Agenda

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health & Social Care Partnership Board Audit Committee

Date: Wednesday, 14 March 2018

Time: 14:00

Venue: Council Chambers, Clydebank Town Hall, Clydebank

Contact: Nuala Quinn-Ross, Committee Officer
Tel: 01389 737210 Email: nuala.quinn-ross@west-dunbarton.gov.uk

Dear Member

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

The business is shown on the attached agenda.

Yours faithfully

JULIE SLAVIN

Chief Financial Officer of the

Health & Social Care Partnership

Distribution:-

Voting Members
Allan Macleod (Chair)
Marie McNair (Vice Chair)
Denis Agnew
John Mooney
Rona Sweeney
Audrey Thompson

Senior Management Team Health Social Care Partnership
Mr C. McDougall
Ms Z. Mahmood

Date of issue: 6 March 2018

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

AUDIT COMMITTEE

WEDNESDAY, 14 MARCH 2018

AGENDA

1 APOLOGIES

2 DECLARATIONS OF INTEREST

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

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

Submit for approval as a correct record, the Minutes of Meeting of the Health & Social Care Partnership Audit Committee held on 20 September 2017.

4 PRESENTATION BY THE GENERAL MANAGER, ORAL HEALTH DIRECTORATE

A presentation will be provided by the General Manager, Oral Health Directorate, NHS Greater Glasgow & Clyde on the measures to tackle the current oral health picture locally.

5 COMMITTEE ACTION LIST **13 - 16**

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

6 AUDIT PLAN 2017/18 PROGRESS REPORT AND AUDIT PLAN 2018/19 **17 - 56**

Submit report by the Chief Internal Auditor on the above.

7 2017/18 ANNUAL ACCOUNTS AUDIT PROCESS **57 - 60**

Submit report by the Chief Financial Officer on the above.

15 WORK UNDERTAKEN TO IMPROVE GRADES AT DUNN STREET RESPITE SERVICE **163 - 174**

Submit report by the Head of Mental Health, Addictions and Learning Disability on the above.

16 ARE THEY INVOLVING US? INTEGRATION AUTHORITIES' ENGAGEMENT WITH STAKEHOLDERS - A REPORT BY THE SCOTTISH PARLIAMENT HEALTH AND SPORT COMMITTEE REPORT **175 - 210**

Submit report by the Interim Head of Strategy, Planning & Health Improvement on the above.

17 LOOKING AHEAD TO THE SCOTTISH GOVERNMENT HEALTH AND SPORT DRAFT BUDGET 2018-19: A CALL FOR GREATER TRANSPARENCY **211 - 258**

Submit report by the Chief Financial Officer on the above.

18 PROVISION OF TAXI SERVICES FOR NON-SCHEDULED AND SCHEDULED TAXI JOURNEYS FOR THE HEALTH AND SOCIAL CARE PARTNERSHIP **259 - 262**

Submit report by the Contracts & Commissioning Officer on the above.

WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD AUDIT COMMITTEE

At a Meeting of the West Dunbartonshire Health and Social Care Partnership Board Audit Committee held in Council Chamber, Clydebank Town Hall, Dumbarton Road, Clydebank, on Wednesday 20 September 2017 at 2.00 p.m.

Present: Allan MacLeod (Chair), Councillor Marie McNair (Vice Chair), Baillie Denis Agnew; Councillor John Mooney and Rona Sweeney.

Attending: Beth Culshaw, Chief Officer of the Health & Social Care Partnership; Julie Slavin, Chief Financial Officer; Jackie Irvine, Head of Children's Health, Care and Criminal Justice Services; Soumen Sengupta, Head of Strategy, Planning and Health Improvement; Colin McDougall, Chief Internal Auditor; Serena Barnatt, Head of People and Change; Peter Lindsay, Senior Audit Manager; Zahrah Mahmood, Senior Auditor and Zoe Maguire, Auditor (Audit Scotland); and Nuala Borthwick, Committee Officer (West Dunbartonshire Council).

Apologies: An apology for absence was intimated on behalf of Audrey Thompson.

Allan MacLeod in the Chair

DECLARATIONS OF INTEREST

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

MINUTES OF PREVIOUS MEETING

The Minutes of Meeting of the Health and Social Care Partnership Audit Committee held on 22 June 2017 were submitted and approved as a correct record.

COMMITTEE ACTION LIST

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

Having heard the Chair and the Chief Finance Officer in elaboration of the Action List, the Committee agreed to note the actions contained therein.

LOCAL CODE OF GOOD GOVERNANCE REVIEW

A report was submitted by the Chief Financial Officer advising of the outcome of the annual self-evaluation undertaken of the Health & Social Care Partnership's compliance with its Code of Good Governance.

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

(1) to note the summary outcome of the recent self-evaluation process undertaken considering how the HSCP Board meets the approved Local Code of Good Governance;

(2) to approve the improvement actions identified to strengthen compliance with the adopted Governance Framework principles;

(3) that an additional column be added to the Annual Review of Code of Good Governance - Summary, detailed within Appendix 2 of the report, to include the total number of criteria per subsection for future reporting; and

(4) to note that the Chief Officer would consider an external annual evaluation with participation from Board Members in future years.

KEY SOURCES OF ASSURANCE FOR INTERNAL AUDIT ANNUAL REPORT FOR THE EAR ENDED 31 MARCH 2017

A report was submitted by the Chief Internal Auditor presenting two key sources of assurance, from the Health and Social Care Partnership's partner organisations, that informed the Chief Internal Auditor's Annual Report for 2016/2017 for the Health and Social Care Partnership Board and supported the Governance Statement included in the 2016/17 Annual Accounts.

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

(1) to propose to NHS Greater Glasgow and Clyde that a clause relating to information sharing be written into future procurement agreements with providers of audit services; and

(2) to note the contents of the report.

AUDIT SCOTLAND: WEST DUNBARTONSHIRE INTEGRATED JOINT BOARD - DRAFT ANNUAL AUDIT REPORT 2016/17

A report was submitted by the Chief Financial Officer presenting the Annual Audit Report and Auditor's letter, for the audit of the financial year 2016/17, as prepared by the Health and Social Care Partnership Board's external auditors, Audit Scotland.

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

(1) to note the contents of the Annual Audit Report to the Integrated Joint Board and the Controller of Audit for the financial year ended 31 March 2017;

(2) to welcome the achievement of an unqualified report covering the HSCP Board's first full financial year;

(3) to note the issues raised, recommendations and agreed management actions contained within the appendices to the report relating to the audited Annual Accounts;

(4) that authority be delegated to the Chair of the HSCP Board, the Chief Officer and Chief Financial Officer to accept and sign the final 2016/17 Annual Accounts on behalf of the Partnership Board; and

(5) to thank the Chief Financial Officer, her team and the team from Audit Scotland for their hard work in delivering the 2016/17 accounts closure process.

AUDITED ANNUAL ACCOUNTS 2016/17

A report was submitted by the Chief Financial Officer presenting the audited Annual Accounts for the year ended 31 March 2017 as delegated by the HSCP Board on 23 August 2017 and highlighting matters of interest.

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

(1) to approve the audited Annual Accounts for 2016/17;

(2) to acknowledge the work of the Chief Financial Officer and assistance from Audit Scotland in finalising the Partnership Board's Audited Annual Accounts; and

(3) to note the contents of the report.

Note:- Peter Lindsay and Zahrah Mahmood, Audit Scotland left at this point in the meeting.

AUDIT PLAN PROGRESS REPORT

A report was submitted by the Chief Internal Auditor providing an update:-

(1) on the planned programme of audit work for the year 2017/18 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 and Social Care Partnership Board; and

(2) on the agreed actions of the audit of the Partnership Board's Governance, Performance and Financial Management arrangements.

After discussion and having heard the Chief Internal Auditor in further explanation of the report and in answer to Members' questions, the Committee agreed to note the progress made in relation to the Audit Plan for 2017/18.

Note:- Rona Sweeney left the meeting during discussion of the above item of business.

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

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

After discussion and having heard the Head of Strategy, Planning & Health Improvement in further explanation of the report and in answer to Members' questions, the Committee agreed to note the contents of the report.

Note:- Rona Sweeney returned to the meeting during consideration of the above item of business.

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

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

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

(1) to note with slight concern the Care Inspectorate rankings for both Dunn Street Respite Service and Sense Scotland Supported Living Glasgow 1 Service with one remaining unchanged in a number of years and the other showing a consistent fall in grades;

(2) that a report would be submitted to the next meeting, following engagement with the newly appointed Link Care Inspector, to provide re-assurance to Members on work being undertaken to improve grades at the above independent sector support services; and

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

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

A report was submitted by the Head of Children's Health, Care and Criminal Justice providing a routine update on the most recent inspection report for Blairvadach Residential Children's House.

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

Note:- Rona Sweeney left the meeting during discussion of the above item of business.

CARE INSPECTORATE REPORTS FOR OLDER PEOPLE'S RESIDENTIAL CARE SERVICES OPERATED BY WEST DUNBARTONSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

A report was submitted by the Head of Community Health and Care Services providing a routine update on the most recent inspection report for one of the Council's Older People's Residential Care Home Services.

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

(1) that a report with an action plan to improve Care Inspectorate grades at Mount Pleasant House would be presented to the next meeting of the Committee; and

(2) to note the contents of the report.

DRAFT STRATEGIC RISK REGISTER

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

After discussion and having heard the Head of Strategy, Planning & Health Improvement in further explanation of the report and in answer to Members' questions, the Committee agreed:-

(1) to note the content of the updated draft Strategic Risk Register; and

(2) to endorse the updated draft Strategic Risk Register for onward recommendation to the West Dunbartonshire Health & Social Care Partnership Board at its next meeting on 22 November 2017.

AUDIT SCOTLAND - SELF DIRECTED SUPPORT 2017 PROGRESS REPORT

A report was submitted by the Head of Strategy, Planning and Health Improvement providing information on the recently published Audit Scotland progress report on Self-Directed Support.

The Head of Strategy, Planning & Health improvement was heard in further explanation of the report.

The Auditor, Audit Scotland was then heard in further explanation of the Audit Scotland Progress Report, as detailed within Appendix 1 to the report, and in answer to Members' questions.

Following discussion and having heard officers in answer to Members' questions, the Committee agreed:-

(1) to note the findings of the Audit Scotland report on Self-Directed Support; and

(2) to note the Partnership Board's intention to revise and update its existing Self-Directed Support Policy which will be reported to the Partnership Board upon completion.

The meeting closed at 15.45 p.m.

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
AUDIT COMMITTEE
COMMITTEE ACTION LIST- updated 23/11/17

Meeting Date - 23 March 2016					
No.	**Action required**	**Date to be completed**	**Responsible Officer**	**Comments**	**Completed**
1.	**Equality Act 2010 Mainstreaming Report** A report on the range of vulnerable and socio-economic groups as well as protected characteristics be provided to the next meeting of the Audit Committee to enable members to consider marginalised groups other than those required by the Equality Act 2010. Public Health and Health Inequalities Report - will address socio-ecomonic factors Updated 14.09.16 - actions combined to form one report.	15 June 2016 Planned for November 2017 HSCP Board	Head of Strategy, Planning and Health Improvement /	Update 20 September 2017 Meeting Letter received 17 June 2017 from Paul Gray, Director General Health & Social Care and Chief Executive NHS Scotland on: - "Maximising the role of NHS Scotland in reducing health inequalities" Main point to note: "NHS Health Scotland will be bringing out further guidance for Health and Social Care Partnerships by October this year." Also, the National Delivery Plan for Health and Social Care promised a national set of public health priorities from the Scottish Govt and agreed with SOLACE and COSLA during 2017 which would inform local, regional and national action - this is still in development at a national level.	

