delayed bed days. A total of 2.5m bed days were used by people age 75+ of which 400k were by delayed patients, an average of 16% of the total bed days for this age group and varying across partnerships from 3.4% to 42%. There is a two-fold variation in the overall bed day rates across partnerships and a 12 fold variation in delayed bed day rates. There is no association between delayed bed day rates and overall bed day rates. We can develop this analysis to include other age groups and to differentiate between specialties and type of delay.

Unplanned admissions



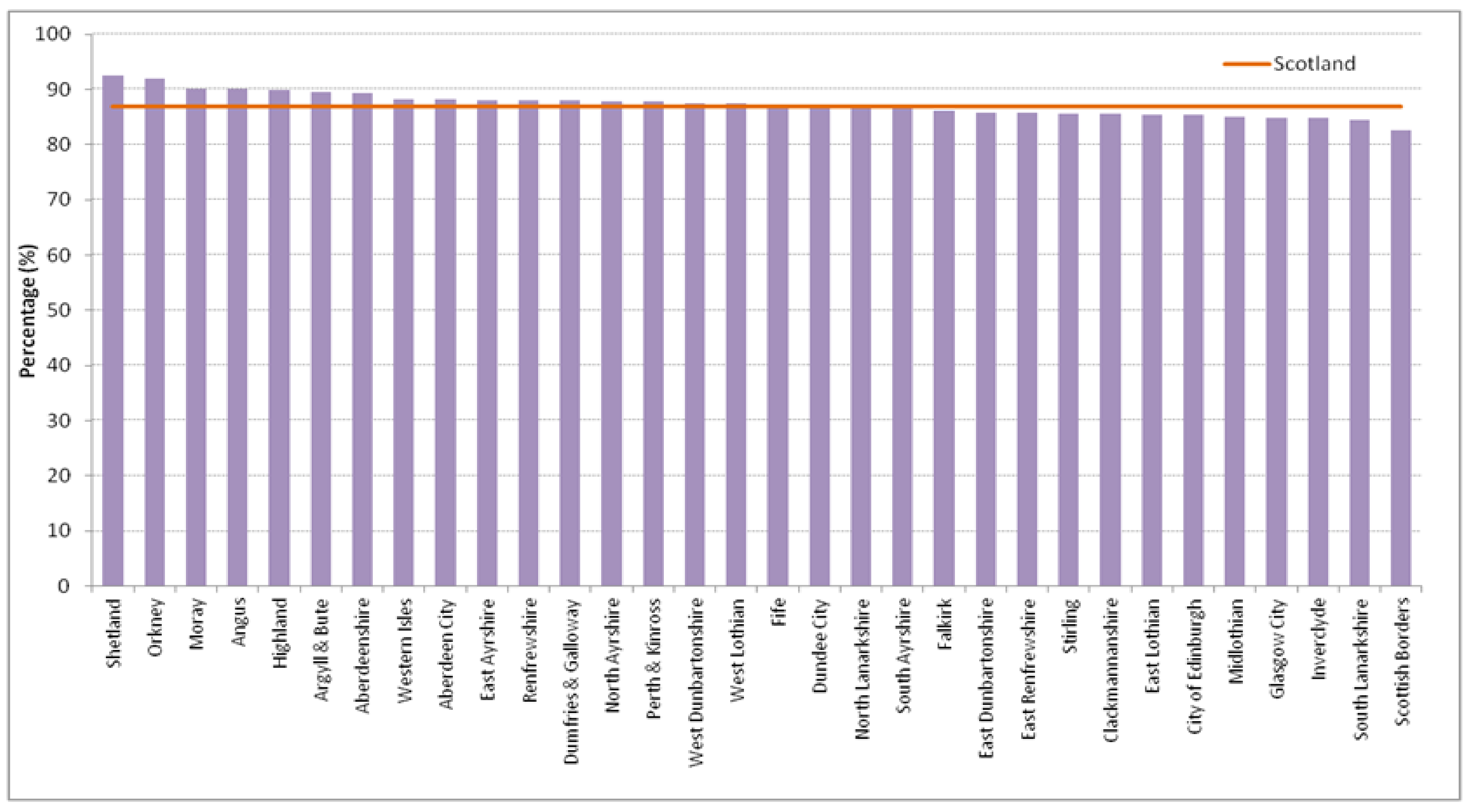
Notes: This chart shows the unplanned admissions per person aged 75+ in all specialties in 2015/16. We can see that the two fold variation seen in the bed days chart is evident here, although there is some slight re-ordering which is to be expected as bed day rates are a function of admission rates and length of stay. We can develop this analysis to consider different age groups and specialties.

Delayed Discharge Census: Standard Delays > 3 days by type of delay



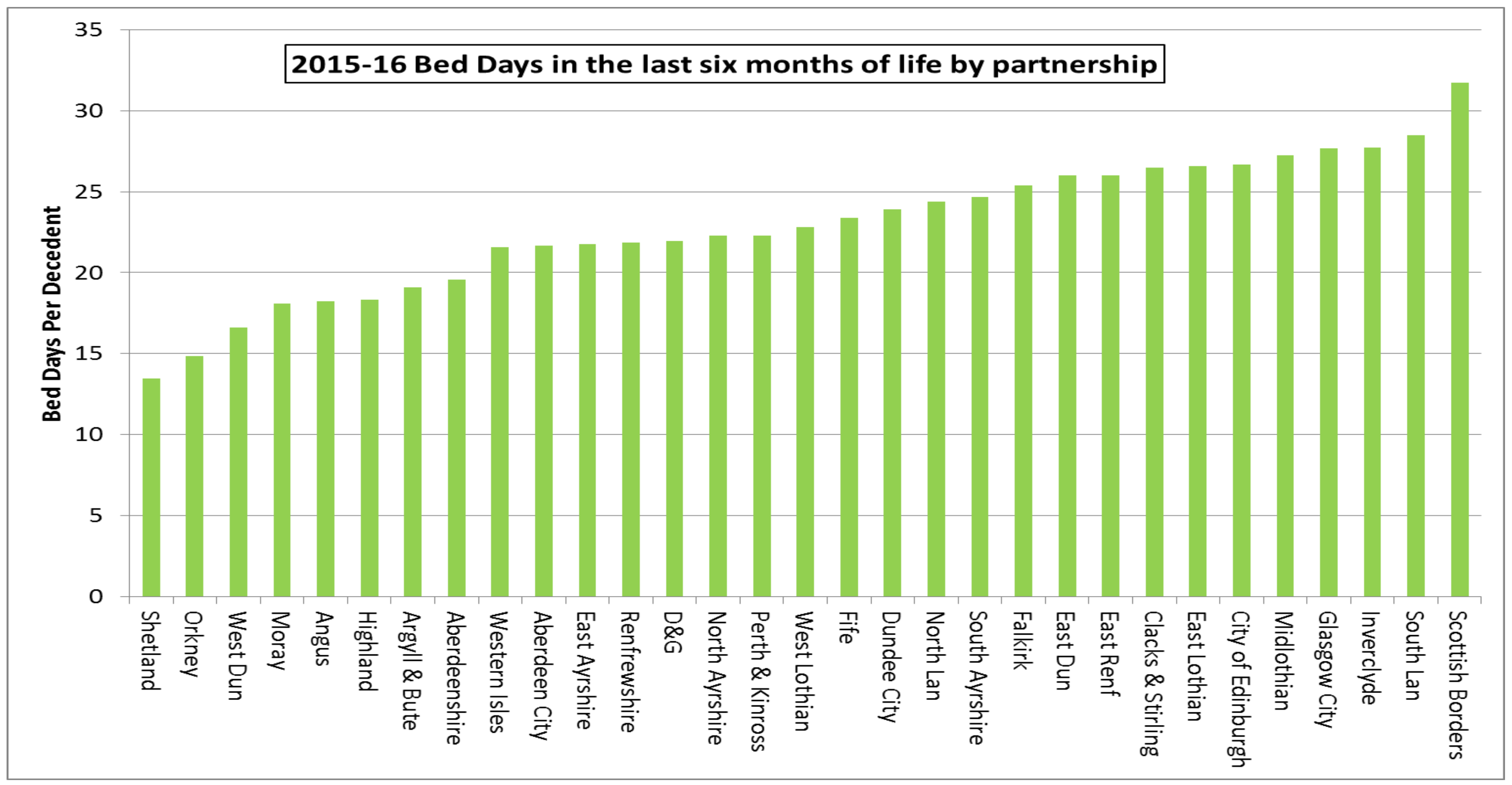
Notes: this chart shows the number of delays by type of across all partnerships. These figures exclude family reasons. There is considerable variation across partnerships. There are also differences in the main reason for delays. For example while care home and home care are key reasons for some partnerships, Code 9 categories appear to be the main reason for others

End of Life (a)



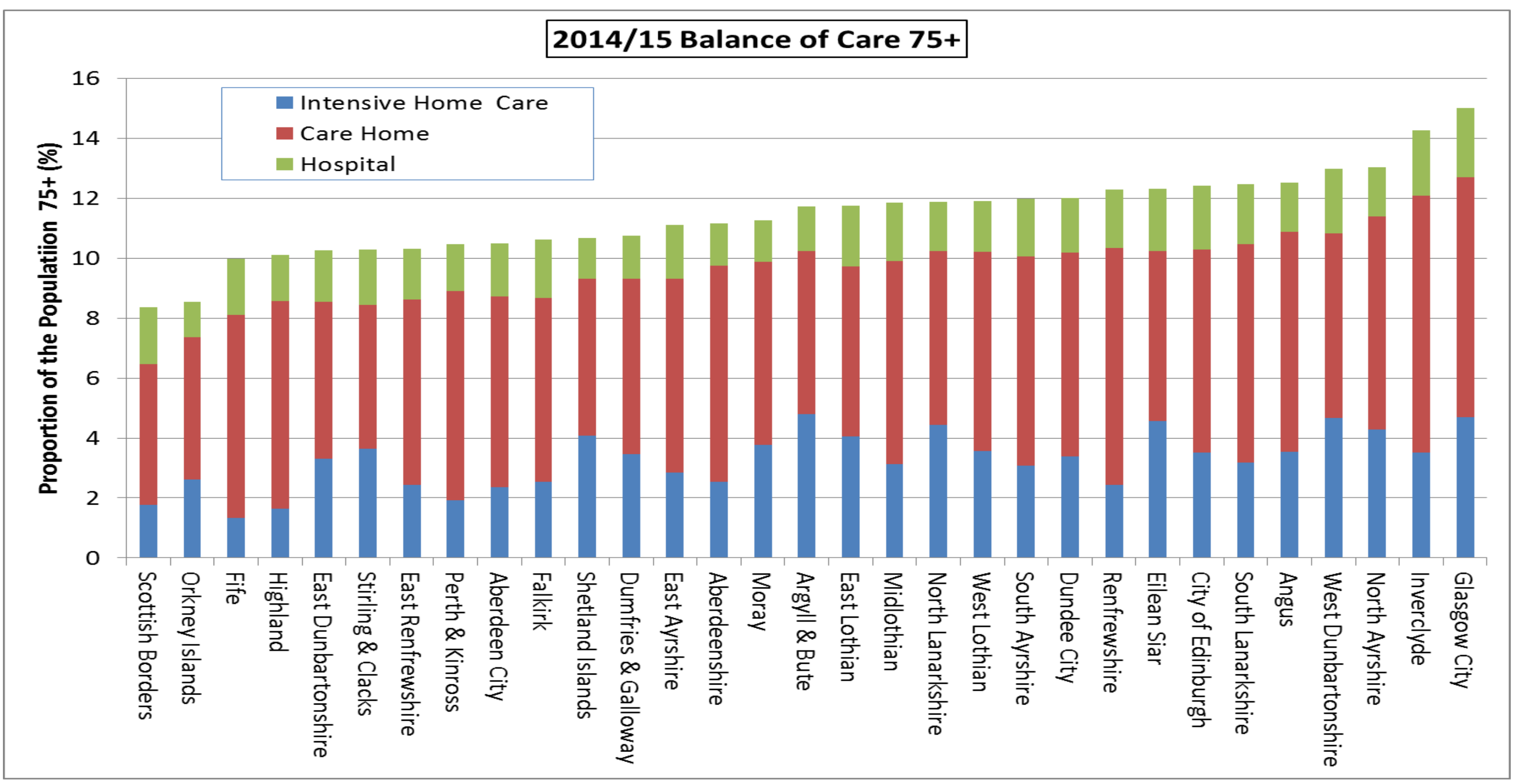
Notes: This chart shows the proportion of the last six months of life spent at home or in a community setting for people who died in 2015/16. There is a difference of 10% across partnerships. We can develop this analysis by considering different age groups and by differentiating between settings.