Meeting Date - 7 December 2016					
No.	**Action required**	**Date to be completed**	**Responsible Officer**	**Comments**	**Completed**
2.	**Audit Scotland Reports on Local Government in Scotland 2016** It was agreed that the Senior Audit Manager, Audit Scotland and the Head of Strategy, Planning and Health Improvement should collaborate to develop a checklist specific to Members of the integration authorities, to enable Members to reflect upon the questions posed in respect of the totality of the Partnership Board's resources and arrangements for health and social care.	Future meeting	Head of Strategy, Planning and Health Improvement / Audit Scotland	Update - June 2017 Officers prioritised development of the local Code of Good Governance to HSCP Board, as that would usefully provide logical parameters for this work with external auditors. Also, felt prudent not to initiate this development prior to changes to the Audit Scotland team assigned to the HSCP Board. Now that HSCP Board local Code of Good Governance approved and new external audit team in place, developmental discussions will now be taken forward with respect to a potential IJB governance checklist. Update - September 2017 Developing a checklist for members of IJB - to be discussed with Audit Scotland after completion of annual audit.	

Meeting Date - 22 June 2017					
No.	**Action required**	**Date to be completed**	**Responsible Officer**	**Comments**	**Completed**
3.	**RECORDS MANAGEMENT PLAN - UPDATE**	Future meeting	Head of Strategy, Planning and Health Improvement	It was agreed that a further report providing an update on RMP would be submitted to a future meeting once an invitation had been received from the Keeper of the Records of Scotland requesting the submission of a Records Management Plan.	
4.	**CLIMATE CHANGE REPORTING AND INTEGRATION JOINT BOARDS**	13 December 2017	Head of Strategy, Planning and Health Improvement	It was agreed that the Head of Strategy, Planning and Health Improvement would prepare a Climate Change Report for presentation and approval at a future meeting of the Partnership Board. Update - September 2017 To be submitted to the next available meeting of the Board/Audit Committee.	

No.	Action required	Date to be completed	Responsible Officer	Comments	Completed
5.	**NHS GGC ORAL HEALTH DIRECTORATE REPORT FOR WEST DUNBARTONSHIRE**	13 December 2017	Head of Strategy, Planning and Health Improvement	It was agreed to invite the General Manager, Oral Health Directorate to a future meeting of the Audit Committee to discuss the performance report generally and measures to tackle the current oral health picture locally. Update September 2017 - future meeting dates sent to the General Manager, Oral Health Directorate in order to have report and presentation on the agenda in the near future.	
6.	**LOCAL GOVERNMENT BENCHMARKING FRAMEWORK 201516** **AUDIT SCOTLAND - SELF DIRECTED SPPORT 2017 PROGRESS REPORT (20 SEPTEMBER 2017)**	Future meeting	Head of Strategy, Planning and Health Improvement	It was agreed that a detailed report on Self-Directed Support in the West Dunbartonshire area and how it compares with other areas would be submitted to a future meeting prior to Audit Scotland's report on the review of Self-Directed Support across the whole of Scotland. It was agreed to note the Partnership Board's intention to revise and update its existing Self-Directed Support Policy which would be reported to the Partnership Board upon completion.	

Meeting Date - 20 September 2017					
No.	**Action required**	**Date to be completed**	**Responsible Officer**	**Comments**	**Completed**
7.	**LOCAL CODE OF GOOD GOVERNANCE REVIEW**	Future meeting	Chief Financial Officer	That an additional column be added to the Annual Review of Code of Good Governance - Summary, to include the total number of criteria per subsection for future reporting.	
8.	**KEY SOURCES OF ASSURANCE FOR INTERNAL AUDIT ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2017**	13 December 2017	Chief Internal Auditor	The Committee agreed to propose to NHS GGC that a clause relating to information sharing be written into future procurement agreements with providers of audit services.	
9.	**CARE INSPECTORATE REPORTS FOR SUPPORT SERVICES OPERATED BY THE INDEPENDENT SECTOR IN WEST DUNBARTONSHIRE**	13 December 2017	Head of Community Health & Care Services	It was agreed that a report would be submitted to the next meeting, following engagement with the newly appointed Link Care Inspector, to provide re-assurance to Members on work being undertaken to improve grades at the independent sector support service.	
No.	**Action required**	**Date to be completed**	**Responsible Officer**	**Comments**	**Completed**
10.	**CARE INSPECTORATE REPORTS FOR OLDER PEOPLE'S RESIDENTIAL CARE SERVICES OPERATED BY WD HSCP**	13 December 2017	Head of Community Health & Care Services	It was agreed that a report with an action plan to improve Care Inspectorate grades at Mount Pleasant House would be presented to the next meeting of the Committee.	
11.	**DRAFT STRATEGIC RISK REGISTER**	June 2018	Head of Strategy, Planning and Health Improvement	It was agreed to endorse the updated draft Strategic Risk Register for onward recommendation to the WD HSCP Board at its next meeting on 22 November 2017.	

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 14 March 2018

Subject: Audit Plan 2017/18 Progress Report and Audit Plan 2018/19

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 2017/18 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;
- Progress on the agreed actions from the audit of the Partnership Board's Governance, Performance and Financial Management Arrangements; and
- Progress on the agreed actions arising Annual Report to the IJB and the Controller of Audit for the financial year ended 31 March 2017 from the External Auditors; and
- Details of the planned programme of work for 2018/19.

2. Recommendations

2.1 It is recommended that the Audit Committee:

- Note the progress made in relation to the Audit Plan for 2017/18; and
- Approve the Audit Plan for 2018/19.

3. Background

Audit Plan 2017/18

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 2018/19

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 recently put out to tender for a new contracted out delivery of Internal Audit services, for Health Services. It is anticipated that a decision will be made on the new provider by the end of March 2018. 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 4.20 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 the Council's Audit Universe which includes all significant activities and systems that contribute to the achievement of the Council's strategic priorities (NB: It is not possible to determine the Health Board element of planned internal audit work for 2018/19 as the Health Board internal audit resource for 2018/19 awaits the outcome of the tendering process);
- a review of the HSCP's Strategic Plan and Risk Register; and
- discussions with the Chief Financial Officer and other senior staff on current financial performance and planned service developments.

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) <u>Progress on Audit Plan 2017/18</u>

<u>West Dunbartonshire Council</u>

4.1 Since 1st April 2017, 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:			
Fostering and adoption payments / allowances (2016/17 Audit Plan)	1	0	0
Guardianship Cases (Mental Health Officer [MHO] Involvement	0	3	2
Corporate Reports:			
Capital Expenditure / Capital Programme	0	0	1
ICT Disaster Recovery/Business Continuity Controls	-	5	2
Purchasing Cards	-	1	6
Register of Gifts, Hospitality & Interests	-	4	2
Creditors	2	10	9
Total	**3**	**23**	**22**

4.2 Recommendations have timescales for completion in line with the following categories:

Category	**Expected implementation timescale**
<u>High Risk:</u> Material observations requiring immediate action. These require to be added to the department's risk register	Generally, implementation of recommendations should start immediately and be fully completed within three months of action plan being agreed
<u>Medium risk</u>: Significant observations requiring reasonably urgent action.	Generally, complete implementation of recommendations within six months of action plan being

	agreed
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 For Social Care audit assignments outstanding actions from recently issued audit reports are included at Appendix A. In addition, Appendix A also contains information on actions arising from audits carried out within the WDC audit plan which have a potential impact on the HSCP as follows:

Recently completed audits (all actions):
- Creditors.

Previously completed audits (outstanding actions):
- ICT Disaster Recovery/Business Continuity Controls;
- Purchasing Cards; and
- Register of Gifts, Hospitality & Interests.

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

NHS Greater Glasgow and Clyde

4.5 The following Internal Audit reports have recently been issued to the NHS Greater Glasgow & Clyde, which are relevant to the Partnership Board:

Review	Report classification	Number of individual findings			
		High	Medium	Low	Total
Waiting times management	High	1	3	1	5
Suicide risk assessment	High	1	2	1	4
Delayed discharge	Medium	-	4	-	4
Temporary staffing: nursing	Medium	-	2	1	3
Key financial controls: accounts payable	Low	-	-	-	-
Key financial controls: fixed assets	Low	-	-	3	3
Total findings		**2**	**11**	**6**	**19**

4.6 Further information of these audit assignment is provided at Appendix B.

4.7 These reports are all from the 2017/18 audit plan and are the most recently issued.

Follow up work

4.8 Internal Audit undertakes 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

4.9 In addition to the reviews referred to above, an audit has been carried out in March 2017 on the West Dunbartonshire Governance, Performance and Financial Management arrangements of the Health & Social Care Partnership Board. The report and agreed actions were presented to the HSCP Board at its special meeting on 22 March 2017. Progress on the agreed actions from this report is provided in Appendix C

4.10 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 2017/18. As a result, three risk based audits from the overall Council audit plan have been rolled forward into 2018/19, including Social Work Tendering and Commissioning. This approach has been agreed in discussion with External Audit.

(b) Audit Plan 2018/19

4.11 The Chief Internal Auditor met with the Chief Officer and Senior Management Team to discuss and develop a programme of work for the financial year 2018/19.

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.

NHS Greater Glasgow and Clyde Internal Audit element

4.13 As mentioned at paragraph 3.5 above, it is not yet possible to determine the Health Board element of planned internal audit work for 2018/19 as the Health

Board internal audit resource for 2018/19 awaits the outcome of a tendering process.

4.14 At the WDHSCP Audit Committee on 20th September 2017, it was minuted:

"After discussion and having heard the Chief Internal Auditor and the Chief Finance Officer in further explanation of the report and in answer to Members' questions, the Partnership Board agreed:-

(1) to propose to NHS Greater Glasgow and Clyde that a clause relating to information sharing be written into future procurement agreements with providers of audit services;"

Attached at Appendix D is a copy of a letter which was sent to the Assistant Director of Finance at NHS Greater Glasgow and Clyde. A response was received confirming that a sentence would added to the tender document for the provision of internal audit services for NHS Greater Glasgow and Clyde stating that the successful candidate may be required to provide assurances to IJB Chief Auditors on HSCP related matters.

4.15 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.

4.16 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 work undertaken by NHS Greater Glasgow and Clyde's appointed internal auditors in order to identify any matters arising relevant to the HSCP Audit Committee.

West Dunbartonshire Council

4.17 WDC's audit plan for 2018/19 includes a number of audit reviews which cover Health & Social Care Partnership service areas, namely:

Audit	Days Allocated	Anticipated Objectives / Key Tasks
Social Work Tendering and Commissioning	25	• Commissioning strategy • Procurement arrangements • Policies and procedures • Payment monitoring • Monitoring of delivery of contracted services
Children with additional needs	25	• Policies and procedures • Monitoring of level of demand,

transitioning into adults		costs and trends • Exchanging of information • Arrangements for assessing impact of Autism on adult services
Charging Policy (non-residential services)	25	• Policies and procedures • Financial assessment process • Review of consistency of application across services • Tapers and buffers • Waiver approvals
Total	**75**	

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

4.18 For the overall internal audit plan for NHS Greater Glasgow and Clyde, the total number of indicative days allocated for all audit activity cannot yet be determined.