End of Life (b)



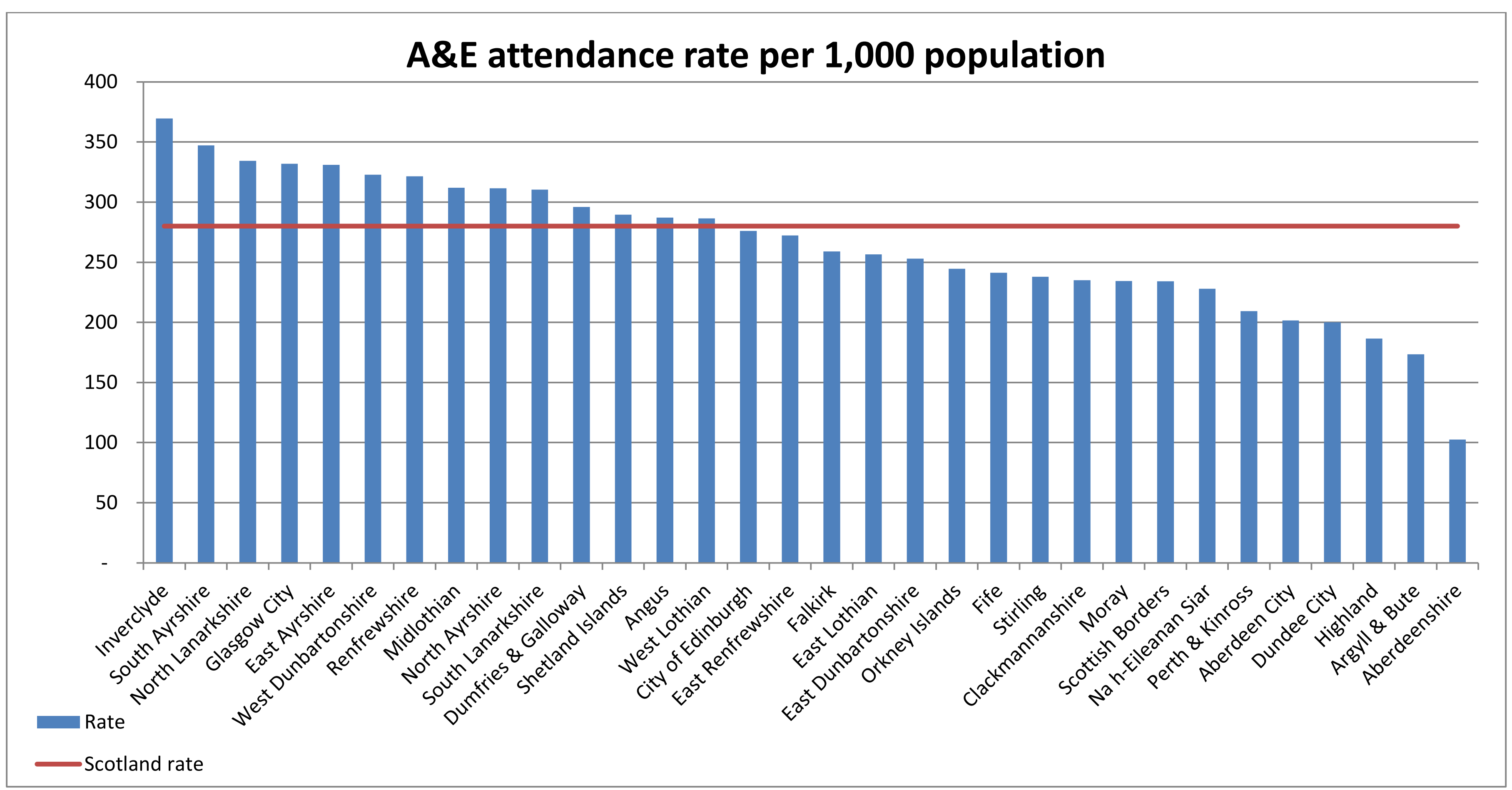
Notes: This chart shows the average unplanned bed days in the last six months of life for people who died in 2015/16. There is a two- fold variation across partnerships. If all Scottish partnerships could attain the same bed days per decedent as Shetland, half a million bed days could be saved-equivalent to the 10% commitment in the Delivery Plan.

Balance of Care



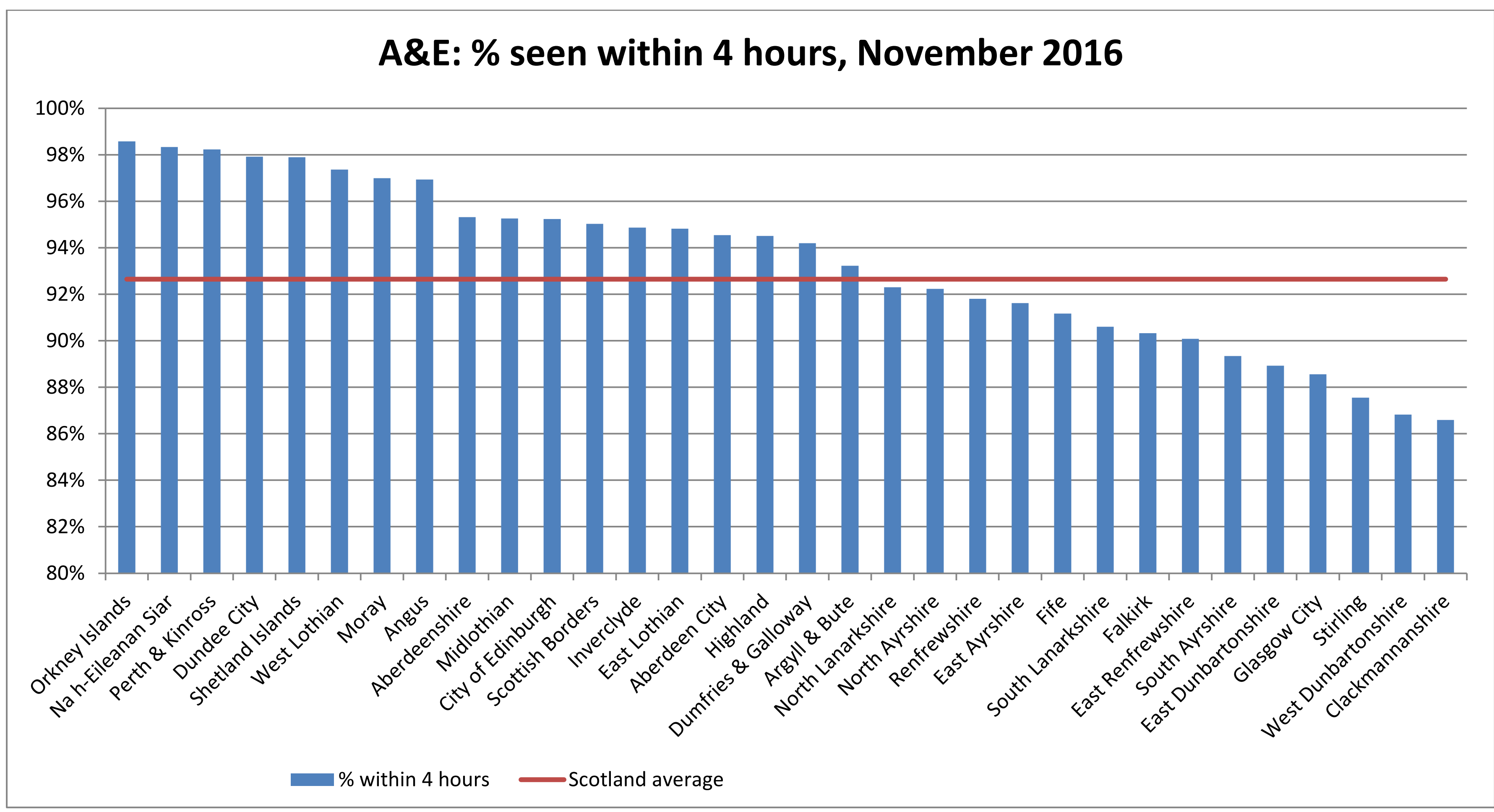
Notes: This chart looks at balance of care for people aged 75+ and shows the proportion of partnership populations aged 75+ who were either in hospital, in a care home or in receipt of 10+ hours home care in 2014/15. There is an almost two-fold variation (8% c/w 15%). Across Scotland, 8.5% of people aged 75+ were either a care home or hospital varying from 5.9% to 10.7% across partnerships. We can develop this analysis to include other age groups and to reflect the balance of care as a spectrum of settings; we can also look at spend across the spectrum.

A&E (a) : **A&E attendance rate per 1,000 population by Partnership 2015/16**



Notes: this shows the attendance rate at A&E per 1000 population by Partnership. There is considerable variation between Partnerships –370 per 1000 population in Inverclyde while 102 attendees per 1000 population in Aberdeenshire (Scotland – 280 per 1000). The difference is likely to reflect a range of issues including demographic factors, proximity of population to A&E facility as well as other healthcare provision .

A&E % seen within 4 hours



Notes: This chart shows performance on the 4 hour wait target by partnership. There is a difference of 11% between the highest performing area and the lowest performing area. The Scotland average is 93%. We can also provide A&E data on conversion rate- eg the proportion of A&E attendances which result in admission to hospital

Item 4

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 22 March 2017

Subject: 2017/18 Annual Revenue Budget Update

1. Purpose

1.1 To provide the Health and Social Care Partnership Board (HSCP) with an update on the progress made with regard to the indicative funding allocation for 2017/18 from our funding partner, NHS Greater Glasgow and Clyde Health Board.

2. Recommendations

2.1 The HSCP Board is recommended to:

- Note the contents of the letter from the Chief Officer to the Chief Executive of NHSGG&C communicating the decision of the HSCP Board;
- Agree to approve an anticipated budget allocation from NHSGG&C for 2017/18 of £80.676m, based on the recurring budget as at 31st December 2016 (Period 9) as being the compliant with the Scottish Government's direction to maintain funding at least at 2016/17 cash levels.

3. Background

3.1 The 2017/18 Annual Revenue Budget Report was presented to the 1 March 2017 HSCP Board. The report provided members with details on the budget allocation offers from both West Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board and their compliance in regard the Scottish Government budget announcements of 15 December 2016 to Local Authorities and Health Boards.

3.2 The key messages from the financial settlement offers were:

- NHS contributions to Integration Authorities (IAs) for delegated health functions will be maintained at least at 2016/17 cash levels;
- Local authorities will be able to adjust their allocations to IAs by up to their share of £80 million below the level of budget agreed in 2016/17; and
- An additional £107m of Social Care funding, routed through Health Boards, in addition to the £250m received in 2016/17.

4. Main Issues

4.1 The Council's 2017/18 budget was approved at the full Council meeting of 22 February 2017. The contribution to the HSCP was set at £60.673m which is a reduction of £0.866m on the 2016/17 budget of £61.539m and is compliant with the Scottish Government's allowable allocation reduction. This allocation was approved by members at the 1 March Board meeting.

4.2 After identification of 2017/18 demographic and inflationary pressures a funding gap of £2m remained on the provision of Social Care Services. The HSCP approved to manage this budget gap through the application of recurring, non-committed element of the 2016/17 Social Care Fund.

4.3 Greater Glasgow and Clyde Health Board will be unlikely to approve the 2017/18 budget before June 2017. However the HSCP was provided with an indicative budget allocation on 11th January 2017, which in the opinion of the Chief Officer and Chief Financial Officer did not comply with the direction issued by the Scottish Government that contributions to Integration Authorities, for delegated health functions must be maintained at least at 2016/17 cash levels.

4.4 This opinion was based on the proposal to allocate a share of a previously unachieved saving of £7.8m relating to 2015/16 CHCP's budget pressures.

4.5 This pressure was pre the establishment of the WD HSCP and the application of this additional savings target would effectively reduce the 2017/18 budget allocation to an amount lower than the 2016/17 recurrent budget base, therefore contravening the direction of Scottish Government.

4.6 After further debate and negotiation a revised offer was received on 23 February 2017 offering a compromise reducing the target from £7.8m to the amount of £3.6m, which would equate to approximately £0.274 million for WDHSCP. Regardless of the reduction the recommendation of the Chief Financial Officer was that this offer should be rejected on the basis that it would take the 2017/18 base budget allocation below the 2016/17 cash level. This recommendation was accepted by the Board at the 1 March 2017 meeting.

4.7 The Chief Officer has formally notified the Chief Executive of NHSGGC&C of this decision in his letter of 7 March 2017 (Appendix 1), with the proposal to continue to pursue a joint resolution.

4.8 To allow the Chief Officer to provide direction to NHSGG&C from the 1 April 2017 to deliver delegated health services in line with the Strategic Plan, it is proposed that the HSCP Board approve an indicative budget of £80.676m for 2017/18 based on calculations (per table below) on the recurring budget as at 31 December 2016 (Period 9).

GG&CHB Allocation Letter 5th July 2016	£000
Recurring Budget – Rollover	75,839
Uplifts Applied: Pay, RT, Contracts	958
Facilities & Depreciation Budgets – Centralised	-901
Minor Adjustments	-16
	75,880
Savings Targets Applied - Month 2	-431
Savings Targets Applied - Month 3	-955
	-1,386
2016/17 Base Allocation – Health	74,494
2016/17 Social Care Fund - pass through	4,921
TOTAL 2016/17 Health Board Allocation	**79,415**
Recurring Budget Adjustments as at Month 9	1,260
Anticipated 2017/18 Recurring Budget Rollover	**80,676**

4.9 The Chief Officer and Chief Financial Officer will continue to work collaboratively with their colleagues in the five other GGC partnerships and the Health Board to reach a satisfactory solution on the roll forward of 2016/17 recurring budget levels and the related inflationary pressures attached to those budgets. This will be presented to the 31 May 2017 Board.

4.10 In the event that a resolution cannot be secured, the Chief Officer has instructed the Chief Financial Officer to commence work on identifying savings options to cover the potential budget gap of £0.274 million in 2017/18.

4.11 Details of these options will be presented to the HSCP Board at its next meeting on 31 May 2017 for consideration and approval if required.

4.12 This report will also provide confirmation of the agreed position in relation to the actual prescribing pressure required to be managed by the HSCP in 2017/18. As previously reported to members the current anticipated gap is in the region of £0.502m to £0.656m.

4.13 This level of pressure is a significant challenge, as the volatility risk around this budget is well documented in periodic finance reports. This pressure is based on the available information, however the true cost will not be known until May 2017 when the full year data is collated.

5. People Implications

5.1 None.

6. Financial Implications

6.1 Other than the financial budget actual/indicative allocations and associated pressures noted above, there are no further financial implications to report at this time.

7. Professional Implications

7.1 None.

8. Risk Analysis

8.1 If agreement cannot be reached between the HSCP and NHSGG&C on the 2017/18 budget allocation then Dispute Resolution measures may require to be implemented.

9. Impact Assessments

9.1 None.

10. Consultation

10.1 This report was prepared in conjunction with Health colleagues.

11. Strategic Assessment

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

Julie Slavin
Chief Financial Officer
22 March 2017

Person to Contact: Julie Slavin – Chief Financial Officer, Garshake Road, Dumbarton, G82 3PU, Telephone: 01389 737311
E-mail julie.slavin@ggc.scot.nhs.uk

Appendices: Appendix 1 – Chief Officer's letter of 7 March 2017 to Chief Executive NHSGG&C Health Board

Background Papers:	HSCP Board Reports 1 March 2017 – 2017/18 Annual Revenue Budget
Wards Affected:	All

Robert Calderwood
Chief Executive
NHS Greater Glasgow & Clyde
JB Russell House
Gartnavel Royal Infirmary
1055 Great Western Road
Glasgow
G12 0XH

Council Offices
Garshake Road
Dumbarton
G82 3PU

Date: 7 March 2017
Direct Line: 01389 737599
E-Mail: keith.redpath@ggc.scot.nhs.uk

Dear Robert

Re: 2017/18 Financial Allocation to HSCPs

I refer to your letter of 23 February 2017 in regard to the above.