4.19 Much of the audit work which is carried out within NHS Greater Glasgow and Clyde's internal auditors 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

4.20 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 to carry out a review of the Local Code of Good Governance.

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 risks which have implications for the IJB as documented in the Risk Register which was approved by the HSCP Board as well as partners' identified risks.

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: **28 February 2018**

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

Appendix B: Further information on NHSGGC Internal Audit Reports

Appendix C: WDHSCP - Internal Audit Reports / External Audit Reports

Appendix D: Letter relating to information sharing between auditors

Background Papers: None

Appendix A
Internal Audit Reports

Generated on: 19 February 2018

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

Project 124. Guardianship Cases (MHO Involvement) (Report Issued November 2017)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
TS&PSR/IAAP/555	1. Private Guardianship Monitoring The senior Mental Health Officer should liaise with the Information Manger (HSCP) to utilise the CareFirst System to monitor the progress of private guardianship applications. This should include the drafting of forms and reports to be incorporated into the CareFirst system. The notes in CareFirst should also incorporate an explanation for delays in the preparation	Senior MHO has established contact with HSCP information Manager and arranged that CareFirst system will be adapted to include new reports specifically designed to capture and record information as recommended. This will incorporate the facility for periodic review/audit reports to be produced.		100%		31-Mar-2018	Drew Lyall	The new report forms are on the DEV system and will be checked with a view to going live within the next 10 working days. Initial period audit will take place 3 months after system goes live.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	of the report. A procedure should also be drafted to be followed by Mental Health Officers to ensure all relevant information and dates are lodged in the system. (Medium Risk)							
TS&PSR/IAAP/556	2. Local Authority Guardianship Monitoring The senior Mental Health Officer should liaise with the Information Manger (HSCP) to utilise the CareFirst System to monitor the progress of local authority guardianship applications. This should include the drafting of forms and reports to be incorporated into the CareFirst system. A procedure should also be drafted to be followed by Mental Health Officers to ensure all relevant information and dates are lodged in the system. The information recorded in CareFirst for Local Authority applications should include the following dates to show if the Council Policy for LA Guardianships are achieved. • Date Minutes of Case Conference Issued; • Date Draft Application Report Completed;	Senior MHO has established contact with HSCP information Manager and arranged that CareFirst system will be adapted to include new reports specifically designed to capture and record information as recommended. This will incorporate the facility for periodic review/audit reports to be produced.		100%		31-Mar-2018	Drew Lyall	The new report forms are on the DEV system and will be checked with a view to going live within the next 10 working days. Initial period audit will take place 3 months after system goes live

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	• Date Final Report Completed; and • Date Guardianship Granted. The notes on the CareFirst should also incorporate an explanation for delays in the preparation of the report. This will enable the Senior MHO to monitor the time taken to prepare the statutory reports and identify the reasons for delays in the completion of the reports. (Medium Risk)							
TS&PSR/IAAP/557	<u>3. Electronic Storage of Guardianship Files</u> Management should develop a clear policy outlining the information that is required to be scanned into case folders. The following minimum information should be contained in each client folder. • Draft Summary Application/Letter of notification; • Mental Health Officers Suitability Report;	All MHOs will be informed of expectations in respect of data storage on x:drive as highlighted, and in accordance with recommendations.		70%		31-Mar-2018	Drew Lyall	This has been discussed during Specialist MHO Team meeting on 29/11/17. Senior MHO will be issuing guidance to all MHOs during week beginning 04/12/17with a view to full implementation thereafter.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	Award of Guardianship. (Low Risk)							
TS&PSR/IAAP/558	4. Review of time taken to complete reports It is important that all AWI reports be completed as quickly as possible to ensure the welfare of the incapacitated adult. To achieve this it is vital to fully understand the reasons, in each case, as to why the recommended timescale for completing the AWI report was not met. It is recommended that applications, once the report is finalised, be reviewed and the reasons for delays in the time taken to complete the report should be fully analysed and documented. This should be possible utilising the CareFirst System following implementation of recommendations 1 and 2 of this action plan. This will enable the MHO Team to understand the reasons for delays and find solutions to speed up the process. (Medium Risk)	A quarterly internal audit will be undertaken in respect of all completed guardianship reports, and this will be distributed as appropriate. This will assist in highlighting performance and progress, but will also serve to indicate areas of resource pressure and other challenges encountered. It should be noted that at times the circumstances leading to the completion of reports are outwith the control of the assigned MHO. This can be due to factors such as delays with the family making contact or with legal processes surrounding the application		10%		31-Mar-2018	Drew Lyall	Initial audit will take place 3 months after new CareFirst forms implemented.
TS&PSR/IAAP/559	5. Review of Guidelines A review of the Guidance Note on Applications for	A review of current guidance and policy will be undertaken, with amendments made as		0%		30-Sep-2018	Drew Lyall	Senior MHO will progress this task from early 2018 with a view to completing well within agreed

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	Welfare Guardianship should be carried out. Timescales should be set the match the increase in number of applications and legislation. (Low Risk)	appropriate and required. This will reflect changes in practice, and the significantly increased demand for reports since the guidance was initially produced						timescale. It will be necessary to review, draft amendments, and submit to SMT for approval.

Project 126. Creditors (Report Issued February 2018)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
T&PSR/IAAP/576	1. Supplier Masterfile Maintenance Processes and procedures are required to set out: - what documentation is required to process a change to supplier master file date (eg letter from supplier); - how changes to bank accounts should be logged and reviewed; - the requirement to confirm changes made to supplier. (High Risk)	Detailed process established, including current bank details are requested and confirmed prior to any change, followed by confirmation of changes back to suppliers Email to mailbox re change to supplier – checking by another member of FSC Asst/Supervisor to segregate checking process. Process update to include monthly audit report to view all accounts that have been changed in last month – sample to be reviewed and verified.		100%	15-Nov-2017	15-Nov-2017	Stella Kinloch	Actions completed - all improvements now implemented.
T&PSR/IAAP/577	2. Agresso Payments - Procedures and frequency of duplicate payments review require updating	Create procedure to review duplicate payments on a - FSC initial review of		100%	31-Dec-2017	31-Dec-2017	Stella Kinloch	complete

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	The Finance Service Centre should consider how frequently this review should be completed and document procedures for the review to be carried out. (Medium Risk)	transactions over £10k.						
T&PSR/IAAP/578	3. Agresso Payments - Identification of duplicate payments Procedures should be updated within the Central Administration Service Team (CAS) to ensure that each invoice is individually entered on to the Agresso system (if this is not done the Agresso system cannot reject invoices with the same invoice number from the same supplier). In addition, CAS should not change invoice numbers to enable the invoices to be processed to Agresso. Invoices which do not have a unique invoice number should be returned to the authorised signatory and a replacement invoice should be requested from the supplier. (Medium Risk)	Reiterate FSC payment processing procedures supported by CAS. CAS processes to be reinforced to key all invoices. All invoices must include unique invoice reference number. CAS team to be updated and procedure confirmed to all services.		100%	31-Dec-2017	31-Dec-2017	Graham Hawthorn; Stella Kinloch	Audit action discussed with all staff and user guides updated to underline this action.
T&PSR/IAAP/579	4. Agresso Payments - Lack of clarity on information required by CAS with batch header CAS procedures should be updated to clarify the	CAS processing procedures to be updated – revisited with team Supporting back up for all payments – cheques and BACS –		100%	31-Dec-2017	31-Dec-2017	Graham Hawthorn; Stella Kinloch	Audit action requirements discussed with all staff and procedures updated to underline action required.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	adequate supporting documents which must always attached to batches and that follow up with the authoriser is necessary to obtain these if they are not initially supplied. Batches should not be processed for payment without relevant supporting documentation being supplied to CAS. (Medium Risk)	requests without supporting invoice will be rejected by CAS.						
T&PSR/IAAP/580	5. Agresso Payments - Insufficient checking of authorised signatories when processing batches for payment CAS should consider implementation of alternative automated process to confirm batches are appropriately authorised. In the interim CAS should ensure sufficient manual checking is undertaken to reduce risk of unauthorised payments to acceptable level. (Low Risk)	Project to be undertaken to streamline online transactional processing, including implementation of online approval process Council wide incorporating post specific financial responsibilities with relevant limits. In the interim checking process will be reinforced with CAS staff.		10%	30-Jun-2018	30-Jun-2018	Graham Hawthorn; Stella Kinloch	Authorised signatory checking process reinforced with relevant CAS staff.
T&PSR/IAAP/581	6. Agresso Payments - VAT processed on invoices which do not show a VAT number CAS staff should be reminded of the requirement to check that all invoices which include VAT should include a VAT registration number on the invoice.	CAS team procedures reinforces that VAT numbers must be included or the invoice rejected.		100%	31-Dec-2017	31-Dec-2017	Graham Hawthorn; Stella Kinloch	CAS staff reminded of the requirement to check that all invoices which include VAT should include a VAT registration number on the invoice. CAS procedure document updated to reinforce this requirement.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	(Medium Risk)							
T&PSR/IAAP/582	7. Agresso Payments - Comino authorised signatory listing is not accurate Signatory list should be updated to ensure it is accurate and procedures should be implemented to ensure the signatory list is kept up to date. (Low risk)	Project to be undertaken to streamline online transactional processing, including implementation of online approval process Council wide incorporating post specific financial responsibilities with relevant limits. In the interim checking process will be reinforced with CAS staff.		10%		30-Jun-2018	Stella Kinloch	CAS procedures reminders issued.
T&PSR/IAAP/583	8. Agresso Payments - Batch header sheet incomplete CAS should: - advise signatories when the batch header is incomplete/inaccurate in order to improve process going forward; and - advise Clydebank Property Company of the requirements relating to batch headers (Low risk)	Reinforce procedures with CAS team		100%		31-Dec-2017	Graham Hawthorn; Stella Kinloch	CAS staff reminded to advise signatories of requirement for batch header when the batch header is incomplete/inaccurate.