West Dunbartonshire HSCP met on 1 March 2017 and considered a report from our Chief Financial Officer in regard to the setting of the budget for 2017/18 including the offer from NHS Greater Glasgow and Clyde.

In general terms, the Integration Joint Board recognises and accepts the position in respect of pensions, rates and prescribing (subject to final details on the inflationary provision for 2017/18).

However, specifically, the IJB voted to reject the position in respect of the allocation of historic savings.

The IJB noted your proposal that the "Board will confirm with Scottish Government that it is appropriate to make this adjustment" in respect to historical savings.

However, it was clear that my IJB were of the view that any formal representations to Scottish Government should be made jointly and not individually by either the Health Board or the IJB.

The IJB agreed to schedule an additional meeting for 22 March 2017 in anticipation that by that time there will have been further discussion on the issue.

Yours sincerely

R Keith Redpath
Chief Officer

Item 5

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 22nd March 2017

Subject: NHSGGC-wide Review of Out of Hours GP Services - Update

1. Purpose

1.1 To bring to the Partnership Board's attention an update on the NHSGGC-wide Review of Out of Hours GP Services.

2. Recommendation

2.1 The Partnership Board is recommended to:

- Note the appended update report by the NHSGGC GP Out of Hours Review Group; and
- Agree that a further report will be brought back to the Partnership Board as the Review progresses.

3. Background

3.1 As specified in the Public Bodies (Joint Working) Act, General Medical Services - including out of hours - are part of the delegated functions for all integration authorities

3.2 The Partnership Board will recall a substantial report on Out of Hours primary care services that was presented to its February 2016 meeting. That report detailed the findings of the national Independent Review of Primary Care Out of Hours Services; and brought to the Partnership Board's attention that a review of the existing GP Out of Hours Service across the NHSGGC-area had just been initiated.

3.3 An update on that work – prepared by the review group for consideration by all IJBs within the NHSGGC area - is attached to this report

4. Main Issues

4.1 In the recently published National Out of Hours Review, out of hours care is defined as "care to a patient which cannot wait until the GP surgery is open again".

4.2 Ensuring safe, accessible services to patients and staff during the Out of Hours period is a key factor in ensuring high quality services to the population of NHS Greater Glasgow and Clyde.

4.3 The review is being undertaken of the current GP service model to ensure an efficient, responsive service that is sustainable going forward.

5. People Implications

5.1 The current service is under consistent pressure due to the increasing lack of availability of GPs willing to participate in the GP Out of Hours service. This is further exacerbated at holiday periods when there is higher levels of demand and call upon the same GPs to work extremely long hours.

6. Financial Implications

6.1 The result of the changes to the tax treatment of GPs working in Out of Hours services for NHSGGC has led to an unfunded cost pressure of £2.5m per annum. Increased rates of pay at times of peak activity - namely Public Holidays and the Festive fortnight – have also resulted in an additional unfunded cost pressure of circa 500k.

6.2 While it is recognised that the service has constantly reviewed its costs and identified cost reducing efficiencies (circa £300k over the last 5 years), it is important that the Out of Hours Service is clear that it is responsible for taking the necessary contingency actions to manage those pressures safely whilst the review is on-going.

7. Professional Implications

7.1 In 2004, the General Medical Services (GMS) contract came into force. This gave General Practitioners (GPs) the opportunity to opt out of providing out of hours care for their patients. The GMS contract means that NHS Greater Glasgow & Clyde is responsible for ensuring all patients can access out of hours care. While access to the GP Out of Hours service was initially intended to be through NHS24, over time a significant number of patients now “walk in” into the service.

8. Locality Implications

8.1 There is a GP Out of Hours service co-located with the Minor Injury Unit at the Vale of Leven Hospital.

9. Risk Analysis

9.1 As per 5.1, the current service is under consistent pressure due to the increasing lack of availability of GPs willing to participate in the GP Out of Hours service.

10. Impact Assessments

10.1 None required for this report.

11. Consultation

11.1 Any significant service changes recommended by the review will be subject to appropriate consultation.

12. Strategic Assessment

12.1 The Health & Social Care Partnership's Strategic Plan 2015-16 recognises that access to and the development of primary medical services is a key consideration in improving the delivery of services.

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

Date: 22nd March 2017

Person to Contact: Soumen Sengupta
Head of Strategy, Planning & Health Improvement
West Dunbartonshire Health & Social Care Partnership,
West Dunbartonshire HSCP HQ, West Dunbartonshire Council, Garshake Road, Dumbarton, G82 3PU.
E-mail: soumen.sengupta@ggc.scot.nhs.uk

Appendices: NHSGGC Out of Hours Service: Review Update

Background Papers: HSCP Board Report (February 2016): Pulling Together - The Report of the Independent Review of Primary Care Out of Hours Services

Wards Affected: All

PROPOSED REVIEW: GP OUT OF HOURS

A joint group has been established by the HSCP Chief Officers to review the provision of the full range of health and social care out of hours. The group considered the paper below at its first meeting. The paper describes the immediate service and financial pressures on GP OOH services. In the light of that current position the steering group agreed to recommend to Chief Officers that an HSCP led review of the GP out of hours service is established. Proposed steps in the review process would include:

- formal consideration of the current issues in each IJB and sign off of the principles for the review process, the programme arrangements and the timescale and process for the review;
- early public and patient engagement to shape and contribute to the review process;
- a formal review oversight group established to develop a detailed review programme by the beginning of April 2017.
- a clear timescale to bring forward proposed changes.

NHS GREATER GLASGOW AND CLYDE - GP OUT OF HOURS SERVICE

1. Background

1.1 NHS Greater Glasgow and Clyde have been carrying out a review of Primary Care Out of Hours services in the context of the recently published National Review by Sir Lewis Ritchie and the Board's service and financial planning for 2016/17.

1.2 In 2004, the General Medical Services (GMS) contract came into force. This gave General Practitioners (GPs) the opportunity to opt out of providing out of hours care for their patients. The GMS contract means that NHS Greater Glasgow & Clyde is responsible for ensuring all patients can access out of hours care. Access to the GPOOH service was initially intended to be through NHS24, however, over time, a significant number of patients now walk in into the service.

1.3 Strategically the new IJBs are responsible for the planning and commissioning of safe and effective OOH services.

1.4 Up until 2015, OOH GPs in the Greater Glasgow Health Board service were independent contractors. In 2015, following a nationwide investigation into the way individual Boards paid out of hours GPs, HMRC implemented a ruling that GPs working in out of hours services required to be on the Board payroll, rather than treated as independent contractors. The result of the changes to the tax treatment of GPs working in out of hours services for GGC has incurred an additional cost of £2.5m per annum. This funding requires to be found on a recurrent basis as to date it has been covered non-recurringly.

Rates of pay are increased at times of peak activity in OOH - namely Public Holidays and the Festive fortnight and this has also resulted in an unfunded cost pressure of c500k.

The service has constantly reviewed its costs and service delivery model and has made cost reducing efficiencies of £300k over the last 5 years.

However with the budget for the entire Board service being £16m, predominately in staff costs, it is not possible for the service to cover these increased staffing costs from within the service.

Currently other WOS Boards pay GPs higher rates than GGC and this is causing high levels of unfilled shifts. The service are using agency staff consistently for the first time since its inception

1.5 We are undertaking a review of the current GP service model to ensure that we can continue to provide an efficient, responsive service that is sustainable going forward. Ensuring safe, accessible services to patients and staff during the Out of Hours period is a key factor in ensuring high quality services to the population of NHS Greater Glasgow and Clyde.

1.6 In the recently published National Out of Hours Review, out of hours care is defined as care to a patient which cannot wait until the GP surgery is open again.

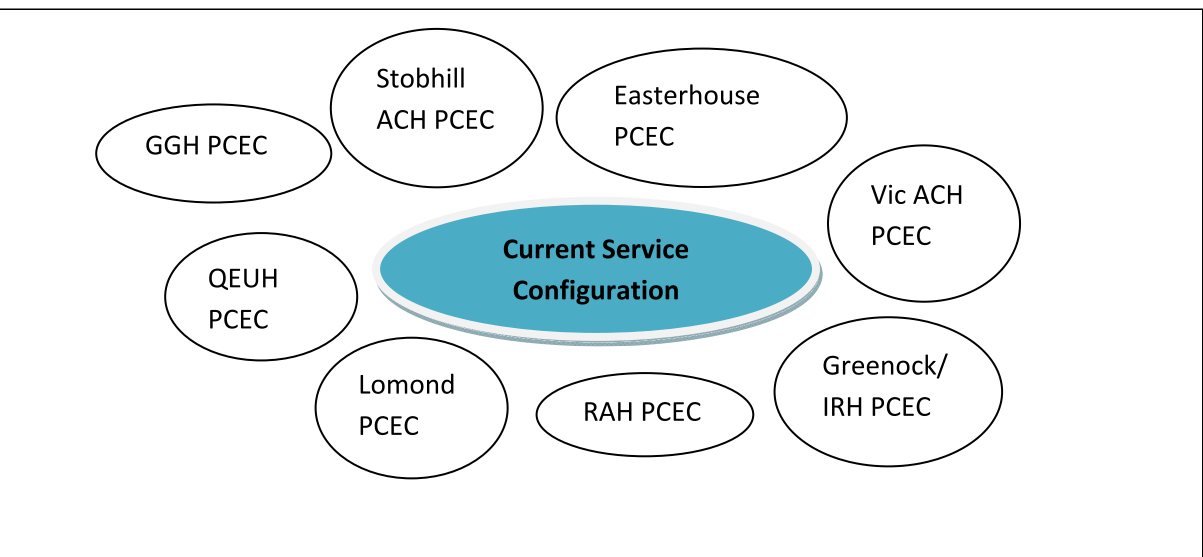
2. Current Service Configuration

2.1 A Home Visiting Service - this extends into Lanarkshire to cover Camglen and to Highland to cover Helensburgh and the Lochside .

2.2 A telephone advice service - this is provided from the Hub at Cardonald by the GP advisor who has a wide role in co-ordinating the service.

2.3 A pre-prioritised call service to support NHS24 - this is provided from the Hub at Cardonald utilising GGC clinical workforce and funded by NHS 24

2.4 8 Primary Care Centres - these are located geographically around the city to support access locally for patients - these centres see patients who are directed by NHS24, or self present and those adjacent to A/E departments will see those redirected by A/E.



The service offers a patient transport service to and from these centres for patients who cannot afford public transport and do not have their own transport. This to minimise the need for home visits.

The service does not operate an appointment system and patients are directed by NHS24 to their nearest PCEC.

- The service is currently adjacent to Emergency Departments at Queen Elizabeth University Hospital, and Royal Alexandra Hospital and overnight at Inverclyde Royal Hospital.
- The service is co-located with Minor Injury Units at Stobhill ACH; Victoria ACH and Vale of Leven.

- There are 3 other centres at Gartnavel General Hospital for West Glasgow, Easterhouse Health Centre - North/East Glasgow and Greenock Health Centre - Inverclyde
- There are only three main centres open overnight at RAH, Victoria ACH and Stobhill ACH. An overnight service is provided by the Home Visiting doctor at IRH and at Vale of Leven.

3. Summary of Work in 2016/17

3.1 Closure of Western Infirmary and Drumchapel Primary Care Centre and centralisation of West sector service at Gartnavel General Hospital.

3.2 Introduction of nurses into centres to reduce demand for medical staff

3.3 Trial of nurses undertaking home visits to test viability of alternative models

3.4 Other work which is also progressing in reviewing pathways into/out of the out of hours service include :

- **Alternative care pathways:** we are working with NHS 24 to implement changes to care pathways which will reduce pressure on the service, eg:

    - 12 hour disposition - improving use of this which will feed back to in hours GP services;
    - introduction of a self care guide for patients;
    - reinforcing SIGN guidelines on use of antibiotics for self limiting conditions - joint letter from LMC and GPOOH has been distributed to all GPs across GGC;
    - pilot of “speak to doctor” being developed within NHS24;
    - introduction of Prescribing pharmacists within NHS24 - this will support reducing demand on GPs for repeat prescriptions;
    - prescribing guidelines for Pharmacies - these are being developed nationally for specific pathways, eg, uncomplicated UTI.

- **Nursing homes:** to reduce the numbers of home visits to nursing homes with the purpose of Pronouncing Life Extinct which put pressure in the service we are changing the interface with nursing homes to reduce demand.

- **Patient Transport Service:** initial review of this has been undertaken to improve efficiency of service.

- **Clyde sector:** Working with the Clyde sector team to consider potential changes to the relationship between the OOH service and hospital based sevices at the IRH and Vale.

4. Activity

4.1 The following provides a description of GPOOH activity which is taken from the published ISD datamart. This reports on all GPOOH services across Scotland with the most recent report scheduled to be published at the end of February 2017.

Note - *the location within ADASTRA in which GGC activity is recorded is slightly different to the way other Boards record this information. Whilst the service have been working with ISD to try to get as accurate a picture as possible, the reported figures are slightly different to those which the service themselves produce although the trend data is consistent.*

4.2 **Consultations**

ISD 2015/16 reports 246,617 Consultations which was 3.3% higher than the previous year.

In 2016/17 the figures have shown a reduction - the latest monthly activity reported for 2016/17 is to October 2016.

	April to October	Variance
2014/15	134,782	
2015/16	139,367	3.4 %
2016/7	131,830	-5.4%

4.3 **Primary Care Centres/Home Visiting**

The following table shows a 2.9% increase in 2015/16 but a 3.7% drop in 2016/17 to Primary Care Centres and a 0.9% drop in 2015/16 and 6% drop in 2016/17 to the Home Visiting service.

	April to October Activity			
	Primary Care Centres		**Home Visiting Service**	
Data Source : ISD	**Activity**	**%age diff**	**Activity**	**%age diff**
2014/15	87701		21360	
2015/16	90238	2.90%	21163	-0.90%
2016/17	86875	-3.70%	19892	-6.00%

4.4 **Recent Experience : West Glasgow**

In July 2016 Drumchapel PCEC closed and was merged with the Western site (which had closed and relocated in November 2015) at Gartnavel. It was anticipated that the numbers of patients attending the Gartnavel site would be less than the numbers previously attending the separate sites and this has in fact been the experience

	13/14	**14/15**	**15/16**	**16/17**
West Glasgow	19040	20514	19673	16240
%diff in year		7.7%	-4.1%	-17.5%

These initial figures suggest that the initial move to Gartnavel resulted in a significant reduction in OOH attendances. Of note when Western site moved, the walk in rate reduced from almost 30% to 15%. This can be explained by:

- lack of accessibility to student and visiting population;
- move away from adjacency to an A/E department.