T&PSR/IAAP/584	9. Agresso Creditors Systems Access - Insufficient Segregation of Duties Staff access levels should be reviewed and amended to ensure that appropriate level of segregation of duties is in place. (High risk)	FSC supervisors' roles to be amended within the system to allow appropriate segregation of duty in a system capacity to mirror processes.		20%		30-Nov-2018	Adrian Gray	A review of staff access levels and FSC roles is in progress.
T&PSR/IAAP/585	10. Agresso Creditors Systems Access– Insufficient review of user access rights User access across Agresso Creditors System should be reviewed and updated to ensure that no staff have access to the system if it is not required. Test user ids should be removed where no longer required. A regular, at least six monthly, review of users on the Agresso Creditors system should be carried out to ensure that all Agresso users still require access and have the appropriate level of access. (Medium risk)	User list to be updated – schedule of review to be actioned.		100%		31-Dec-2017	Adrian Gray	The accounts payable posting role has been reviewed and only those who are currently required to key invoices have access. The Admin Support Unit Supervisor will advise when any additional users require access. A review of user access and access levels will now take place on a six monthly basis.
T&PSR/IAAP/586	11. Agresso - Lack of controls around ordering of goods and services Authorised signatories who approve invoices for payment should be reminded of the requirement to check that orders have been made by an approved person. (Low risk)	Procurement and Financial responsibilities to be reinforced via online guidance.		100%		31-Jan-2018	Derek McLean	Updated below and above £50k procurement guidance published on the intranet, as well as awareness sessions being run

T&PSR/IAAP/587	12. Authorised Signatory Responsibilities - Lack of Awareness of Policies and Procedures Staff should be reminded of the relevant information on the intranet, for example, Financial Regulations, Accounts Payable best practice guidance and Audit Circular No 2 - Certification by Authorised Signatories (Low risk)	Procurement and Financial responsibilities have been reinforced via communications to SMN linking online guidance and relevant links on various occasions in the past. This will be done again.		100%		31-Jan-2018	Stella Kinloch	final comms will be produced along with year end performance data
T&PSR/IAAP/588	13. Webuy - Administrator access Review of Webuy users should be completed with full administrator access being removed/restricted for the majority of the current users who have administrator access. (Medium risk)	Procurement Developments (PD) team will review the system admin list, and remove where role isn't necessary. Procurement will run a report every six months to check such access.		100%		30-Nov-2017	Derek McLean	User list reviewed and only Procurement Developments team sys admins have admin rights
T&PSR/IAAP/589	14. Webuy - No system controls to prevent requisitioners approving orders System controls should be enhanced to prevent requisitioners being allowed temporary approver access. A log of changes made to the system should be created to include details of who has requested the change and who has made the change. Webuy administrators should be reminded that requisitioners should not be given approval access (even on a delegated basis).	PD team will review the system controls in placee to see if it is possible to prevent a requisitioner getting approval access on a delegated level. Internal procedure and communication issued stating that a requisitioner will not be granted delegated approver access. PD team will implement an appropriate method of recording system changes.		100%		31-Jan-2018	Derek McLean	Review of the system rights on approvals confirms that no requisitioner can approve an order.

	(Medium risk)							
T&PSR/IAAP/590	15. Webuy users have been identified who can raise and authorise orders To ensure segregation of duties system controls should be enhanced to prevent a user being able to have approver access to an area where they are also requisitioner. (Medium risk)	PD team will confirm that a requisitioner cannot also approve the same order.		100%		31-Jul-2018	Derek McLean	The system controls have been implemented where a user cannot approve their own order, however there are situations where a user can be a requisitioner, and an approver (H&SCP care home manager can raise orders in an emergency but their orders will route to their manager), however they are in different Approval Rule Groups preventing self authorisation
T&PSR/IAAP/591	16. Webuy System Users - Discrepancies with authorised users on Comino authorised signatories list A review should be carried out between Webuy and the Comino signatories list to bring them in line and to investigate and resolve any discrepancies. (Medium risk)	There should be no approvers in Webuy who are not registered as an authorised signatory on Comino. PD team will review the list and immediately remove any authoriser who is not on Comino and advise the service area. Business rule groups will be changed to re-route orders to an appropriate authoriser.		80%		31-Mar-2018	Derek McLean	Procurmement Dev team are emailing approvers on Webuy to asking them to be put on as an authorised signatory. Deadline given, and users who have note responded will be removed as an approver from Webuy. The task of identifying and removing is currently ongoing
T&PSR/IAAP/592	17. Webuy - Log of changes to user access rights A log should be created to document who has requested changes to the system and also who has made the changes on the system. Related emails requesting changes to users should be retained and stored centrally. (Low risk)	All change requests received will be stored to ensure a trail of changes is held		100%		31-Dec-2017	Derek McLean	All user access rights changes are being logged and kept. E-mail requests are being stored. Also created a form to ask users to complete for all new users to control access permission and is on the procurement intranet

T&PSR/IAAP/593	18. Webuy procedures for system administration Procedures documents should be developed and provided to all relevant staff within Procurement Developments team to ensure a consistent approach is taken. (Low risk)	Standard documentation will be developed to add, amend, and deactivate users, rule groups etc.		10%		30-Apr-2018	Derek McLean	2 procedures complete (Procedures for adding a supplier, and adding a user). 18 more still to do.
T&PSR/IAAP/594	19. Webuy System User Access Rights and Levels A regular, annual, review of users on the Webuy system should be carried out to ensure that all Webuy users still require access and have the appropriate level of access. (Low risk)	User rights check will be run every six months.		100%		31-May-2018	Derek McLean	review has been carried out and has been diarised for a 6 monthly check (May 18) Check to consists of: Users still active, Approvers list, Approval delegation check.
T&PSR/IAAP/595	20. Webuy payments do not meet requirements of the Financial Regulations Consideration to be given to how the requirements of the Financial Regulations should be incorporated within Webuy. (Medium risk)	Discuss with Legal to update Financial Regulations to make it clearer in the segregation of e-invoice process.		50%		27-Apr-2018	Derek McLean	Draft text sent to Legal for next update to Financial Regulations.
T&PSR/IAAP/596	21.Webuy - No notification of new approved users from Finance Service Centre Regular updates should be provided from the Finance Service Centre to the Webuy administrators to advise of new users who require to be set up on the system and leavers who should have their Webuy access removed.	Finance Service Centre has been requested to inform PD when users are amended or removed from authorised signatories.		100%		31-Dec-2017	Stella Kinloch	FSC procedures updated and team reminded

	(Low risk)							

Project 120. ICT Disaster Recovery/Business Continuity Controls (Report Issued August 2017)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
CS/IAAP/519	1. Underlying Technical Controls required to facilitate automatic failover to DR site still to be configured/tested Management must set in place plans and timescales to effectively test failover preparedness to the primary DR site. (Medium Risk)	This work has several dependencies including location, other organisations and 3rd party suppliers and elements will be completed/tested at different times with view to solution being in place during 2018.		75%	30-Jun-2018	30-Jun-2018	Brian Miller	Jan 18 - 3 milestones of 4 completed. Systems relocated to new data centre and new firewall fully operational
CS/IAAP/520	2. DR Plans for the main telephony delivery systems have yet to be implemented/tested Management must set in place plans and timescales to effectively test DR arrangements for the main telephony systems. (Medium Risk)	ICT will develop the implementation plan for this test by the end of October		33%	31-Oct-2017	30-Mar-2018	Brian Miller	Feb 18 - The date for this has been changed to 30th March 18 as we are still awaiting the install of the resilient line from Aurora House to William Patrick Library, this is currently with BT openreach for installation. Alongside the requirement for the DR line to be in place, there is an existing routing issue with BGP routing in William Patrick Library. Professional services have been engaged to resolve this issue
CS/IAAP/521	3. Systems without parallel DR arrangements are not fully tested Management must put in place effective plans and timescales to effectively test	ICT Management will deliver a testing schedule for these systems by 30th Nov 2017 ICT will implement the		50%	30-Jun-2018	30-Jun-2018	James Gallacher; Patricia Kerr	Schedule completed. Testing phase will begin after date centre move and as and when system outages occur,.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	DR arrangements for large departmental and corporate systems. (Medium Risk)	above testing schedule by 30th June 2018						
CS/IAAP/525	7. Lack of formal DR testing schedule at primary DR site ICT should maintain a log of incidents where DR/Failover arrangements have been successful in a live setting In the event of no live incidents, then ICT should implement a DR testing schedule (Medium Risk)	ICT management will maintain a log of live failover incidents by 31st August 2017 ICT will update the DR policy to reflect a testing schedule where live failovers have not occurred by 31st December 2017		50%	31-Dec-2017	30-Mar-2018	Brian Miller	Jan 18 - 1 milestone of 2 completed. This project has been delayed due to the reallocation of staff to the higher priority PSN & data center projects. The due date for this Action has been extended to reflect this

Project 121. Purchasing Card Audit (Report Issued August 2017)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
CS/IAAP/528	2b. Terminating Purchase Cards when employees leave As part of the employee leaving process a procedure should be added to ensure that any purchase cards an employee holds are terminated. (Low risk)	Further development required with Workforce Management System to identify staff with CPC to have automated notifications where staff move location, section or terminate employment to ensure robust management of CPC distribution and manager notifications.		0%	30-May-2018	30-May-2018	Stella Kinloch	Development schedule to be reviewed due to change in WMS Officer. Continued notification pending new schedule for development work.

Project 122. Register of Gifts, Hospitality & Interests (Report Issued November 2017)

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
T&PSR/IAAP/535	2. Registers - HSCP It is recommended that two separate Registers be established one relating to Gifts & Hospitality and one relating to Interests. The department should determine who should be responsible for the maintenance of the registers. (Medium Risk)	This requirement has been recognised within the HSCP's annual review on its compliance with the Code of Good Governance. The HSCP will establish two separate registers by liaising with Council colleagues on best practice format and process. With the agreement of the Chief Officer a member of staff will be identified to develop and maintain registers.		80%	31-Dec-2017	31-Jan-2018	Julie Slavin	Guidance to be issued to HSCP staff on arrangements on the requirements for updating registers by end of February. Registers will be maintained by HSCP Finance team until after the 2017/18 year end, after which future arrangements will be reviewed.
T&PSR/IAAP/536	3. Guidance & Declaration Form In relation to the Register of Gifts & Hospitality and Declaring Interests, the following is recommended: • The title of the guidance be renamed which covers both offers and acceptance of Gifts, Hospitality & Interests e.g. 'Guidance of Acceptance & Offers of Gifts, Hospitality & Declaring Interests. • The Guidance should be revised and updated particularly in relation to the Register of Interests. This should include the	Agreed, relatively minor changes to be made.		53%		31-Mar-2018	Peter Hessett	As at 22 February draft with internal audit and considering HR comments

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	requirement for Senior Officers i.e. Strategic Leads and above to make an annual return which would be either confirming all/any interests already declared or making a nil return. • A separate declaration form should be established for declaring private interests which may result in a conflict or conflict of interests with the work of Officers and not incorporated with Gifts & Hospitality. (Medium Risk)							
T&PSR/IAAP/537	4. Code of Conduct The 'Code of Conduct should be updated to ensure consistency with the guidance relating to the Register of Gifts, Hospitality and Declaring Interests i.e. that declarations should be made regardless of whether the offer of a gift or hospitality is accepted or refused. (Medium Risk)	Agreed. Technical amendment to be made to Code and communicated via Workforce Update and Staff Bulletin		50%		31-Mar-2018	Darren Paterson	Technical amendment to Code of Conduct completed, communicated to TUs and uploaded to intranet. Due date changed to 31st March to allow timing of communication to coincide with next Workforce Update and Staff Bulletin.
T&PSR/IAAP/539	6. Date Guidance Prepared As the guidance document relating to the Register of Gifts, Hospitality and Declaring Interests was updated in March 2017, the date should be recorded on the guidance to ensure that staff are making reference to the correct and most up to date version.	Agreed		53%		31-Mar-2018	Peter Hessett	As at 22 February draft with internal audit and considering HR comments

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	In addition, the retention periods for the register and declaration forms should also be documented within the guidance i.e. current plus five years. (Low Risk)							

Appendix B

NHS Greater Glasgow and Clyde
Internal Audit Activity Report for Integration Joint Boards – December 2017

Background

Integration Joint Boards direct both NHS Greater Glasgow and Clyde and the local authority to deliver services that enable the Integration Joint Board to deliver on its strategic plan.