The West population may not be typical and this experience might not be mirrored should other services move. The following table provides a description of the mode of arrival of patients to other Primary Care Centres across GGC as a percentage of the total attendances.

	as %age of attendances at PCEC			
	NHS24	Walk-in	Refer MIU/E	Other
Easterhouse	75%	23%	0%	2%
Greenock	87%	12%	0%	1%
Inverclyde	97%	0%	0%	3%
Lomond	32%	51%	7%	10%
Renfrewshire	84%	9%	2%	5%
QEUH	71%	21%	6%	2%
Stobhill	63%	29%	1%	7%
Victoria	67%	27%	1%	5%

4.5 The following table describes the current daily average attendances to the PCEC's :

Current Daily average activity								
	Vic ACH	QEUH	GGH	Stobhill A	Easterhou	RAH	IRH	Vale
Monday	66	18	30	48	26	29	11	26
Tuesday	64	19	31	49	26	27	12	24
Wednesday	61	19	29	46	24	28	10	24
Thursday	61	19	29	43	23	27	10	23
Friday	65	20	33	47	26	28	11	25
Saturday	202	76	133	133	98	103	47	85
Sunday	197	77	132	133	97	103	43	84

4.6 **Postcode analysis of attendances**

Of the total attendances, the Greater Glasgow area accounts for 70.4% of attendances, Clyde sector 27.3% and out of board area 2.3%.

- In the out of board area, attendances from the ML (Motherwell) catchment area are highest at 18.5% followed by KA (Kilmarnock) at 18.4%, EH (Lothian) at 9.6% and G74 (East Kilbride) at 8.7%.
- In the Greater Glasgow area - G33 (Blackhill, Riddrie…) account for 6.2% of Greater Glasgow attendances, following by G81 (Dalmuir…) at 4.9%, G32 (Springboig….) at 4.4% and G53 (Pollok…) at 4%
- In the Clyde area - G83 (Balloch) is the highest at 15%, followed by G82 (Dumbarton) at 12.2%, PA2 (Foxbar….) at 9.8% and PA3 (Ferguslie….) at 7%.

GPOOH POSTCODE DISTRIBUTION OF ATTENDANCES (based on year 2014/15)								
Out of Board Area			Greater Glasgow Area			Clyde		
Postcode	Area	%age	Postcode	Area	%age	Postcode	Area	%AGE
overall		2.3%	overall		70.4%	overall		27.3%
following describes highest users of out of board area			*of the Greater Glasgow areas - following is highest postcode areas*			*of the Clyde areas - following is highest postcode areas*		
ML	ML Motherwell	18.5%	G33	Blackhill, Riddrie, Ruchazie, Garthamlock, Stepps	6.2%	G83	Balloch, Luss	15.0%
KA	KA Kilmarnock	18.4%	G81	Dalmuir, Faifley, Duntocher	4.9%	G82	Dumbarton	12.2%
EH	EH Lothian	9.6%	G32	Springboig, Shettleston, Carmyle, Carntyne	4.4%	PA2	Foxbar, Glenburn, Hu nterhill	9.8%
G74	G74 East Kilbride	8.7%	G53	Pollok, Nitshill, Darnley	4.0%	PA3	Ferguslie, Linwood	7.0%
AB	AB Aberdeen	6.9%	G21	Cowlairs, Gargad, Barmulloch, Barlornock, Robroyston	3.9%	PA16	Greenock	6.5%
FK	FK Falkirk	6.3%	G42	Polmadie, Battlefield, Crosshill, Govanhill	3.9%	PA4	Renfrew, Inchinnan	6.3%
DD	DD Dundee	4.0%	G13	Jordanhill, knightswood, yoker	3.8%	G84	Helensburgh	6.3%
KY	KY Kirkcaldy	3.4%	G66	Lenzie, Lennoxtown	3.7%	PA5	Johnston, Elderslie	5.7%
			G69	Gartcosh, Chryston	3.7%	PA1	Paisley central, Ralston	5.3%
			G15	Drumchapel	3.6%	PA15	Greenock	5.5%
			G52	Mosspark, Cardonald, Penilee	3.6%	G78	Barrhead, Neilston, Uplawmoor	5.0%
			G41	Shawlands, Pollokshields, Strathbung	3.5%	PA14	Port Glasgow	3.9%
			G73	Rutherglen	3.4%			
			G44	Cathcart, Kingspark, Croftfoot	3.1%			
			G64	Bishopbriggs, Torrance	3.1%			
			G72	Cambuslang	2.9%			
			G20	Ruchill, N Kelvinside, Woodside	2.9%			
			G51	Kinningpark, Ibrox, Govan	2.7%			

5. Challenges for the Service

5.1 The current service is under consistent pressure due to the increasing lack of availability of GPs willing to participate in the GP Out of Hours service. This is further exacerbated at holiday periods when there is higher levels of demand and call upon the same GPs to work extremely long hours

5.2 The reasons for this are multifactorial but it cannot be ignored that the workload at PCECs and home visiting sessions is a disincentive for GPs who would traditionally have done OOH sessions. It is also evidenced that doctors towards the end of their careers, who traditionally would have done a significant number of sessions, are being replaced by younger doctors who may do a few sessions but nowhere near the number of sessions previously done by their departing colleagues.

There are many other contributing factors including:

- superannuation issues;
- remuneration in comparison to other Boards(Glasgow offers the lowest rates of pay);
- employment status (neighbouring Boards recognise Private Limited companies) and regularly use Agency to fill shifts;
- day time workload of GPs;
- day time locum GP rates are higher than out of hour rates so more attractive for GPs to cover in rather than out of hours;
- walk in numbers to the centres are steadily increasing;
- volume of attendances at weekends and increased waiting times creates a challenging environment to work in;
- ability to provide suitable training environment for GP trainees - feedback from GPs is indicating that the workload is greater than the ability to undertake detailed case discussion and to provide appropriate clinical supervision.

5.3 Despite these difficulties the service has remained robust. Only on a handful of occasions has it been required to close a site. Gartnavel closed on three occasions when Drumchapel remained open and Easterhouse once. It is however a regular occurrence now to have to operate midweek with one or two home visiting shifts remaining unfilled or that the doctor had to be moved into a PCEC. Lomond and RAH are the sites which are particularly hard to find doctors to work in.

5.4 Home Visiting - the service is required to reach calls within the timeframe allocated by NHS 24, ie, within 1 hour/within 2 hours/within 4 hours. Although the overall percentage of times achieved is usually 90% and above, within these figures are a whole number of within 1 and within 2 hour calls which go out of time. The management team and Quality Assurance Group monitor these calls and there is genuine concern that activity at weekends at times exceeds capacity. This is less so midweek and thus it is to midweek provision that the potential for efficiency has been identified.

6. Next Stage

6.1 The next stage of the review is to look at the number of Primary Care Centres from which the service is operational and consider the potential to reduce these and the number of walk in patients.

6.2 The service currently do not operate an appointment system - if such a system were to be introduced, this would give the service more control over where a patient was directed. Issues with an appoint system include potential challenges in setting up the infrastructure to enable an appointment system and defining the length of a GP consultation could lead to the requirement for additional numbers of clinicians. Also, seeking to have patients directed to PCECs by NHS 24 depending on their postcode would be a significant change for NHS 24 which has operational policies agreed on a Scotland wide basis. It is worth mentioning this here as some of our options for reorganisation potentially direct patients to an acute site outwith their postcode area for acute receiving with the attendant risks involves.

6.3 Primary Care Centres are staffed predominantly by one doctor and a Trainee and in bigger centres they are supported by Minor Illness Nurse Practitioners. At some of the busier centres two doctors may be on rota depending on day of week and demand.

6.4 The KPI of the service is to see patients within the time stratification applied by NHS24 at triage and tries to do this in order of time of arrival but endeavours to see all patients within one hour of arrival. A process is in place to bring in additional doctors should this time period be exceeded - this is either the Home Visiting doctor linked to the site or a back up doctor who is on call from home (these doctors are paid a retainer to be immediately available from home if required). Currently these back up shifts are rarely filled.

6.5 Rationalising the number of Primary Care sites would provide an opportunity to consolidate services, perhaps to increase the sustainability of the service, potential to reduce walk-in numbers and may contribute towards the savings plan. This will come predominantly through a reduction in support service costs.

6.6 There are a number of key strategic decisions to be made that would then inform a service model. The rest of this section includes initial appraisal of options for further discussion and development.

- Option 1 - should sites be co-located with main ED/Receiving Units, ie, GRI/QUEH/ RAH.
- Option 2 - mixture of acute and community sites linked to population centres.
- Option 3 solely community centres.

6.7 **Description of Options**:

- **Option 1 - colocation with main ED/Receiving Units**

  - **Advantages:**

    - high walk in rate may reduce;
    - consolidates clinical staff on one site in each area which allows potential to redesign shift patterns and skill mix;
    - makes service less vulnerable if a clinician calls off at short notice;
    - potential to improve training environment for GP registrars.

  - **Disadvantages:**

    - removes centres from areas with high levels of deprivation and this will reduce ease of access for these vulnerable groups of patients;
    - These will be high volume sites, particularly at weekends, which may make it even more difficult to attract GPs to work in such an environment;
    - busy transport moves - would reduce any further opportunities to reduce Patient Transport service;
    - potential impact on increased attendances to Emergency Departments;
    - challenges to accommodate such a large service on one site;
    - suitable area within GRI would require to be found as service not currently located on this site and at QEUH Children's Hospital as current area not suitable for expansion.
    -

- **Option2 - mixture of acute and community based on demand**

  - **Advantages:**

    - could develop a pattern with fewer sites midweek;
    - potential to improve training environment for GP registrars mid week;
    - opportunity to redesign shift patterns and skill mix mid week;
    - moving from an acute site has shown to potentially reduce walk-ins (a/e redirects are counted as walk-ins) and overall attendances.

  - **Disadvantages:**

    - potential impact on increased attendances to Emergency Departments;
    - removal from acute site and proximity to acute receiving and resuscitation if not on ED/Receiving site;
    - reduces ease of access for people who stay in either rural areas or areas of high deprivation;
    - potential increased patient transport requirement.

- **Option 3 - entirely in community settings**

  - **Advantages:**

    - frees up space on acute sites;
    - clearly differentiates GP and hospital services;
    - subject to sites selected potential reduction in walk-ins;
    - consolidates clinical staff on one site in each area which allows potential to redesign shift patterns and skill mix;
    - makes service less vulnerable if a clinician calls off at short notice.

- **Disadvantages**

  - will require new locations to be found - Easterhouse only community site currently;
  - significant costs of moving IT etc;
  - significant workforce challenges depending on location and number of sites;
  - depending on sites chosen could lead to people attending local ED instead
  - Removes ability for ED to redirect.

7. Conclusion

7.1 The OOH service view is that three overnight sites are required may be the best arrangement-one in the North, one in the South and one in Clyde.

7.2 Requirements midweek evening and overnight offer opportunities for change and efficiency, whereas weekends are extremely busy with PCECs fully occupied and at times significant waiting times developing. The service feel that investment in weekend services is required.

7.3 The service would propose that the number of weekend sites remain the same but midweek reducing the number of sites to five (Stobhill ACH; Victoria ACH; RAH - all overnight and GGH and Easterhouse to midnight). It is the view that this is both likely to provide efficiency savings, offer stabilisation of the service, and continue to provide accessible high quality care.

7.4 These options need initial consideration to agree which are taken forward to be discussed with a wider group of stakeholders.

GPOOH Service
24th January 2017
Revised 2nd February 2017

NHS GREATER GLASGOW AND CLYDE
GP OUT OF HOURS SERVICE - COMPARATOR OTHER BOARDS

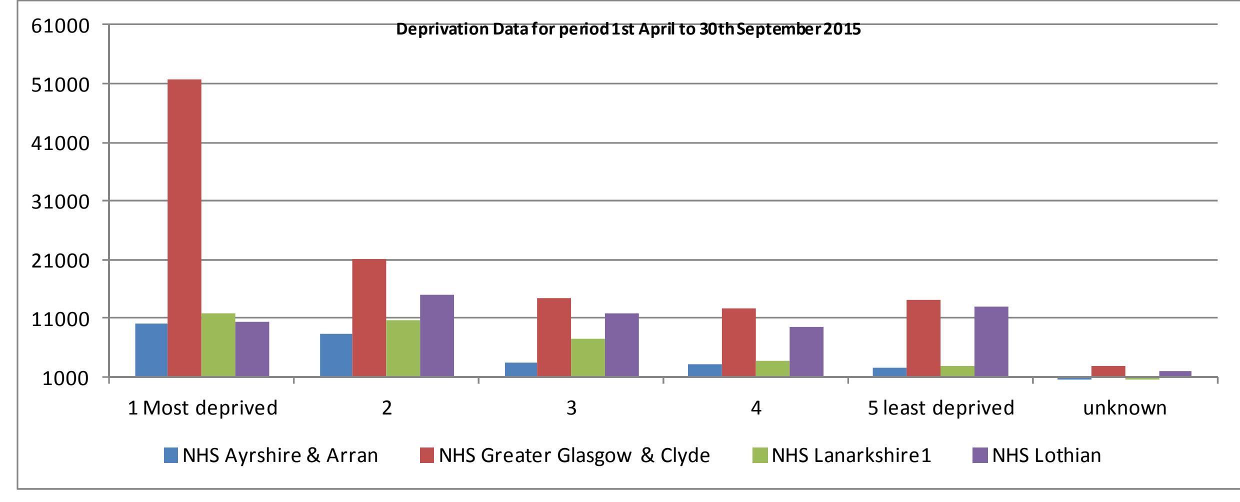
1. As part of the review of the GGC GP Out of Hours service, the way in which GP OOH services are undertaken in other Health Board areas has been considered and in particular Lothian and Lanarkshire have been examined in more detail.

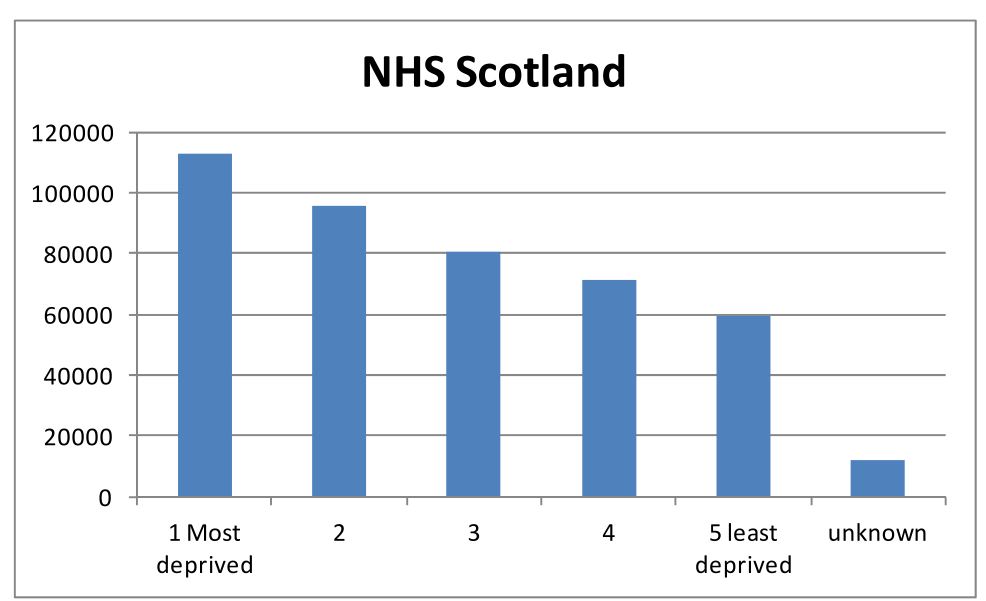
2. ISD provide monthly activity/performance reports on GP Out of Hours services across Scotland - the focus of these reports are activity by referral source and performance against the response times for Home Visiting. A six monthly and annual report is also produced and the 2015/16 report is scheduled to be released at the end of February 2017. The following provides a comparator for the GGC service against other Board areas in Scotland - activity is taken from the 2014/15 6 month report and a snapshot for January 2016.

3. **Rate of patients per 1,000 population** - Greater Glasgow & Clyde has the highest rate of attendance by patients per 1,000 population at 102, followed by Tayside at 92. Lothian and Lanarkshire have significantly lower rates at 72 and 57 respectively. Table below provides summary of rates taken from ISD report 2015 for all Board areas.

Rate of patients	
	per 1,000 population
Highland	81
Tayside	92
Grampian	81
Forth Valley	78
Fife	83
GGC	102
Lothian	72
A&A	77
Lanarkshire	57
Borders	66
Orkney	47
Western Isles	54
D&G	76

4. **Range of attendances by deprivation category** - the first graph provides a visual of attendances by deprivation category for GGC, Lothian, Ayrshire & Arran and Lanarkshire and the second graph for NHS Scotland overall. The profile for GGC is quite markedly different to that of the other Boards with 44% of attendances coming from the most deprived groups. Lothian is 17%, Lanarkshire 31% and Ayrshire and Arran 35%.





5. **Number and percentage of Consultations** - GGC consultations are 26% of the total consultations across Scotland, with Lothian accounting for 14% and Lanarkshire 9%. 59% of these consultations are directed to PCEC in GGC with 52.7% and 63.1% in Lothian and Lanarkshire. GGC has the lowest Home Visiting ratio, with 14.6% of Consultations resulting in a Home Visit. 15.8% and 20.5% of Consultations in Lothian and Lanarkshire result in a Home Visit. The following table provides activity for all Board areas broken down by treatment option.

Health Board	Number of Patients	Number and Percentage of Consultations									
		Number						Percentage (based on Total Consultations)			
		Total	PCEC	Home Visit	OOH Doctor/Nurse Advice	Other		PCEC	Home Visit	OOH Doctor/Nurse Advice	Other
Scotland	**894,474**	**997,112**	**557,476**	**192,563**	**205,775**	**41,298**		**55.9%**	**19.3%**	**20.6%**	**4.1%**
Ayrshire & Arran	58,494	62,481	29,906	21,555	11,001	19		47.9%	34.5%	17.6%	0.0%
Borders	15,921	24,396	8,369	8,374	7,652	1		34.3%	34.3%	31.4%	0.0%
Dumfries & Galloway	24,410	26,806	10,184	7,751	8,740	131		38.0%	28.9%	32.6%	0.5%
Fife	64,360	68,556	38,632	12,809	10,779	6,336		56.4%	18.7%	15.7%	9.2%
Forth Valley	47,662	51,622	28,631	12,878	10,048	65		55.5%	24.9%	19.5%	0.1%
Grampian	100,674	116,535	65,292	21,048	24,853	5,342		56.0%	18.1%	21.3%	4.6%
Greater Glasgow & Clyde	233,479	261,471	155,423	38,100	52,988	14,960		59.4%	14.6%	20.3%	5.7%
Highland	51,280	53,507	33,552	11,367	8,323	265		62.7%	21.2%	15.6%	0.5%
Lanarkshire	79,565	85,268	53,775	17,483	13,956	54		63.1%	20.5%	16.4%	0.1%
Lothian	127,058	140,295	73,991	22,134	36,641	7,529		52.7%	15.8%	26.1%	5.4%
Orkney	2,122	2,152	969	476	700	7		45.0%	22.1%	32.5%	0.3%
Shetland	1,504	1,529	561	521	395	52		36.7%	34.1%	25.8%	3.4%
Tayside	84,698	99,032	56,947	17,079	18,550	6,456		57.5%	17.2%	18.7%	6.5%
Western Isles	3,247	3,462	1,244	988	1,149	81		35.9%	28.5%	33.2%	2.3%

6. **Multiple attendances** - the table below shows the distribution of attendances for Scotland and GGC, Lothian, Ayrshire & Arran and Lanarkshire. One attendance only accounts for 72.4% of activity across Scotland. In GGC this is 70.8%; Lothian 72.5% Ayrshire & Arran 75.1%; and Lanarkshire 78.7%.

5 or more attendances account for 3% of total Scotland activity - in GGC this is 2%, Lothian 2.5%, Ayrshire & Arran 2.1% and Lanarkshire 1.3%.

2 or more attendances accounts for 18% of activity across Scotland : in GGC this is 20.1%; Lothian 18.5%; Ayrshire & Arran 16.3% and Lanarkshire 14.9%.

Health Board of T	Total Number of Patients[2]	1 Attendance	2 Attendances	3 Attendances	4 Attendances	5 or more Attendances
NHS Scotland	**306,909**	**222,131**	**55,393**	**15,389**	**6,137**	**7,859**
NHS Ayrshire & Arr	20724	15568	3384	923	396	453
NHS Greater Glasg	84126	59543	16920	4333	1632	1698
NHS Lanarkshire[1]	29481	23190	4393	1124	390	384
NHS Lothian	43679	31653	8064	2102	747	1113

7. **Home Visits performance** - a key performance indicator measured by HIS is the response time to Home Visits as triaged and set by NHS24. The following table describes the %age within and outwith time for Boards across Scotland. GGC is the best performing site with 94.6% of Home Visits within time, followed by Borders at 93.7%. Lothian, Ayrshire & Arran and Lanarkshire performance noted at 87.9%, 87.4% and 70.8% respectively.

%age of 1,2 and 4 Hour Home Visits - triaged by NHS24		
Board	**On Time %**	**Over Time %**
Ayrshire & Arran	87.4%	12.6%
Borders	**93.7%**	**6.3%**
Dumfries & Galloway	87.3%	12.7%
Fife	77.1%	22.9%
Forth Valley	83.3%	16.7%
Grampian	79.6%	20.4%
GGC	**94.6%**	**5.4%**
Highland	77.1%	22.9%
Lanarkshire	70.8%	29.2%
Lothian	87.9%	12.1%
Orkney	81.1%	18.9%
Shetland	83.1%	16.9%
Tayside	70.4%	29.6%
Western Isles	84.6%	15.4%

8. **Additional information gathered :**

- **Patient Transport** - GGC is the only Board which provides a dedicated patient transport service. Other Board areas will utilise Taxi's or on occasion pool cars to transport patients.

- **Primary Care Centres** -

  - GGC has 9 PCECs located in a mixture of acute and primary care sites. Lanarkshire has 3 PCECs which are all located in primary care sites and Lothian has 5 PCECs located in a mixture of acute and primary care sites.
  - Appointments - GGC do not operate an appointment system. Lothian and Lanarkshire do operate such a system and NHS24 is gatekeeper of this.
  - Walk-ins - GGC have a high percentage of walk in patients to the PCEC who are seen and treated. Lothian and Lanarkshire discouraged this and unless extremely unwell, any patients who do walk in are advised to call NHS24 for an appointment.

- **Nurse Practitioners** - GGC, Lothian and Lanarkshire all have Nurse Practitioners with both Lothian and Lanarkshire building up this resource and continuing to progress staff through the training course - Lanarkshire aim is to have 40% Nurse Practitioners on rota.

- **Cost per head of population** - of the three boards, Lanarkshire has highest cost per head of population at £12.21 with GGC and Lothian reporting £10.51 and £10.05 respectively.

- **Interface with other professionals** -

  - GGC is colocated in a central hub with the CPN OOH service, NHS24 and SAS. The Service support the untriaged telephone call service for NHS24.
  - Lothian support telephone call handling for evening and night district nursing services from their Hub. They operate professional to professional services with SAS. They also have ability to offer a planned review service to patients in the community at request of primary care clinicians.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 22nd March 2017

Subject: RECRUITMENT OF CHIEF OFFICER

1. Purpose

1.1 To consider the retirement of the Board's Chief Officer and agree the process to appoint a successor.

2. Recommendations

2.1 The Partnership Board (IJB) are recommended to approve the process set out below to recruit a new Chief Officer.

3. Background

3.1 Section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014 states: "(1) an integration joint board is to appoint a member of staff, a chief officer" and "(6) before appointing a person as chief officer an integration joint board is to consult each constituent authority".

4. Main Issues

4.1 Section 9 of the Integration Scheme sets out the arrangements in relation to the Chief Officer agreed by the Council and the NHS Board. The Chief Officer appointed by the Integration Joint Board will be employed by either the Council or the NHS Board and will be seconded by the employing party to the IJB and will be the principal advisor to and officer of the IJB.

4.2 The Chief Officer's role is to provide a single senior point of overall strategic and operational advice to the Integration Joint Board and be a member of the corporate management teams of West Dunbartonshire Council and NHS Greater Glasgow and Clyde.

4.3 The Chief Officer is responsible for the operational management and performance of Integrated Services, and such other hosted Partnership services as are delegated to the Integration Joint Board.

4.4 A process has been developed between NHS Greater Glasgow and Clyde and West Dunbartonshire Council. It is proposed that the six voting members of the Partnership Board, along with both Chief Executives will form the recruitment committee to appoint the new Chief Officer.

The Strategic Lead, People and Technology from West Dunbartonshire Council will act as HR advisor to the panel. The panel will be chaired by the Chair of the Partnership Board. The successful candidate will be appointed in

accordance section 10 Section of the Public Bodies (Joint Working) (Scotland) Act 2014. Once an appointment has been made a paper will be presented to the Partnership Board to recommend formally appointing the new Chief Officer to the Board.

4.5 The above process is proposed as follows:

Recruitment Stage	Planned Dates
Recruitment Marketing Campaign Opens	By Friday 3rd March 2017
Closing date	Noon Thursday 16th March 2017
Short listing Packs issued to appointments panel	Friday 17th March 2017
Candidate Assessment Reports & Interview Packs issued to appointments panel	To be confirmed
Panel Interviews	To be confirmed

5. People Implications

5.1 The people aspects are dealt with under sections 9, 10 and 11 of the integration scheme.

6. Financial Implications

6.1 None

7. Professional Implications

7.1 The appointment of a Chief Officer is required by section 10 of the 2014 Act.

8. Locality Implications

8.1 None

9. Risk Analysis

9.1 If the Integrated Joint Board do not appoint to the Chief Officers role it will be non compliant with section 10 of the 2014 Act.

10. Impact Assessments

10.1 This paper is covered by the Equality Impact Assessment which was undertaken for the Integration Scheme.

11. Consultation

Not applicable.

12. Strategic Assessment

12.1 Not Applicable.

Author: Serena Barnatt
Head of People and Change
West Dunbartonshire Health & Social Care Partnership

Date: 1st March 2017

Person to Contact: Serena Barnatt, Head of People and Change
West Dunbartonshire Health & Social Care Partnership,
West Dunbartonshire HSCP HQ, West Dunbartonshire Council, Garshake Road, Dumbarton, G82 3PU.
.
E-mail: serena.barnatt2@ggc.scot.nhs.uk

Appendices: **None**

Background Papers:

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

Integration Scheme (Body Corporate) Between West Dunbartonshire Council and Greater Glasgow Health Board.

Wards Affected: **ALL**

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Partnership Board: 22nd March 2017

Subject: Audit Plan 2016/17 Progress Report and Audit Plan 2017/18

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;
- Details of the planned programme of work for 2017/18; and
- The findings of the completed Audit of the Partnership Board's Governance, Performance and Financial Management Arrangements

2. Recommendations

2.1 It is recommended that the Audit Committee:

- Note the progress made in relation to the Audit Plan for 2016/17;
- Approve the Audit Plan for 2017/18; and
- Approve the action plan within the completed Audit of the Partnership Board's Governance, Performance and Financial Management report.

3. Background

Audit Plan 2016/17

3.1 This report provides a summary to the Partnership Board of recent the Internal Audit activity at the Council and the Health Board which may have an impact upon the delivery of the strategic plan.

Audit Plan 2017/18

3.2 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.

3.3 The PSIAS also requires that the plan should be based on a clear understanding of the organisation's functions and the scale of potential audit areas. The plan should be partly informed by consultation with key stakeholders, including the Audit Committee and senior management. The Audit Committee should approve the Internal Audit plan.

3.4 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 20 allocated audit days for the Partnership Board referred to at paragraph 4.18 below are absorbed into the cost of the Council's Internal Audit Team.