Both NHS Greater Glasgow and Clyde and the local authority have internal audit functions that conduct audits across each organisation and report the findings of these to the respective audit committees.

Members of the Integration Joint Board have an interest in the outcomes of audits at both NHS Greater Glasgow and Clyde and the local authority that have an impact upon the Integration Joint Board's ability to deliver the strategic plan.

This report provides a summary for the Integration Joint Board of the internal audit activity within NHSGGC which has an impact upon the delivery of the strategic plan.

NHS Greater Glasgow and Clyde Internal Audit Activity

At the NHSGGC Audit and Risk Committee meeting on 12th December 2017, the Board's internal auditors, PwC, reported on the following:

Review	Report classification	Number of individual findings			
		High	Medium	Low	Total
1. Waiting times management	High	1	3	1	5
2. Suicide risk assessment	High	1	2	1	4
3. Delayed discharge	Medium	-	4	-	4
4. Temporary staffing: nursing	Medium	-	2	1	3
5. Key financial controls: accounts payable	Low	-	-	-	-
6. Key financial controls: fixed assets	Low	-	-	3	3
Total findings		**2**	**11**	**6**	**19**

High risk indicates findings that could have a significant:
impact on operational performance; or
monetary or financial statement impact or
breach in laws and regulations resulting in significant fines and consequences; or
impact on the reputation or brand of the organisation.

Medium risk indicates findings that could have a moderate:
impact on operational performance; or
monetary or financial statement impact; or
breach in laws and regulations resulting in fines and consequences; or
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
monetary or financial statement impact; or
breach in laws and regulations with limited consequences; or
impact on the reputation of the organisation.

1. **Waiting times management - high risk**
   Following the findings of a previous audit report, a new corporate capacity planning exercise was undertaken. The programme of demand and capacity gap assessment and improvement was intended to provide a consistent approach to addressing the deteriorating performance against waiting times targets. Workshops have taken place in order to aid the Acute Directors in identifying potential efficiency drivers which can be implemented in order to increase productivity and capacity across the board. Whilst a significant level of time and resource has been expended to date on implementing the programme of demand and capacity gap assessment and improvement, there is a risk that this exercise will not deliver its key objectives due to the current lack of project management discipline and the absence of a capacity planning approach that considers actual available resource. As such, without refining the programme further to address the issues raised within this report, there is a risk that management's response to the deteriorating performance against waiting time targets will be insufficient. For this reason this report was classified as overall high risk.

2. **Suicide risk assessment – high risk**
   NHS Greater Glasgow and Clyde has a series of risk assessment protocols in place, which address numerous mental health risk factors including suicide. At present there are three key risk assessment tools in place across Mental Health services, Child and Adolescent Mental Health Services and Emergency Departments.
   Whilst patient safety is dependent on effective clinical process and judgement, the risk assessment process is important to ensuring that at risk patients are identified and managed through the appropriate pathways and acts as an important aid to clinical judgement. PwC acknowledged that clinical research indicates that the positive predictive value of suicide risk assessment tools can be as low as 5%, and that there is consequently no direct correlation between completion of a tool and a reduction in suicide rates.
   Overall PwC found that whilst there are risk assessment tools in place which have been tailored for specific service needs, these are not being completed in practice in accordance with the requirements of the Board's policies. Whilst the appropriate clinical care may have been provided in these cases, in numerous instances there was a lack of evidence that the appropriate considerations were made.
   Whilst they acknowledged the continued clinical debate on the extent to which suicide risk assessment tools have an impact on suicide rates, they expected that staff within NHSGGC would follow the Board's policies in relation to use of the tools.
   They also found that there are gaps in the coordination of suicide risk assessment across service areas in NHS Greater Glasgow and Clyde. At the time of the report, Board suicide prevention guidelines covered adult mental health services only, rather than including CAMHS, Acute and Primary Care services.
   A revised risk management policy has been developed after extensive consultation. It introduced a new risk management tool which includes user and carer input, is embedded in the electronic care record, and links directly to care planning and is accompanied by five new auditable standards. Implementation will be supported by SPSP and a new Quality Improvement hub in Mental Health. The data provided in this report will form a useful baseline to assess the effectiveness of this new suite of measures in adult, LD, addictions and older peoples' mental health services.
   Management recognise that the use of risk assessment tools was not fully compliant with policy in the audits conducted in CAMHS and ED, two areas that have not so far had the benefit of SPSP support. Performance needs to be improved, and a suite of measures including training, prompts to policy awareness and audit will be introduced.

As part of the revision of risk management policy, management has recognised that an overarching framework of Suicide Prevention Guidance needed to be developed to bring together all relevant policies into one coherent document. That is now available online through Staffnet. The document did not expressly reference risk management in CAMHS and Acute settings, and that oversight will be corrected.

Management accepted the criticism of suicide prevention training (as distinct from risk management training) made in this audit. This was previously subject to a HEAT target and Scottish Government support for training materials, both of which have now lapsed. A working group to reinstate appropriate training has been established.

It is the Board's view that pathways are in place to guide the management of suicidal behaviour in ED, but it is accepted there is scope to improve the clarity and availability of that guidance.

3. Delayed discharge – medium risk

In 2015/16 NHS Greater Glasgow and Clyde received additional funding from the Scottish Government of £23.66m allocated across the Board's six Health and Social Care Partnerships (HSCPs) over a period of three years. This funding came from the national Integration Fund and was designed to support reduced numbers of delayed discharges.

The key finding of this report is that, in order to drive tangible and sustainable improvement against delayed discharge targets, a more detailed, data-driven and targeted approach must be taken in order to identify and change underlying root causes at a granular, departmental and patient-pathway level. This approach should be based on available delayed discharge data, lost bed days data and any additional understanding that can be gained on detailed underlying root causes for delay. Actions should then be targeted towards the areas which present the poorest performance. By doing this, the Board will be better equipped to create and prioritise meaningful actions.

The Board has reported the risk of an increase in delayed discharges and increased bed days due to pressures on local authority funding as the highest scored risk in their corporate risk register. This risk does have a financial implication, however, the other risk relates to the wellbeing of patients due to the deterioration caused by each subsequent day spent in an acute hospital bed. Whilst this is clearly a risk being faced by the Board, the findings of this report do not support the assertion that it is the most significant corporate risk being faced by NHSGGC.

PwC acknowledged that the challenges in improving delayed discharge performance are complex, multi-faceted and variable across the different HSCPs. Differences in patient populations, demographics, the number of stakeholders involved, and other external factors render a single, consistent approach ineffective.

This review, and the patient case studies conducted, has identified a number of underlying causes for delay. Whilst there are numerous others, these included:

- patient and family choice;
- availability of care homes;
- social work referral/SMAT process;
- slow email communication between healthcare providers; and
- restrictive and inflexible patient pathways.

4. Temporary staffing: nursing – medium risk

In the last 12 months the Board has initiated a series of actions to consider the use of temporary staffing across nursing and midwifery. At present the focus is on reducing the level of agency use. Whilst in the longer term it is the objective that reliance on bank staff will be reduced, it has been acknowledged that bank staff will always be required as a contingency across the health service.

The Board has in place policies and processes to manage the use of temporary staff. The Board follows national guidelines when it comes to workforce planning. Work has been done over the last six months by management to examine rostering and the underlying factors that impact the use of temporary staffing. A number of initiatives are underway to improve and help teams with rostering, sickness absence, enhanced observations and recruitment. The findings and recommendations raised within this report demonstrate that the root cause of the issues is the need to set consistent minimum standards for approving the use of agency requests, for managing and monitoring complaints and to ensure proper on-boarding of agency staff.

NHSGGC accepts the findings of the review and will progress associated actions where practical and reasonable to do so, specifically in relation to the on boarding of agency staff.

5. Key financial controls: accounts payable – low risk

NHSGGC spends around £1.5bn per annum on non-pay related costs. These cover areas of core expenditure including prescribing, estates, suppliers, and service costs. The accounts payable process is critical to ensuring that goods and services are only paid for when they have been appropriately received and that payment processing is controlled. The controls within the accounts payable process are important in ensuring the accuracy and completeness of financial information, that suppliers are paid accurately and on a timely basis and also that the risk of fraud is managed.

In the current year PwC had no new findings to report and have concluded that, in line with prior years, the control environment for accounts payable remains strong. Overall controls were found to be well designed and sample testing of their operation noted no exceptions. This report has therefore been classified as low risk.

6. Key financial controls: fixed assets – low risk

The fixed asset portfolio of NHS Greater Glasgow and Clyde (NHSGGC) represents a balance of £2.1 billion on the Board's balance sheet. This is comprised of £1.7 billion of buildings representing the large and complex estate of NHSGGC. The size and diversity of the fixed asset balance of NHSGGC can present risks associated with ensuring that all assets are captured and held at an appropriate value within the financial statements. Key financial controls are critical to ensuring that the fixed asset balance is reflected accurately within the accounts.

Overall, PwC found that controls are in place to ensure fixed assets are accounted for appropriately, but identified some minor areas for improvement to ensure that processes are suitably formalised and consistently operating as expected.

Management accepts the findings within this report and has an action plan in place to address them.

Appendix C
WDHSCP - Audit Reports

Generated on: 19 February 2018

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

Project 1. WDHSCP Governance, Performance & Financial Management (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
WDHSCP-001	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.		60%	31-Oct-2017	30-Jun-2018	Julie Slavin	Preparatory work continues to be undertaken by HSCP Officers. It has been confirmed that the Keeper (National Records of Scotland) will not be inviting any IJBs to formally begin preparing and then submitting their RMPs before the process for all of the other public authorities originally scheduled has been completed. It is anticipated that the first series of requests to IJBs

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
								to submit RMPs will go out in January 2018.
WDHSCP-002	2. Partnership governance 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.		100%	31-Aug-2017	31-Aug-2017	Julie Slavin	Chief Financial Officer and Head of Strategy, Planning & Health Improvement have prepared a local Code of Good Governance (as per CIPFA Guidance), which has been approved by the HSCP Board. A compliance self-assessment has been completed in accordance with CIPFA recommendations, with ongoing engagement of Chief Internal Auditor and external auditor. This self-assessment has identified a number of improvement actions and has been used to develop an improvement action plan. This will be presented to the September 2017 meeting of the HSCP Audit Committee for approval.