3.5 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;
- a review of the HSCP's Strategic Plan and Risk Register;
- discussions with the Chief Financial Officer and other senior staff on current financial performance and planned service developments; and
- the incorporation of recommendations from the set of Audit Scotland Reports on the progress of Integration.

3.6 West Dunbartonshire Council's Audit and Risk Manager, Colin McDougall, has been appointed as the Chief Internal Auditor for the Health & Social Care Partnership Board and routinely reports to the members of the Audit Committee on internal control and audit matters. The Chief Internal Auditor of the Health & Social Care Partnership Board 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 appropriate issues within the Health & Social Care Partnership.

3.7 Audit Scotland 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 an IJB, are kept fully informed of the impact of integration for users of local health and care services. The existence of the HSCP Audit Committee provides the opportunity for such scrutiny to take place.

4. Main Issues

(a) Progress on Audit Plan 2016/17

West Dunbartonshire Council

4.1 Since 1st April 2016, the following Internal Audit reports have been issued to the Council, which are relevant to the Partnership 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
Use of Consultants	0	1	1
	0	14	4

4.2 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

4.3 Outstanding actions from previously issued audit reports are included at Appendix A, along with the full action plan from one recently issued action plan.

4.4 Internal Audit will undertake follow up work to confirm the implementation of the recommendations.

4.5 The planned audit on Fostering and Adoption is currently in progress. The planned audit on Scottish Social Services Council Registration has not yet commenced.

4.6 As a result of a significant amount of investigations work to which the Internal Audit team has had to respond it has not been possible to fully complete the risk based audit plan for 2016/17. As a result, four risk based audits from the overall Council audit plan have been rolled forward into 2017/18, including Employment Support (Social Work initiative for vulnerable people). This approach has been agreed in discussion with External Audit.

<u>NHS Greater Glasgow and Clyde</u>

4.7 In the period, the following Internal Audit reports have been issued to the NHS Greater Glasgow & Clyde, which are relevant to the Partnership Board:

Audit Title	Opinion	Number and Priority of Recommendations		
		High	Medium	Low
Waiting Times / TTG	High Risk	1	2	-
Key Financial Controls - Payroll	Medium Risk	-	3	2
Key Financial Controls - Accounts Payable	Low Risk	-	-	2
Key Financial Controls - General Ledger	Low Risk	-	-	1
Performance Monitoring and Reporting in Acute Services	Low Risk	-	2	-
Complaints Handling Procedures	Low Risk	-	1	3
		1	8	8

4.8 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

4.9 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 HSCP Audit Committee with any matters of concern being drawn to the attention of this Committee.

WD Health & Social Care Partnership Board

4.10 In addition to the reviews referred to above, an audit has been carried out on the West Dunbartonshire Governance, Performance and Financial Management arrangements of the Health & Social Care Partnership Board. A report on this audit is provided at Appendix B of this report. That report confirms that the systems examined are generally working effectively, with there being appropriate governance arrangements and documentations in place that provide a framework for effective organisational decision making; and that a satisfactory performance management and reporting arrangements framework has been established.

(b) Audit Plan 2017/18

4.11 The Chief Internal Auditor met with the Chief Officer, the Head of Strategy, Planning & Health Improvement and the Chief Financial Officer to discuss and agree a programme of work for the financial year 2017/18.

4.12 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.

4.13 The Chief Internal Auditor monitors delivery of the plan continuously during the year using a number of performance indicators. Progress is reported to HSCP Audit Committee members on a regular basis.

4.14 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 HSCP Audit Committee.

West Dunbartonshire Council

4.15 WDC's audit plan for 2017/18 includes a number of audit reviews which cover Health & Social Care Partnership service areas, namely:

Audit	Days Allocated	Objectives / Key Tasks
Employment Support (Social Work initiative for vulnerable people) – rolled forward from 2016/17	20	• Determination of suitability of clients • General cash controls • Recording of income and expenditure process • Stock control • General compliance with Council polices regarding fire assessments, health and safety training etc.
Guardianship Cases (MHO involvement)	20	• Legal requirements • Management of cases • Training • Resources available

Use of Care First functionality for financial management	25	• Functionality options and opportunities to develop further • Extent of use of available processes • Commitment information • Authorisation process re addition / amendments / cessation of care packages • Control and validation of rate / unit cost / pension changes
Social Work Tendering and Commissioning	25	• Commissioning strategy • Procurement arrangements • Policies and procedures • Payment monitoring • Monitoring of delivery of contracted services
Total	**90**	

These audits, together with other Council wide system reviews, help to inform an opinion on the control environment within the Health & Social Care Partnership.

NHS Greater Glasgow and Clyde

4.16 For the overall internal audit plan for NHS Greater Glasgow and Clyde, the total number of indicative days allocated for all audit activity has not yet been confirmed by PWC.

4.17 Much of the audit work which is carried out within NHS Greater Glasgow and Clyde by PWC covers services which are delegated to the Partnership Board and the findings of these reviews also contribute to an opinion of the control environment

WD Health & Social Care Partnership Board

4.18 In addition to the reviews referred to above, the Health & Social Care Partnership has a draft audit plan which includes 20 days drawn from the Internal Audit Service of West Dunbartonshire Council. This will be used to service this audit committee and carry out a review of:

- General Policies and procedures;
- Financial Regulations;
- Reserves Policy; and

- Risk Management Strategy.

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 Partnership Board'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**
Chief Internal Auditor – Health & Social Care Partnership Board

Date: **22 March 2017**

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

Appendices: Appendix A: Internal Audit Reports – WDC Internal Audit Team

Appendix B: Internal Audit Report – WDHSCP: Governance, Performance and Financial Management Review

Background Papers: None

Appendix A: Internal Audit Reports - WDC Internal Audit Team

Generated on: 28 February 2017

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

Project 107. Home Care (Report Issued November 2016)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
CS/IAAP/469	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.		50%	31-Mar-2017	31-Mar-2017	Lynne McKnight	All staff reminded of requirement to scan in and out of client visits. Individual staff who are not adhering to this are identified, and phones / electronic tags are checked for potential errors. Team performance reported at team meetings.
CS/IAAP/470	1(b). CM2000 missed clock ins and clock outs It is recommended that Home Care management	There is already a significant reduction in administration of timesheets for Home		50%	31-Mar-2017	31-Mar-2017	Lynne McKnight	Individual discussions with staff regarding low compliance rates. Organisers report team

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	put in place an action plan in order to ensure the compliance with clock in and clock out increases within CM2000. (Medium Risk)	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.						performance at team meetings, highlighting top compliance rate, and low performance rates, and targets. Improvements monitored by organisers, reporting to service managers. Scheduling of evening visits under test for full implementation.
CS/IAAP/471	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. (Medium Risk)	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.		40%	30-Jun-2017	30-Jun-2017	Lynne McKnight	Processes for CM2000 have been reviewed, and management representation at CM2000 users group to share good practice. Financial procedures, medication and risk assessments have been reviewed
CS/IAAP/472	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.		75%	31-Mar-2017	31-Mar-2017	Lynne McKnight	Policy / guidelines for mobile phone use updated and issued. All high bills investigated individually. Inappropriate use has been re-charged to workers.

Project 112. Use of Consultants (Report Issued March 2017)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
CS/IAAP/496	All services within the Council should ensure that a performance review is carried out within one month following the completion of each consultancy contract.. A Performance Review Certificate should be completed as evidence of the review. (Low Risk)	A formal review at the end of a period of consultancy work is good practice and should enable officers to confirm if objectives / targets / outputs / outcomes have been met as well as recording the consultant's performance against KPIs and any lessons learned. A Performance Review Certificate to facilitate this will be developed based on the Supplier Relationship Management policy and will be completed within one month of the end of each consultancy contract.		0%	30-Jun-2017	30-Jun-2017	Annabel Travers	Action on track.
CS/IAAP/497	Services should ensure that the correct procurement procedures are followed as stated in Section Q of the Financial Regulations Dec 2015 when engaging consultants. In deciding the appropriate procurement route Services must consider expected cumulative spend on the particular type of work, in compliance with Financial Regulations. (Medium Risk)	With immediate effect all Roads & Transport Service consultancy contracts will be procured through the Scotland Excel and /or the South Lanark Consultancy framework contracts. For specialist consultancy works where alternative Consultants exist, appropriate procurement processes will be followed. Consultancy Services		100%	31-Mar-2017	31-Mar-2017	Stewart Paton; Raymond Walsh	Action complete.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
		staff are instructed to follow the correct procurement procedures relative to the commissioning of consultants. Staff were emailed a link to the relevant section (Section Q) of the Financial Regulations, a copy of which has been posted at a visible location within the office. Staff are requested to contact Corporate Procurement should they have any queries.						

Appendix B

INTERNAL AUDIT SERVICES

REPORT REF No S/023/17 (March 2017)

West Dunbartonshire Health and Social Care Partnership Board Governance, Performance & Financial Management Review

INDEX OF CONTENTS

Section	Contents		Page No.
1.	**Director's Summary**		**2**
2.	**Main Report**		**3**
	2.1	**Introduction**	**3**
	2.2	**Scope and Objectives**	**3**
	2.3	**Findings**	**4**
3.	**Action Plan**		**9**

Personnel referred to in this report :

Soumen Sengupta - **Head of Strategy, Planning & Health Improvement**

Julie Slavin - **Chief Financial Officer**

Auditor: Lutfun Rahman

1. DIRECTOR'S SUMMARY

General

An audit was conducted on a review West Dunbartonshire Health and Social Care Partnership (WDHSCP) Board's Governance, Performance & Financial Management arrangements and we are pleased to report that the systems examined are generally working effectively.

The review highlighted that opportunities exist to strengthen internal controls and enhance the service provided, the most important of which are listed below;

- A Records Management Plan is not yet completed for the WDHSCP Board to approve. This is because the Scottish Government is still preparing a model plan for all IJBs to follow. This Plan should be completed for approval by the WDHSCP Board as soon as the model plan is available in order to comply with the statutory requirement.
- The document "Delivering Good Governance in Local Government: Framework" (CIPFA / SOLACE), which was published in 2016, provides an update to the previous document that originates from 2007. Within the revised framework, there is a requirement for Elected Members and Officers to consider various aspects in relation to significant partnership arrangements. Therefore management within WDC and WDHSCP should, as part of their regular management meetings, identify any issues in relation to partnership governance arrangements and agree any resultant improvement actions in order comply with the best practice.

Full details of these opportunities and any other points that arose during the audit are included in the Action Plan, which forms Section 3 of this report.

2. MAIN REPORT

2.1 INTRODUCTION

2.1.1 Under the Scottish Government's Public Bodies (Joint Working) (Scotland) Act 2014 the Health Board and the Council have agreed to formally delegate health and social care services for adult and children to a third party which is described in the Act as an Integration Joint Board (IJB). For West Dunbartonshire it is known as West Dunbartonshire Health & Social Care Partnership (WDHSCP) Board.

2.1.2 An audit review was carried out on WDHSCP Board's Governance, Performance & Financial management as part of the planned of audit for 2016-17.

2.2 SCOPE AND OBJECTIVES

2.2.1 The auditor reviewed integration scheme, strategic plan, and financial regulations along with various other policy documents that are in place.

2.2.2 The auditor also reviewed minutes and papers from WDHSCP Board meetings and Audit Committee meetings.

2.2.3 An audit launch meeting was held on the 21 December 2016 with Soumen Sengupta (SS) – Head of Strategy, Planning & Health Improvement and Julie Slavin (JS) - Chief Financial Officer.

2.2.4 The auditor also held further meetings and discussions with JS and SS.

2.2.5 The main areas of the audit were:

- Governance arrangements and documentations review;
- Performance management and reporting arrangements review; and
- Financial management and performance review.

2.3 FINDINGS

2.3.1 The findings are based upon evidence obtained from discussions with staff, reviewing documents.

2.3.2 The audit was conducted in conformance with the Public Sector Internal Audit Standards (PSIAS).

Governance arrangements and documentations review

2.3.3 Good governance is important for public bodies to provide reassurance to all its stakeholders that they are delivering high-quality, cost-effective services through effective systems and process for managing issues, such as risk, performance, finance and information.

2.3.4 **Integration Scheme – May 2015:** This document sets out the details how the partnership was implemented within the WD area including its mission, purpose, and integration model, delegation of duties, finance, performance and risk management.

2.3.5 The WDHSCP Board comprises a wide range of service users and partners including 6 voting members equally split with three elected members and three non- executive directors of the health board, . There are eighteen non-voting members, which include the Chief Officer and the Chief Financial Officer.

2.3.6 The Chief Officer provides overall strategic and operation advice and is directly accountable to the WDHSCP Board for all of its responsibilities.

2.3.7 **Strategic Plan** The first strategic plan was approved by the WDHSCP Board on the 1st July 2015, which it also confirmed as the being the commencement date for the new integrated arrangements. The legislation required that first Strategic Plan to detail the locality arrangements: these were confirmed as being one for the Clydebank area and one for the Dumbarton and Alexandria area. The HSCP Board's Second Strategic Plan for 2016-19 was agreed in May 2016. The Strategic Plans have detailed key performance indicators; and the progress on these has been and continues to be reported via various reports to the WDHSCP Board and the Audit Committee. The Strategic Plans also summarised key financial, workforce, and professional implications.

2.3.8 **Financial Regulations:** The Financial Regulations are a key component of the WDHSCP Board's governance arrangements. They set out the responsibilities of the WDHSCP Board and senior officers in relation to the proper administration of the WDHSCP Board's finances, legality and limit of the expenditure, budgetary control, and risk management arrangements that the WDHSCP Board have to put in place.

2.3.9 **Standing Orders:** These were approved in July 2015 and are made in accordance with the Public Bodies (Joint Working) (Scotland) Act 2014 and

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

2.3.10 The WDHSCP Board and the Audit Committee meet on a regular basis throughout the year. The auditor has noted the meetings are taking place at least on a quarterly basis. All meetings are held and minuted as per the requirements of the Standing Orders. The Chief Internal Auditor can confirm based on his attendance at the Audit Committee that there is a good level of scrutiny and discussion taking place at these meetings.

2.3.11 **Strategic Risk Register:** A system for managing risks should be included in an effective system of governance arrangements which is also required by the Financial Regulations. Therefore the WDHSCP Board approved its integrated Strategic Risk Register in November 2015. This has been reviewed and updated in November 2016. This demonstrates a robust process of risk management is in place.