Project 2. WDHSCP External Audit Annual Report 2016/17

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
WDHSCP-003	1. Hospital Acute Services (Set Aside) Arrangements for the sum set aside for hospital acute services under the control of WDIJB are not yet operating as required by legislation and statutory guidance. A notional figure was included	A working group has been formed with NHSGGC finance colleagues, CFOs and the Scottish Government to establish processes for planning, quantifying and performance management of		20%	30-Jun-2018	30-Jun-2018	Julie Slavin	The group has agreed on a data set which should satisfy the legislative requirements for measuring activity around set-aside budgets.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	in the accounts under a transitional arrangement agreed by the Scottish Government. Risk: In future years the sum set aside recorded in the annual accounts will not reflect actual hospital use. Recommendation: NHSGGC and WDIJB should establish processes for planning and performance management of delegated hospital functions and associated resources in 2017/18.	delegated hospital functions and associated resources in 2017/18.						
WDHSCP-004	2. Budget Monitoring There were differences in the figures reported to the Board in May and the surplus in the draft accounts reported to the Audit Committee in June. Risk: Budget reports may not provide sufficient information to enable members to review performance and make the necessary decisions. Recommendation: A report which reconciles any movements from the final outturn report to the accounts should be provided to the Board and Audit Committee.	Going forward, a year end summary report will be provided for the Board and Audit Committee.		0%	30-Jun-2018	30-Jun-2018	Julie Slavin	This is a one-off year end report that cannot be produced until end of June 2018. Therefore no progress can be recorded at this time.
WDHSCP-005	3. 2017/18 Budget The budget for 2017/18 was not approved till 23 August 2017, which means that the Board was operating without	2017/18 Budget has been approved at the August 2017 Board Meeting. We will continue to ensure		50%	30-Jun-2018	30-Jun-2018	Julie Slavin	Discussions and scenario planning already underway for 2018/19.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	a fully approved budget for almost six months of the financial year. Risk: Operating without a fully approved budget makes financial management and decision making more difficult and may negatively affect the quality of service delivery. Recommendation: The Board should continue to ensure that budgets for future years are approved as a matter of urgency.	future budgets are agreed as a matter of priority.						
WDHSCP-006	4. Medium to Long term Financial Plans There are no medium to long term financial plans in place. This is increasingly important as demand pressures increase, financial settlements continue to reduce and fundamental service redesign over a longer time frame becomes necessary. Risk: WDIJB is not planning adequately over the medium to long term to manage or respond to significant financial risks. Services may be affected if their sustainability is not planned. Recommendation: A long term financial strategy (5 years +) supported by clear and detailed financial plans	This has been committed through further actions in our Annual Governance Statement and is now also included in our Improvement Action Plan as part of our review of the Local Code of Governance.		25%	28-Feb-2018	28-Feb-2018	Julie Slavin	Financial planning for 2018/19 is currently underway. This will form the basis of a 3 year medium term financial strategy. When completed and approved by the HSCP Board it will be extrapolated over the longer term.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	(3 years +) should be prepared Plans should set out scenario plans (best, worst, most likely).							
WDHSCP-007	5. Local Code Good Governance Arrangements The requirement in 2016/17 for the IJB to publicly report on their compliance with their Local Governance Code was not met. Risk: WDIJB did not adopt the requirements of the Delivering Good Governance Framework in 2016/17. Recommendation: WDIJB should review compliance against their Local Code and publicly report on this for 2017/18.	This has been included as part of the agenda for the September Audit Committee for approval from the Board. Going forward the annual review will form part of our draft annual accounts timetable		0%	30-Jun-2018	30-Jun-2018	Julie Slavin	This annual review will form part of the annual accounts exercise. Therefore this is not required to be started until late February 2018.
WDHSCP-008	6. Internal Audit The internal auditors of NHSGGC do not share copies of individual internal audit reports with the IJB or attend meetings of the IJB's Audit Committee. Risk: Officers and Board members may be unable properly discharge their scrutiny and governance responsibilities. Recommendation: The WDIJB should develop a protocol with the auditors to facilitate for all internal audit reports that affect the IJB are made available to its	Discussions have commenced with the NSGGC Assistant Director of Finance. We will work to develop an agreement, if possible within the existing terms of contract between HNSGGC and PwC.		30%	30-Jun-2018	30-Jun-2018	Julie Slavin; Colin McDougall;	Discussions have taken place with NHSGGC Assistant Director of Finance asking that this request forms part of any new contract negotiations for internal audit services. Also other Integrated Joint Boards have been approached with requests to share their arrangements.

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	Audit Committee.							
WDHSCP-009	7. Value for Money While there is evidence of elements of Best Value being demonstrated by the joint board, there is no mechanism for formal review. Risk: Opportunities for continuous improvement are missed. Recommendation: The IJB should undertake a periodic and evidenced formal review of its performance against the Scottish Government Best Value framework	Version:0.9 StartHTML:0000000105 EndHTML:0000000321 StartFragment:0000000141 EndFragment:0000000285 demonstrate that in a climate of financial austerity targets are on track.		15%	31-Jul-2018	31-Jul-2018	Julie Slavin	Discussions have taken place with procurement colleagues and SMT. There has been agreement on what service areas will be reviewed initially.
WDHSCP-010	8. Annual Performance Report The 2014 Regulations require that an Annual Performance Report be approved and submitted within four months of the financial year end this was not achieved for 2016/17 with the report being submitted on 23 August. Risk: Non compliance with statutory regulations which is required to be reported by auditors. In addition, late submission delays the ability of Board members to review performance and progress improvement actions Recommendation: The	To seek approval from the Board to publish a draft of the Annual Performance Report by 31 July subject to Board approval at the next available meeting.		25%	31-Jul-2018	31-Jul-2018	Julie Slavin	

Action Code	Recommendation	Agreed Action	Status	Progress Bar	Original Due Date of Action	Actual Due Date of Action	Assigned To	Note
	WDIJB should ensure the Annual Performance Report is approved and submitted within the deadline							

West Dunbartonshire COUNCIL

NHS Greater Glasgow and Clyde

West Dunbartonshire
Health & Social Care Partnership

Appendix D

James Hobson
Assistant Director of Finance
Greater Glasgow & Clyde Health Board
JB Russell House
Gartnavel Royal Hospital
1055 Great Western Road
Glasgow
G12 0XH

Address: Hartfield Clinic
Latta Street
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Date: 18th January 2018
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E-Mail: julie.slavin@ggc.scot.nhs.uk

Dear James,

Re: Internal Audit Arrangements NHSGGC

I am writing to you on the request of WD HSCP Audit Committee following consideration of two reports presented to them at our last meeting, in relation to the 2016/17 Annual Audit Report by Audit Scotland and the 2016/17 Annual Audit Report by the IJB Chief Internal Auditor. The presentation of both reports raised questions from the members around the level of detail provided by NHSGGC Internal Audit in relation to audits carried out which have either a direct or indirect impact on the HSCP.

The 2016/17 Annual Audit Report by Audit Scotland under the heading "Governance and Transparency" had a recommendation that while WDIJB has effective governance arrangements in place, "Internal audit arrangements and expectations need to be further clarified and formalised between the IJB and NHS Greater Glasgow & Clyde (NHSGGC)."

The IJB's Chief Internal Auditor Annual Report covered the reliance placed on the internal control arrangements of both WDC and NHSGGC and the different arrangements on access to internal audit reports. For WDC audits the CO, CFO and CIA have access to the full internal audit report which covers scope, objectives, areas covered, sample size, findings and recommendations. If so requested, the IJB would also have access to the full audit report, but normal practice is that the CIA will provide a summary with key actions required to mitigate identified risks.

However for NHSGGC audits the CIA receives only a summary of the audit undertaken and evaluation of the risks identified. While welcome, the WDIJB would request that a protocol be put in place that would allow sight of the full audit report to the CIA to allow for a more informed assessment to be made of

the identified risks and actions. Given that the NHSGGC Audit Committee is held in private, it would not be the intention of the CIA to present these reports to the HSCP Audit Committee.

I would be grateful if you could discuss with your procurement colleagues the possibility of inserting a clause in the new contract tender about to be issued for NHSGGC internal audit services around a new protocol for information sharing? If useful, I have some details of an information sharing protocol between the Ayrshire IJBs' and PwC, in their capacity as internal auditors for Ayrshire & Arran Health Board.

Yours sincerely

Julie Slavin
Chief Financial Officer

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 14 March 2018

Subject: 2017/18 Annual Accounts Audit Process

1. Purpose

1.1 To provide the Audit Committee, an overview of the preparation of the 2017/18 Annual Accounts of the HSCP Board identifying legislative requirements and key stages.

2. Recommendations

2.1 Members are asked to:

- Note the contents of the report; and
- Agree to present this report to the HSCP Board on 2 May 2018, seeking delegated authority for the Audit Committee to approve the unaudited annual accounts, including the annual governance statement for submission to the HSCP Board's external auditors, Audit Scotland, by 30 June 2018.

3. Background

3.1 The West Dunbartonshire Integrated Joint Board (WDIJB), known as the West Dunbartonshire Health and Social Care Partnership Board (HSCP), is a legal entity in its own right.

3.2 Integrated Joint Boards are specified in legislation as a "section 106" body under the terms of the Local Government Scotland Act 1973 and as such is expected to prepare annual accounts in compliance with the Code of Practice on Accounting for Local Authorities in the United Kingdom.

4. Main Issues

4.1 The annual accounts for the HSCP Board will be prepared in accordance with appropriate legislation and guidance. An overview of the process is set out below.

4.2 **Financial Governance & Internal Control;** the regulations require the Annual Governance Statement to be approved by the HSCP Board or a committee of the HSCP whose remit include audit & governance. This will assess the effectiveness of the internal audit function and the internal control procedures of the HSCP Board. Under the approved Terms of Reference the Audit Committee meets this requirement.

4.3 **Unaudited Accounts;** the regulations state that the unaudited accounts are submitted to the External Auditor no later than 30th June immediately

following the financial year to which they relate. Scottish Government guidance states that best practice would reflect that the HSCP Board or committee whose remit includes audit and governance should consider the unaudited accounts prior to submission to the external auditor.

4.4 **Right to Inspect and Object to Accounts:** the public notice period of inspection should start no later than 1st July in the year the notice is published. This will be for a period of 3 weeks and will follow appropriate protocol for advertising and accessing the unaudited accounts.

4.5 **Approval of Audited Accounts**: the regulations require the approval of the audited annual accounts by the HSCP Board or a committee of the HSCP whose remit include audit & governance. This will take account of any report made on the audited annual accounts by the "proper officer" i.e. Chief Financial Officer being the Section 95 Officer for the HSCP Board or by the External Auditor by the 30th September immediately following the financial year to which they relate. In addition any further report by the external auditor on the audited annual accounts should also be considered.

4.6 The Audit Committee will consider for approval the External Auditors report and proposed audit certificate (ISA 260 report) and the audited annual accounts at its meeting on 26 September 2018.

4.7 **Publication of the Audited Accounts:** the regulations require that the annual accounts of the HSCP Board be available in both hard copy and on the website for at least five years, together with any further reports provided by the External Auditor that relate to the audited accounts.

4.8 The annual accounts of the HSCP Board must be published by 31st October and any further reports by the External Auditor by 31st December immediately following the year to which they relate.

4.9 **Key Documents:** the regulations require a number of key documents (within the annual accounts) to be signed by the Chair of the HSCP Board, the Chief Officer and the Chief Financial Officer, namely:

Document	**Signatory**
Management Commentary	Chair of the HSCP Board Chief Officer
Statement of Responsibilities	Chair of the HSCP Board Chief Financial Officer
Remuneration Report	Chair of the HSCP Board Chief Officer
Annual Governance Statement	Chair of the HSCP Board Chief Officer
Balance Sheet	Chief Financial Officer

5. People Implications

5.1 There are no people implications.

6. Financial Implications

6.1 There are no financial implications other than those detailed in the report.

7. Professional Implications

7.1 None

8. Locality Implications

8.1 None

9. Risk Analysis

9.1 No risk analysis was required.

10. Impact Assessments

10.1 None

11. Consultation

11.1 This report was shared with the HSCP Board's external auditors.

12. Strategic Assessment

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

The report is in relation to a statutory function and is for noting. As such, it does not directly affect any of the strategic priorities.