2.3.12 There is a **Code of Conduct** in place for members of the WDHSCP Board providing guidance on remuneration, allowances, gifts and hospitality, financial and non-financial interests. There are also codes of conduct for the WDC and the Health Board, all of which are in agreement with one another. Both the Chief Officer and the Chief Financial Officer adhere to the code of conduct of their employing organisations as well as the WDHSCP Board. A **Records Management Plan** is yet to be completed for the Partnership Board to approve. This is because the Scottish Government is currently preparing a model plan for all IJBs to follow. When that is completed and published a Records Management Plan will be prepared for local approval.

2.3.13 There is a statutory requirement for the WDHSCP Board to have a **Complaints Handling Procedure** in place. WDHSCP has worked with the Scottish Public Services Ombudsman (SPSO) and the Scottish Government to develop a template Complaints Handling Procedure for use by all IJBs; and a local complaints handling procedure for the WDHSCP Board has been prepared for approval and will be effective from the 1st April 2017. The procedure relates to any complaints with respect to how the WDHSCP Board discharges its responsibilities.

2.3.14 There is an on-going commitment for the WDHSCP Board members' development and support within the approved WDHSCP Workforce and Organisational Development Strategy. An elected members' briefing session was run, which included an invite to former CHCP/Shadow HSCP Committee members, in advance of the WDHSCP Board going live. There is a plan for another training and development session post-elections.

2.3.15 A Scheme of Delegation is in place that allows for the efficient running of WDHSCP, through appropriate allocation of tasks and responsibilities by West Dunbartonshire Council and the Health Board, and this contributes to the overall internal control framework.

2.3.16 The document "Delivering Good Governance in Local Government: Framework" (CIPFA / SOLACE), which was published in 2016, provides an update to the previous document that originates from 2007. This is intended to be used as best practice for developing and maintaining a locally adopted code of governance within local authorities and applies to their governance statements from the financial year 2016/17 onwards. Within the revised framework, there is a requirement for Elected Members and Officers to consider various aspects in relation to significant partnership arrangements. Management within WDC and WDHSCP should, as part of their regular management meetings, identify any issues in relation to partnership governance arrangements and agree any resultant improvement actions.

2.3.17 The Auditor concludes that the WDHSCP Board has appropriate governance arrangements and documentations in place and they provide a framework for effective organisational decision making.

2.3.18 **Post implementation review:** - as part of the governance review process the auditor concluded that the WDHSCP Board has appropriate governance arrangement, robust process and effective internal control system in place with competent Management Board. Regular WDHSCP Board meetings are taking place, all policies and procedures in place, with the exception of few, as required by laws and regulations. However, it is to be noted that a full post implementation review has not been carried out as part of this audit.

Performance management and reporting arrangements review

2.3.19 Performance management aims to improve the effectiveness of public services and to have a positive impact on outcomes for individuals and communities. Performance management is generally composed of the below interlinked elements:

i) Performance measurement;

ii) Target-setting;

iii) Rewards and/or sanctions; and

iv) Benchmarking.

2.3.20 The Public Bodies (Joint Working) (Scotland) Act 2014 requires that an annual performance report is completed within four months of the year end. This is a statutory requirement for the 2016/17 year - however the Partnership Board received its first such report for the year 2015/16, covering the first nine months of activity.

2.3.21 The annual performance report to 31st March 2016 covers key service areas and carer groups, balance of care, best value achieved, good governance, performance assessment, strategic needs assessments and Care Inspectorate gradins.

2.3.22 In the annual performance report there were 36 key performance indicators (PIs), 22 of these were green, 8 amber and 6 red, where

- o Green means target achieved or exceeded;
- o Amber means target narrowly missed; and
- o Red means target missed by 15% or more.

The work to address these red key PIs and other key PIs was detailed within the Strategic Plan for 2016-19. Reporting on progress and impact is detailed in individual reports focused on care groups.

2.3.23 Since April 2016, a Quarterly Public Performance Report has been submitted to the WDHSCP Board. The second report has been submitted covering July to September 2016 quarter. The Quarterly Public Performance Reports relate to those key PIs within the Strategic Plan where there is data available for that period. Some of the key PIs in the Strategic Plan are not available on a quarterly basis.

2.3.24 The Local Government Benchmarking Framework (LGBF) 2014/15 was carried out last year. When the next set of LGBF data is published nationally, it will be incorporated into the WDHSCP Board's next annual performance report. In addition, there are a number of benchmarking processes underway within the WDHSCP - e.g. Scottish Government and Information Services Division Scotland are working with WDHSCP and other Partnerships on a major exercise for benchmarking performance in relation to unscheduled care. That data will be reflected within specific reports to the WDHSCP Board on a topic-by-topic basis.

2.3.25 The Auditor can therefore conclude that the WDHSCP Board has established a satisfactory performance management and reporting arrangements framework.

Financial management and performance review

2.3.26 The Integration Scheme sets out the detail of the integration arrangement agreed between the Health Board and West Dunbartonshire Council.

2.3.27 The Chief Officer is the accountable officer of the Partnership Board in all matters except finance. The Chief Financial Officer is the accountable officer for financial management and administration of the WDHSCP Board. The Chief Financial Officer is line managed by the Chief Officer, and professionally supervised and formally supported by the Council Section 95 Officer and the Health Board Director of Finance.

2.3.28 Legislation empowers the WDHSCP Board to hold reserves which should be accounted for in the financial accounts and records of the WDHSCP Board. The reserve policy sets out the arrangements between the parties for dealing with any overspends and underspends.

2.3.29 The WDHSCP allocates the resources it receives from the Health Board and the Council in line with Strategic Plan. There is a requirement of the Strategic Plan for the development of separately agreed efficiency and savings proposals on an annual basis to mitigate the considerable risk of recurrent imbalance.

2.3.30 WDHSCP Board budget for 2016/17 was not formally set at the beginning of the financial year due to the delays of the Scottish Government's financial plan. The Council budget was set on 24 February 2016 which provided confirmation around the Council element of the funding for 2016/17. The Health Board budget was formally approved on 28 June 2016. Therefore, the WDHSCP Board set an interim budget in May based on assumed funding from the health board which had a total net expenditure of £137.377million, comprising of contributions from the Council £61.539 million and the Health Board £75.839million. The final budget was, following notification in July 2016, a net expenditure of £140.954million comprising contribution from the Council £61.539million and the Health Board £79.415 million. This includes the WDHSCP Board's £4.921million share of the increased investment by the Scottish Government.

2.3.31 The financial reports are presented at every WDHSCP Board Meeting by the Chief Financial Officer. The financial reports as at 31 December 2016 presented to the WDHSCP Board is reporting a projected underspend of £2.774million for 2016/17 in the social care budget. The WDHSCP Board's health care budget is reporting an overall break even position.

2.3.32 The WDHSCP Board budget for 2017/18 is yet to be formally set. The Council budget was set on 22 February 2017 which provided confirmation around the Council element of the funding for 2017/18. The contribution to the WDHSCP Board was set at £60.673million which is a reduction of £0.866 on the 2016/17 budget of £61.539million. However this is in line with the Scottish Government's allowable allocation reduction. The reduction in budget will be managed through the application of non-committed element of £2.0 million the 2016/17 Social Care Fund as per November 2016 Board Report. The Health Board have not yet formally approved their 2017/18 budget. The direction issued by the Scottish Government to IJBs for delegated health functions must be maintained at least at 2016/17 cash levels: for WDHSCP Board it was £80.676 million.

2.3.33 The factual accuracy of this report has been verified by the officers involved in the audit.

2.3.34 The Auditor would like to thank all staff involved in the audit process for their time and assistance.

1.	A Records Management Plan is yet to be completed for the WDHSCP Board to approve. This is due to the Scottish Government is preparing a model plan for all IJBs to follow.	It is recommended that when a model plan is completed and published a Records Management Plan prepared for local approval by the Partnership Board in order to comply with the statutory requirement.	Low Risk	This will be completed at the earliest opportunity, with WDHSCP officers having already engaged with Scottish Government officials on the drafting of the model Records Management Plan.	Head of Strategy, Planning & Health Improvement.	October 2017
2.	The document "Delivering Good Governance in Local Government: Framework" (CIPFA / SOLCE), which was published in 2016, provides an update to the previous document that originates from 2007. This is intended to be used as best practice for developing and maintaining a locally adopted code of governance within local authorities and applies to their governance statements from the financial year 2016/17 onwards. Within the revised framework, there is a requirement for Elected Members and Officers to consider various aspects in relation to significant partnership arrangements.	It is recommended that management within WDC and WDHSCP should, as part of their regular management meetings, identify any issues in relation to partnership governance arrangements and agree any resultant improvement actions in order comply with the best practice.	Low Risk	Preliminary discussions have already taken place, and initial scoping begun with respect to partnership governance arrangements as relates to the WDHSCP Board.	Chief Financial Officer	August 2017

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health and Social Care Partnership Board: 22 March 2017

Subject: Audit Scotland: West Dunbartonshire Integrated Joint Board Annual Audit Plan 2016/17

1. Purpose

1.1 To present the Audit Scotland Annual Audit Plan, for the audit of the financial year 2016/17, to the Health & Social Care Partnership Board for information.

2. Recommendation

2.1 The Partnership Board is recommended to note Audit Scotland’s 2016/17 Audit Plan.

3. Background

3.1 In July 2016 the Accounts Commission appointed Audit Scotland as the external auditor for the West Dunbartonshire Integrated Joint Board for the five year period from 2016 to 2021.

3.2 Audit Scotland had served as the IJB’s external auditor for 2015/16, the inaugural year of the partnership after its establishment on 1 July 2015. The continuation of appointment of Audit Scotland allows for the positive working relationships established in 2015/16 to be built upon to achieve the desired outcome of an unqualified audit opinion at the end of the 2016/17 annual accounts process.

3.3 The initial step is the production of the Annual Audit Plan (Appendix 1). Based on discussions with staff, attendance at board meetings and a review of supporting information, the plan is focused on the identification of the main risk areas for the West Dunbartonshire Integrated Joint Board.

4. Main Issues

4.1 The key audit risks, which are categorised into financial risks and wider dimension risks, and the planned audit work are set out in Exhibit 1 of the appended report.

4.2 The audit outputs and their target dates, which are based on presentation of Annual Audit Report to the Audit Committee on 20 September 2017, are detailed in Exhibit 2 and Exhibit 4.

4.3 The planned work in 2016/17 includes:

- an audit of the financial statements and provision of an opinion on whether:
  - they give a true and fair view of the state of affairs the partnership as at 31 March 2017 and its income and expenditure for the year then ended; and
  - the accounts have been properly prepared in accordance with relevant legislation including: the Local Government (Scotland) Act 1973; the 2016/17 Code of Practice on Local Authority Accounting in the United Kingdom (the Code) and the Integrated Resources Advisory Group (IRAG) Guidance.
- a review and assessment of the partnership's governance and performance arrangements in a number of key areas including budgetary control and key systems of internal control; and
- the IJB's financial sustainability in the medium to long term to conclude on;
  - the effectiveness of financial planning; and
  - the appropriateness and effectiveness of arrangements in place to address identified funding gaps.

4.4 Auditing standards require internal and external auditors to work closely together to make best use of available audit resources. To support the external audit opinion on the financial statements formal reliance will be placed on the completed internal audit reviews of:

- Home Care
- Fostering and Adoption payments/allowances

5. People Implications

5.1 None associated with this report.

6. Financial Implications

6.1 The audit fee for the 2016/17 audit of the IJB is £17,400, which is small increase of £300 (1.8%) on the 2015/16 cost. In determining the fee, account is taken on the risk exposure of the IJB, the management assurances in place and the level of reliance taken from the work of internal audit.

6.2 Audit Scotland's fee assumes receipt of the unaudited financial statements by 30 June 2017 and covers the cost of planning, delivery, reporting and the auditor's attendance at committees.

7. Professional Implications

7.1 None associated with this report.

8. Locality Implications

8.1 None associated with this report.

9. Risk Analysis

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

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

12. Strategic Assessment

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

Author: Julie Slavin – Chief Financial Officer,

Date: 22 March 2017

Person to Contact: Julie Slavin – Chief Financial Officer,
Garshake Road, Dumbarton, G82 3PU.
Telephone: 01389 737311
e-mail: julie.slavin@ggc.scot.nhs.uk

Appendices: Audit Scotland - Annual Audit Plan 2016/17

Background Papers: Audit Committee 14 September 2016 – Item 14
WDC Audit and Performance Review Committee: 8 March 2017- Item 8

Wards Affected: All

West Dunbartonshire Integrated Joint Board

Annual Audit Plan 2016/17

Prepared for West Dunbartonshire Integrated Joint Board
March 2017

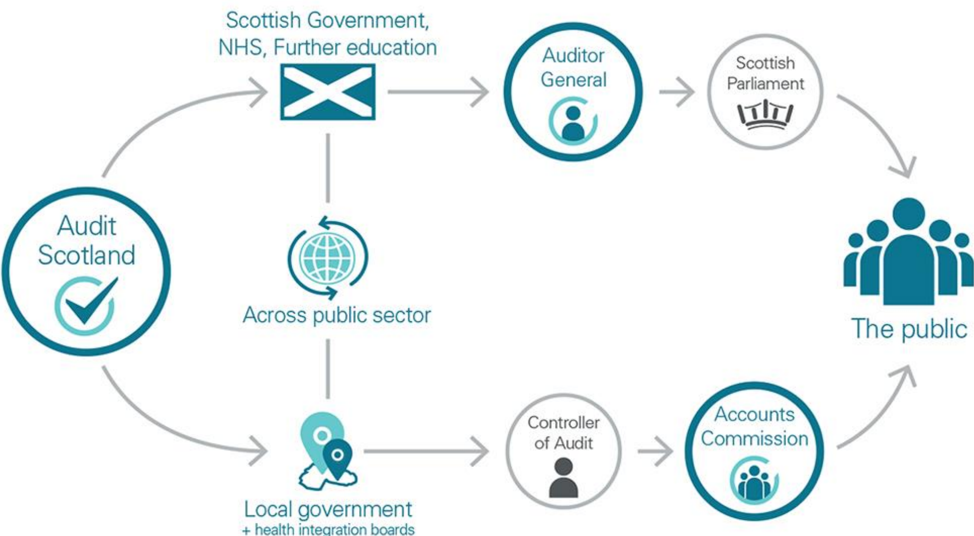
Who we are

The Auditor General, the Accounts Commission and Audit Scotland work together to deliver public audit in Scotland:

- The Auditor General is an independent crown appointment, made on the recommendation of the Scottish Parliament, to audit the Scottish Government, NHS and other bodies and report to Parliament on their financial health and performance.

- The Accounts Commission is an independent public body appointed by Scottish ministers to hold local government to account. The Controller of Audit is an independent post established by statute, with powers to report directly to the Commission on the audit of local government.

- Audit Scotland is governed by a board, consisting of the Auditor General, the chair of the Accounts Commission, a non-executive board chair, and two non-executive members appointed by the Scottish Commission for Public Audit, a commission of the Scottish Parliament.



About us

Our vision is to be a world-class audit organisation that improves the use of public money.

Through our work for the Auditor General and the Accounts Commission, we provide independent assurance to the people of Scotland that public money is spent properly and provides value. We aim to achieve this by:

- carrying out relevant and timely audits of the way the public sector manages and spends money

- reporting our findings and conclusions in public

- identifying risks, making clear and relevant recommendations.

Contents

Risks and planned work 4

- Audit risks 4
- Reporting arrangements 5
- Audit fee 6
- Responsibilities 6

Audit scope and timing 7

- Financial statements 7
- Internal audit 9
- Audit dimensions 9
- Independence and objectivity 11
- Quality control 11

Risks and planned work

1. This annual audit plan contains an overview of the planned scope and timing of our audit and is carried out in accordance with International Standards on Auditing (ISAs), the *Code of Audit Practice*, and any other relevant guidance. This plan identifies our audit work to provide an opinion on the financial statements and related matters and meet the wider scope requirements of public sector audit. The wider scope of public audit contributes to conclusions on the appropriateness, effectiveness and impact of corporate governance, performance management arrangements and financial sustainability.

Audit risks

2. Based on our discussions with staff, attendance at committee meetings and a review of supporting information we have identified the following main risk areas for West Dunbartonshire Integrated Joint Board. We have categorised these risks into financial risks and wider dimension risks. The key audit risks, which require specific audit testing, are detailed in Exhibit 1.

Exhibit 1

Audit Risk		Management assurance	Planned audit work
Financial statement issues and risks			
1	**Risk of management override of controls** ISA 240 requires that audit work is planned to consider the risk of fraud, which is presumed to be a significant risk in any audit. This includes consideration of the risk of management override of controls in order to change the position disclosed in the financial statements.	*Owing to the nature of this risk, assurances from management are not applicable.*	Detailed testing of journal entries. Review of accounting estimates. Focused testing of accruals and prepayments. Evaluation of significant transactions that are outside the normal course of business.
2	**Financial statements preparation** The 2016/17 financial statements will require income, expenditure and year end balances to be agreed with West Dunbartonshire Council and NHS Greater Glasgow and Clyde. There is a risk that the procedures for agreeing the year end balances are not fully embedded and that the financial statements are not delivered to the agreed timescale and in the required format.	Monthly monitoring of financial information. Officers review the guidance issued by IRAG and LAASAC. Processes and procedures will be agreed to ensure information is provided in a timely manner to support the delivery of the financial statements.	Continued engagement with officers prior to the accounts being prepared to ensure that the relevant information is disclosed and the timetable is met. Service auditor assurances will be obtained from the auditors of West Dunbartonshire Council and NHS Greater Glasgow and Clyde over the completeness, accuracy and allocation of the income and expenditure.

	Audit Risk	Management assurance	Planned audit work
3	**Risk of fraud over expenditure** The expenditure of the IJB is processed through the financial systems of West Dunbartonshire Council and NHS Greater Glasgow and Clyde. There is a risk that non IJB related expenditure is incorrectly coded to IJB accounts.	Robust budget monitoring	Gaining assurances from the auditors of the council and health board over the accuracy, completeness and appropriate allocation of the IJB ledger entries. Carry out audit testing to confirm the accuracy and correct allocation of IJB transactions, and that they are recorded in the correct financial year.
Wider dimension risks			
4	**Financial sustainability** The board will need strong financial management and budgetary control to address the challenges and risks to future finances.	Ongoing review of budgets and financial performance	Review ongoing budget monitoring reports to ensure they accurately reflects the position of the partnership. Obtain evidence of remedial action being taken on areas of overspend.
5	**Chief Officer** The incumbent Chief Operating Officer is due to retire in July 2017. Recruitment for a replacement has commenced, however there is a risk that the replacement will not have sufficient time for a comprehensive handover of duties.	Procedures will be put in place to ensure that the new appointee is appropriately updated.	We will liaise with the current Chief Operating Officer throughout the recruitment process.

Reporting arrangements

3. Audit reporting is the visible output for the annual audit. All annual audit plans and the outputs as detailed in Exhibit 2, and any other outputs on matters of public interest will be published on our website: www.audit-scotland.gov.uk.

4. Matters arising from our audit will be reported on a timely basis and will include agreed action plans. Draft management reports will be issued to the relevant officer(s) to confirm factual accuracy.

5. We will provide an independent auditor's report to West Dunbartonshire Integrated Joint Board and the Accounts Commission summarising the results of the audit of the annual accounts. We will provide the Accountable Officer and the Controller of Audit an annual report on the audit containing observations and recommendations on significant matters which have arisen in the course of the audit.

Exhibit 2
2016/17 Audit outputs

Audit Output	Target date	Audit Committee Date
Annual Audit Report including ISA 260 requirements	20 September	20 September
Signed Independent Auditor's Report	21 September	N/A

Audit fee

6. The agreed audit fee for the 2016/17 audit of West Dunbartonshire Integrated Joint Board is £17,400. In determining the audit fee, we have taken account of the risk exposure of West Dunbartonshire Integrated Joint Board, the planned management assurances in place and the level of reliance we plan to take from the work of internal audit. Our audit approach assumes receipt of the unaudited financial statements, with a complete working papers package on 30 June 2017.

7. Where our audit cannot proceed as planned through, for example, late receipt of unaudited financial statements or being unable to take planned reliance from the work of internal audit, a supplementary fee may be levied. An additional fee may also be required in relation to any work or other significant exercises outwith our planned audit activity.

Responsibilities

Health and Social Care Partnership Audit Committee and Accountable Officer

8. Audited bodies have the primary responsibility for ensuring the proper financial stewardship of public funds, compliance with relevant legislation and establishing effective arrangements for governance, propriety and regularity that enable them to successfully deliver their objectives.

9. The audit of the financial statements does not relieve management or the IJB Audit Committee, as those charged with governance, of their responsibilities.

Appointed auditor

10. Our responsibilities as independent auditor are established by the Local Government (Scotland) Act 1973 and the Code of Audit Practice, and guided by the auditing profession’s ethical guidance.

11. Auditors in the public sector give an independent opinion on the financial statements. We also review and report on the arrangements within the audited body to manage its performance, regularity and use of resources. In doing this, we aim to support improvement and accountability.

Audit scope and timing

Financial statements

12. The statutory financial statements audit will be the foundation and source for the majority of the audit work necessary to support our judgements and conclusions. We also consider the wider environment and challenges facing the public sector. Our audit approach includes:

- understanding the business of West Dunbartonshire Integrated Joint Board and the associated risks which could impact on the financial statements
- assessing the key systems of internal control, and establishing how weaknesses in these systems could impact on the financial statements
- identifying major transaction streams, balances and areas of estimation and understanding how West Dunbartonshire Integrated Joint Board will include these in the financial statements
- assessing the risks of material misstatement in the financial statements
- determining the nature, timing and extent of audit procedures necessary to provide us with sufficient audit evidence as to whether the financial statements are free of material misstatement.

13. We will give an opinion on the financial statements as to:

- whether they give a true and fair view of the financial position of the audited bodies and their expenditure and income
- whether they have been properly prepared in accordance with relevant legislation, the applicable accounting framework and other reporting requirements.

Materiality

14. Materiality defines the maximum error that we are prepared to accept and still conclude that our audit objective has been achieved. It helps assist our planning of the audit and allows us to assess the impact of any audit adjustments on the financial statements. We calculate materiality at different levels as described below. The calculated materiality values for West Dunbartonshire Integrated Joint Board are set out in Exhibit 3.

Exhibit 3
Materiality values

Materiality level	Amount
Planning materiality - This is the calculated figure we use in assessing the overall impact of audit adjustments on the financial statements. It has been set at 1% of gross expenditure for the year ended 31 March 2017 based on the latest audited accounts.	£1.38 million
Performance materiality - This acts as a trigger point. If the aggregate of errors identified during the financial statements audit exceeds performance materiality, this would indicate that further audit procedures should be considered. Using our professional judgement, we have calculated performance materiality at 50% of planning materiality.	£690,000
Reporting threshold - We are required to report to those charged with governance on all unadjusted misstatements in excess of the 'reporting threshold' amount. This has been calculated at 1% of planning materiality.	£ 20,000

15. We review and report on other information published with the financial statements including the management commentary, annual governance report and the remuneration. Any issue identified will be reported to the Audit Committee.

Timetable

16. To support the efficient use of resources it is critical that a financial statements timetable is agreed with us for the production of the unaudited accounts. An agreed timetable is included at Exhibit 4 which takes account of submission requirements and planned Audit Committee dates:

Exhibit 4
Financial statements timetable

Key stage	Date
Consideration of unaudited financial statements by those charged with governance	22 June
Latest submission date of unaudited financial statements with complete working papers package	30 June
Latest date for final clearance meeting with Chief Financial Officer	1 September
Agreement of audited unsigned financial statements; Issue of Annual Audit Report including ISA 260 report to those charged with governance	13 September
Independent auditor's report signed	21 September

Internal audit

17. Auditing standards require internal and external auditors to work closely together to make best use of available audit resources. We seek to rely on the work of internal audit wherever possible and as part of our planning process we carry out an assessment of the internal audit function. Internal audit is provided by a team from West Dunbartonshire Council and NHS Greater Glasgow and Clyde on a joint basis.

Adequacy of Internal Audit

18. Overall, we concluded that the internal audit service generally operates in accordance with Public Sector Internal Audit Standards (PSIAS) and has sound documentation standards and reporting procedures in place.

Areas of reliance

19. To support our audit opinion on the financial statements we plan to place formal reliance on the following planned internal audit reviews:

- Home Care
- Fostering and adoption payments/allowances

Audit dimensions

20. Our audit is based on four audit dimensions that frame the wider scope of public sector audit requirements as shown in Exhibit 5.

Exhibit 5
Audit dimensions

21. The appointed auditor's annual conclusions on these four dimensions will contribute to an overall assessment and assurance on best value.

Financial sustainability

22. As auditors, we consider the appropriateness of the use of the going concern basis of accounting as part of the annual audit. We will also comment on the

body's financial sustainability in the longer term. We define this as medium term (two to five years) and longer term (longer than five years) sustainability. We will carry out work and conclude on:

- the effectiveness of financial planning in identifying and addressing risks to financial sustainability in the short, medium and long term

- the appropriateness and effectiveness of arrangements in place to address any identified funding gaps

Financial management

23. Financial management is concerned with financial capacity, sound budgetary processes and whether the control environment and internal controls are operating effectively. We will review, conclude and report on:

- whether West Dunbartonshire IJB has arrangements in place to ensure systems of internal control are operating effectively

- whether West Dunbartonshire IJB can demonstrate the effectiveness of budgetary control system in communicating accurate and timely financial performance

- how West Dunbartonshire IJB has assured itself that its financial capacity and skills are appropriate

- whether West Dunbartonshire IJB has established appropriate and effective arrangements for the prevention and detection of fraud and corruption.

Governance and transparency

24. Governance and transparency is concerned with the effectiveness of scrutiny and governance arrangements, leadership and decision-making and transparent reporting of financial and performance information. We will review, conclude and report on:

- whether West Dunbartonshire IJB can demonstrate that the governance arrangements in place are appropriate and operating effectively.

- whether there is effective scrutiny, challenge and transparency on the decision-making and finance and performance reports.

- the quality and timeliness of financial and performance reporting.

Value for money

25. Value for money refers to using resources effectively and continually improving services. We will review, conclude and report on whether:

- West Dunbartonshire IJB can provide evidence that it is demonstrating value for money in the use of its resources.

- West Dunbartonshire IJB can demonstrate that there is a clear link between money spent, output and outcomes delivered.

- West Dunbartonshire IJB can demonstrate that outcomes are improving.

- There is sufficient focus on improvement and the pace of it.

Independence and objectivity

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

27. The engagement lead for West Dunbartonshire Integrated Joint Board is Fiona Mitchell-Knight, Assistant Director. Auditing and ethical standards require the appointed auditor to communicate any relationships that may affect the independence and objectivity of audit staff. We are not aware of any such relationships pertaining to the audit of West Dunbartonshire Integrated Joint Board.

Quality control

28. International Standard on Quality Control (UK and Ireland) 1 (ISQC1) requires that a system of quality control is established, as part of financial audit procedures, to provide reasonable assurance that professional standards and regulatory and legal requirements are being complied with and that the independent auditor’s report or opinion is appropriate in the circumstances.

29. The foundation of our quality framework is our Audit Guide, which incorporates the application of professional auditing, quality and ethical standards and the Code of Audit Practice issued by Audit Scotland and approved by the Auditor General for Scotland. To ensure that we achieve the required quality standards Audit Scotland conducts peer reviews, internal quality reviews and is currently reviewing the arrangements for external quality reviews.

30. As part of our commitment to quality and continuous improvement, Audit Scotland will periodically seek your views on the quality of our service provision. We welcome feedback at any time and this may be directed to the engagement lead.

West Dunbartonshire Integrated Joint Board

Annual Audit Plan 2016/17

If you require this publication in an alternative format and/or language, please contact us to discuss your needs: 0131 625 1500 or **info@audit-scotland.gov.uk**

For the latest news, reports and updates, follow us on:

Audit Scotland, 4th Floor, 102 West Port, Edinburgh EH3 9DN
T: 0131 625 1500 E: **info@audit-scotland.gov.uk**
www.audit-scotland.gov.uk

AS.1.0