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

Author: **Julie Slavin – Chief Financial Officer**

Date: **18 February 2018**

Person to Contact: Julie Slavin – Chief Financial Officer,
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Appendices: None

Background Papers: **Audit Committee Terms of Reference**

Wards Affected: None

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 14 March 2018

Subject: Audit Scotland: West Dunbartonshire Integrated Joint Board Annual Audit Plan 2017/18

1. Purpose

1.1 To present to the Audit Committee the Annual Audit Plan produced by the IJB's external auditors, Audit Scotland, for the audit of the financial year ending 31 March 2018.

2. Recommendation

2.1 The Partnership Board is recommended to note and comment on Audit Scotland's 2017/18 draft 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 since its establishment on 1 July 2015. The positive working relationships established through the audits of the last 2 financial years will continue to be built upon to help achieve the desired outcome of an unqualified audit opinion at the end of the 2017/18 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 Annual Audit Plan contains an overview of the planned scope and timing of Audit Scotland's external audit of West Dunbartonshire Health and Social Care Partnership Integration Joint Board. It includes their identification of key audit risks, which are categorised into financial risks and wider dimension risks. These key audit risks require specific testing and are detailed in Exhibit 1 of the Annual Audit Report.

4.2 The audit outputs and their target dates, which are based on presentation of Annual Audit Report to the Audit Committee on 26 September 2018, are detailed in Exhibit 2.

4.3 The planned work in 2017/18 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 2018 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 and the 2017/18 Code of Practice on Local Authority Accounting in the United Kingdom (the Code).
- An audit based on four audit dimension (Exhibit 5) which will help contribute to the overall assessment and assurance that the IJB are achieving best value. An area that requires development as West Dunbartonshire Health and Social Care Partnership strive to deliver on the objectives of its Strategic Plan in a climate of continued financial austerity.

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 areas of internal audit work including:

- Guardianship Cases (MHO involvement); and
- Use of Care First functionality for financial management.

5. People Implications

5.1 None associated with this report.

6. Financial Implications

6.1 The proposed audit fee for the 2017/18 audit of the IJB is £24,000, which is increase of £6,600 (38%) on the 2016/17 cost. This fee is consistent with the fees for all Integrated Joint Boards, but is a significant increase on last year. Within Exhibit 2 – section 7 details are provided on how the fee is determined. Further explanation of the fee can be found in Appendix 2.

6.2 Audit Scotland's fee assumes receipt of the unaudited financial statements by 30 June 2018 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: 18 February 2018

Person to Contact: Julie Slavin – Chief Financial Officer,
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Appendices: Appendix 1: Audit Scotland - Annual Audit Plan 2017/18

Appendix 2: Audit Scotland – Statutory Fees 2017/18
Audits Letter

Background Papers: None

Wards Affected: All

West Dunbartonshire Integration Joint Board

Annual Audit Plan 2017/18

AUDIT SCOTLAND

Prepared for West Dunbartonshire Integration Joint Board
February 2018

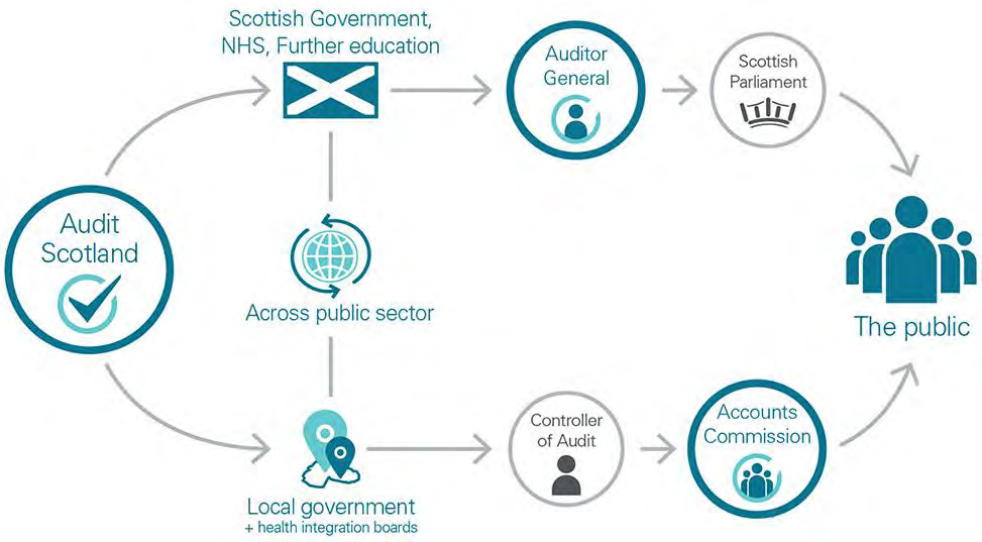
Who we are

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

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.

2. 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

3. 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 Integration Joint Board (WDIJB). 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
2017/18 Key audit risks

Audit Risk	Source of 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 in this instance.	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 **Risk of fraud over expenditure** The expenditure of WDIJB 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 testing to confirm the accuracy and correct allocation of IJB transactions, and that they are recorded in the correct financial year.

Audit Risk	Source of assurance	Planned audit work
3. Hospital acute services (Set Aside) A notional figure for 2016/17 for the "set aside" for hospital acute services under the control of WDIJB was agreed with NHSGGC. This was a transitional arrangement for 2016/17 and no such arrangement has been agreed by the Scottish Government for 2017/18. The IJB needs to ensure its arrangements for calculating and reporting the set aside comply with the statutory guidance.	A working group has been formed which includes representatives from the six Glasgow IJBs, the Scottish Government and NHSGGC. Continued progress is being made and a dataset has been agreed.	The audit of the set aside will compare the IJBs accounting treatment with current accounting requirements. Non compliance will be reported. Continue to liaise with the CFO on progress of the working group.
Wider dimension risks		
4 Financial sustainability At the time of writing this plan, the IJB is projecting an overspend of £1.277million. £280,000 of the overspend relates to Health and is due mainly to the delay in achieving some previously approved savings and pressures on equipment for people discharged from hospital. £997,000 of the overspend relates to Children's Services for the increased demand for foster places, kinship care and residential schools. The IJB had provisionally agreed to fund this from their unallocated reserves, bringing their unallocated reserves levels below the IJBs prudential reserve target. The IJB has planned to hold members' sessions to focus on particular budget pressure areas. There are also no medium to long term financial plans in place. This is increasingly important as demand pressure increases, financial settlements continue to reduce and fundamental service redesign over a longer time frame becomes necessary.	Review ongoing budget monitoring reports to ensure they accurately reflect the position of the partnership. Obtain evidence of remedial action being taken on areas of overspend.	Review of the IJB's final year end position. Review of financial and budgetary reports. Review progress of producing long term financial strategy and plans. The March 2018 financial outturn will be reported in the annual audit report.
5 Best Value IJBs should have arrangements in place to demonstrate how they are fulfilling their duty of Best Value.	This is within the planned scope of work to be completed by the IJB Chief Financial Officer and the Head of Strategy, Planning and Health	Review any available evidence of best value work being undertaken by the IJB and liaise with CFO. A position statement will be

Audit Risk	Source of assurance	Planned audit work
There is currently no mechanism for formal review of BV arrangements in the IJB. There is a risk that opportunities for continuous improvement are missed.	Improvement.	reported in the annual audit report.
6 **Risk management arrangements** At present, there is no process for WDIJB members, the CO and CFO to identify and register any interests. There is a risk that the IJB cannot demonstrate and assure itself and its partner bodies that it is being open and transparent in its organisational decision making.	This is within the planned scope of work to be completed by the IJB Chief Financial Officer.	Review the progress of WDIJB in developing their risk management arrangements.

Reporting arrangements

4. 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.

5. 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.

6. We will provide an independent auditor's report to WDIJB, and Accounts Commission setting out our opinions on the annual accounts. We will provide the IJB and Accounts Commission with an annual report on the audit containing observations and recommendations on significant matters which have arisen in the course of the audit.

Exhibit 2
2017/18 Audit outputs

Audit Output	Target date	Audit Committee (or equivalent) Date
Annual Audit Plan	31 March 2018	14 March 2018
Annual Audit Report	30 September 2018	26 September 2018
Independent Auditor's Report	30 September 2018	26 September 2018

Audit fee

7. The proposed audit fee for the 2017/18 audit of WDIJB is £24,000 (2016/17 £17,400). This is consistent with the fees for all of the Integration Joint Boards which are audited by Audit Scotland. The 2017/18 audit fee reflects the audit work required to ensure that the IJB accounts comply with disclosure requirements. In determining the audit fee, we have taken account of the risk exposure of the IJB,

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 2018.

8. 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

Audit Committee and Chief Financial Officer

9. 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.

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

Appointed auditor

11. Our responsibilities as independent auditor are established by the 1973 Act for local government, and the Code of Audit Practice (including supplementary guidance) and guided by the auditing profession's ethical guidance.

12. Auditors in the public sector give an independent opinion on the financial statements and other specified information accompanying 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

13. 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 Integration 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 WDIJB 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.

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

- whether they give a true and fair view in accordance with applicable law and the 2017/18 Code of Practice on Local Authority Accounting in the United Kingdom of the financial position of the West Dunbartonshire Integration Joint Board as at 31 March 2018 and its income and expenditure for the year then ended
- whether they have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2017/18 Code
- whether they have been prepared in accordance with the requirements of the Local Government (Scotland) Act 1973, The Local Authority Accounts (Scotland) Regulations 2014, and the Local Government in Scotland Act 2003.

Materiality

15. We apply the concept of materiality in planning and performing the audit. It is used in evaluating the effect of identified misstatements on the audit, and of any uncorrected misstatements, on the financial statements and in forming our opinion in the auditor's report.

16. We calculate materiality at different levels as described below. The calculated materiality values for West Dunbartonshire Integration 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 set of audited accounts (2016/17).	£1.817 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 70% of planning materiality.	£1.272 million
Reporting threshold (i.e. clearly trivial) – 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, rounded to a memorable amount.	£20,000

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

Timetable
18. 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	20 June
Latest submission date of unaudited annual accounts with complete working papers package	30 June
Latest date for final clearance meeting with Chief Financial Officer	7 September
Issue of letter of representation and proposed independent auditor's report	26 September
Agreement of audited unsigned annual accounts	26 September
Issue of Annual Audit Report including ISA 260 report to those charged with governance	26 September
Independent auditor's report signed	30 September

Internal audit

19. 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 West Dunbartonshire Council overseen by the Audit and Risk Manager.

Adequacy of Internal Audit

20. Our review of the internal audit service concluded that it has sound documentation standards and reporting procedures in place and it complies with the main requirements of the Public Sector Internal Audit Standards.

Areas of Internal Audit reliance

21. In respect of our wider dimension audit responsibilities we also plan to consider other areas of internal audit work including:

- Guardianship Cases (MHO involvement)
- Use of Care First functionality for financial management

Audit dimensions

22. 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

Source: Code of Audit Practice

23. In the local government sector, the appointed auditor's annual conclusions on these four dimensions will help contribute to an overall assessment and assurance on best value.

Financial sustainability

24. 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

25. 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 the IJB has arrangements in place to ensure systems of internal control are operating effectively
- whether the IJB can demonstrate the effectiveness of budgetary control system in communicating accurate and timely financial performance
- how the IJB has assured itself that its financial capacity and skills are appropriate
- whether the IJB has established appropriate and effective arrangements for the prevention and detection of fraud and corruption.

Governance and transparency

26. 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 the 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
- whether the board and Audit Committee members and staff demonstrate high standards of behaviour and receive sufficient training and development
- the quality and timeliness of financial and performance reporting.

Best Value

27. IJBs should have arrangements in place to ensure that they can demonstrate how they are fulfilling their duty of Best Value. It is recognised that this is an area that IJBs need to develop. We are to monitor and report on progress in the annual audit report.

Independence and objectivity

28. Auditors appointed by the Accounts Commission or Auditor General must comply with the Code of Audit Practice and relevant supporting guidance. 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 Director of Audit Services, who serves as Audit Scotland’s Ethics Partner.

29. The engagement lead for Audited Body 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 WDIJB.

Quality control

30. 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.

31. 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 (and relevant supporting guidance) 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.

32. 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.

Adding Value

33. Through our audit work we aim to add value to the Audited Body. We will do this by ensuring our Annual Audit Report provides a summary of the audit work done in the year together with clear judgements and conclusions on how well the Audited Body has discharged its responsibilities and how well it has demonstrated the effectiveness of its arrangements. Where it is appropriate we will recommend actions that support continuous improvement and summarise areas of good practice identified from our audit work.

West Dunbartonshire Integration Joint Board

Annual Audit Plan 2017/18

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**

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AUDIT SCOTLAND

Ms Beth Culshaw
Chief Officer
West Dunbartonshire IJB
Council Offices
Garshake Road
Dumbarton
G82 3PU

13 December 2017

15 DEC 2017

Dear Ms Culshaw,

Audit Scotland Statutory fees – 2017/18 audits

The purpose of this letter is to give you an indication of the fees for the 2017/18 audit of West Dunbartonshire IJB. This is based on Audit Scotland's overall budget proposals that will be considered by the Scottish Commission for Public Audit (SCPA).

Fee setting arrangements

We have set audit fees based on our fee strategy which was revised in 2016 following consultation with stakeholders. The two key principles underpinning our fee setting arrangements are that:

- audit fees should be set with the objective of recovering the full cost of audit work in each sector
- the cost of the audit should be independent of the identity or location of the auditor.

We reduced average fees by 8.6% in real terms last year. We told you then that we expected to further reduce 2017/18 audit fees in real terms. I am pleased to confirm that this year we are reducing average fees by a further 1.1% in real terms.

Fees

The expected fee for each body assumes that it has sound governance arrangements in place and operating effectively throughout the year, prepares comprehensive and accurate unaudited accounts and meets the agreed timetable for the audit.

The average change in audit fees from the 2016/17 for local government bodies is -1.1% in real terms (+0.5% in cash terms).

Expected fee for 2017/18

We did not set an expected fee last year and asked your auditor to assess the audit needs for 2016/17 and agree an appropriate fee with you. We have consulted with all IJB auditors and assessed the time it took to audit IJBs in 2016/17. Based on this work, we are now able to set an expected fee. The expected fee for West Dunbartonshire IJB for the 2017/18 audit is:

	2017/18	2016/17
Auditor remuneration	£16,470	£11,860
Pooled costs	£1,460	£1,040
Contribution to PABV	£5,020	£3,790
Audit support costs	£1,050	£710
Total expected fee	£24,000	£17,400

The actual amount that you will pay will depend on the amount of the audit fee agreed with your auditor Fiona Mitchell-Knight of Audit Scotland. Fees can be agreed between the auditor and audited body by varying the auditor remuneration by up to 10% above the level set (20% for bodies with an expected fee below £25,000), for example, where significant local issues require additional work to be undertaken. In exceptional circumstances higher remuneration can be agreed with the prior agreement of Audit Scotland.

Future fees

Following the 2017/18 audits of IJBs we will consult with auditors once more to ensure that the 2018/19 expected fee fairly reflects the audit requirements.

What do audited bodies receive for the fee?

The scope of the public sector audit model in Scotland, as explained more fully in Public audit in Scotland[1] means that the audit fees cover a wide range of audit work and related outputs.

All bodies receive a **financial statements audit** that includes an auditor's opinion on whether the financial statements present a true and fair view for the year. This opinion is supplemented by an annual audit report that summarises the key audit findings and auditor conclusions on aspects of the wider scope requirements of the Code of Audit Practice[2]. These are public documents and help to explain the local audit work that was undertaken and key findings.

Every year around 10 to 12 **performance audit reports** are produced and published on our website. The aim of these is to provide independent assurance to the people of Scotland that public money is being spent properly and that it provides value for money. Local government bodies contribute to the costs of relevant reports through audit fees. Other performance audit work is funded by the Parliament. Some examples of forthcoming reports **due out in 2018 and 2019** are:

- Early learning and childcare
- Local Government Overview reporting in 2017/18
- Managing the implementation of the Scotland Acts
- Scottish Fire and Rescue Service - an update
- Are ALEOs improving council services?
- Children and young people's mental health

Best Value toolkits have also been prepared to provide support to all public bodies in improving their services.

Invoices

Bodies will be invoiced shortly for a payment on account, based on 1/3 of the expected fee. Further instalments (adjusted where possible for the amount of the fee agreed with the auditor) will be invoiced in March/April 2018 and August 2018.

A final invoice will be issued if necessary, once all 2017/18 audits are complete, to adjust for any late changes to agreed fees.

Please let me know if there is anything that you wish to clarify or discuss further.

Yours sincerely

Elaine Boyd

Elaine Boyd
Assistant Director – Appointments and Assurance

[1] http://www.audit-scotland.gov.uk/docs/corp/2015/as_150511_public_audit_scotland.pdf
[2] http://www.audit-scotland.gov.uk/report/code-of-audit-practice-2016

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 14th March 2018

Subject: Audit Scotland Report on NHS in Scotland 2017

1. Purpose

1.1 To bring to the Audit Committee's attention the recently published Audit Scotland report on the NHS in Scotland 2017.

2. Recommendation

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

3. Background

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

3.2 Audit Scotland published its annual report on how the NHS in Scotland is performing in October 2017 and is appended here.

4. Main Issues

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

- Health funding continues to increase but NHS boards had to make unprecedented levels of savings in 2016/17, as operating costs also continue to rise. The lack of financial flexibility, with NHS boards required to break even at the end of each financial year, and lack of long-term planning are barriers to moving more care out of hospitals.
- Demand for health services continues to rise but previous approaches of treating more people in hospital are no longer enough.
- The overall health of the Scottish population continues to be poor and significant health inequalities remain.
- There is significant activity under way by the Scottish Government, NHS boards, and integration authorities to transform the healthcare system in Scotland and building blocks for moving more care out of hospital are being put in place. A key action is developing a financial framework to set out how existing and future funding will be used to move more care into the community.

5. People Implications

5.1 With respect to the workforce considerations highlighted within the Audit Scotland report, Audit Committee members will recall that two key themes of the Health & Social Care Partnership's Workforce & Organisational Development Strategy are a "capable workforce" and a "sustainable workforce", with an update having been presented at the November 2017 meeting of the Partnership Board.

6. Financial Implications

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

7. Professional Implications

7.1 The Chief Medical Officer and the National Clinical Strategy (presented to the Partnership Board at its May 2016 meeting) outline the need to reduce waste, harm and variation in treatment and clinical practice given the estimate that 20 percent of mainstream clinical practice brings no benefit to the patient.

8. Locality Implications

8.1 None associated with this report.

9. Risk Analysis

9.1 With respect to the issues pertaining to governance in the report, the Audit Committee will have been reassured by the most recent positive report on Audit Scotland's Annual Audit Report and Accounts for West Dunbartonshire Health & Social Care Partnership Board that was presented by Audit Scotland at the September 2017 meeting.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

12. Strategic Assessment

12.1 This report on the above national audit will provide important evidence and context for the on-going implementation of the current Strategic Plan.

Author: Wendy Jack – Interim Head of Strategy, Planning & Health Improvement West Dunbartonshire Health & Social Care Partnership.

Date: 31st October 2017

Person to Contact: Wendy Jack – Interim Head of Strategy, Planning & Health Improvement, Garshake Road, Dumbarton. G82 3PU.
Telephone: 01389 776864
e-mail: wendy.jack@west-dunbarton.gov.uk

Appendices: Audit Scotland: NHS in Scotland (October 2017)

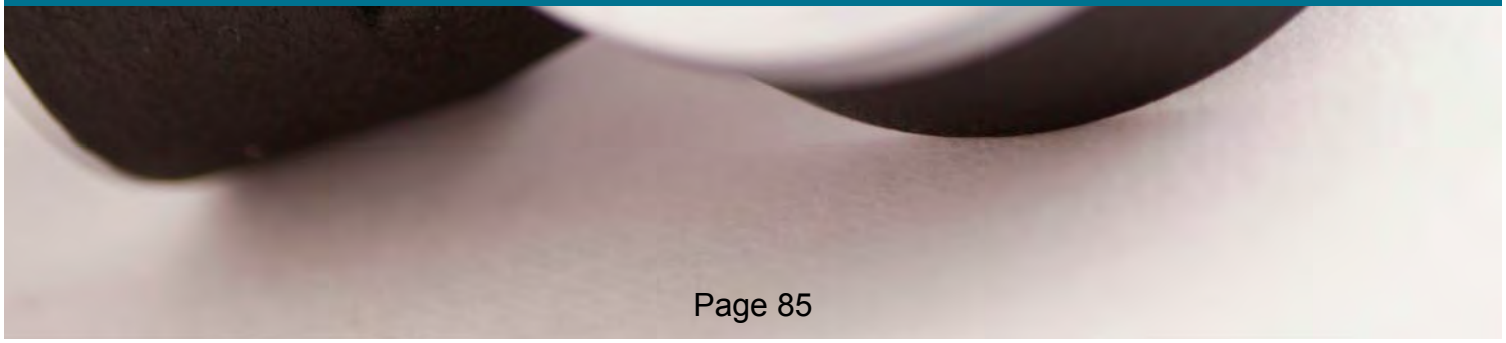
Background Papers: None

Wards Affected: All

NHS in Scotland 2017

AUDITOR GENERAL

Prepared by Audit Scotland
October 2017



NHS in Scotland 2017

The Auditor General's role is to:

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

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

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

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

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

Contents

PDF download

Web link

Interactive Tableau exhibit, where further information can be viewed at an NHS board level

Exhibit data

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

Summary

Key messages

1 Every day the NHS provides vital services to thousands of people across Scotland. It has a budget of around £13 billion each year, equivalent to 43 per cent of the overall Scottish budget in 2016/17. At some time in their lives, everyone in Scotland will use a service provided or funded by the NHS, from dentists and GPs to hospital services such as maternity and orthopaedics. In 2016/17, the NHS in Scotland employed almost 140,000 whole-time equivalent staff, performed 1.5 million hospital procedures and conducted an estimated 17 million GP consultations.

2 The NHS in Scotland is 70 years old next year. In the intervening decades since it was set-up demographic and health trends have changed significantly and demand for services has increased dramatically. We have reported many times on the challenges facing the NHS including increasing costs, growing demand, and the continuing pressures on public finances. In 2016/17, these challenges continued to intensify. Demand for healthcare services continues to increase and more people are waiting longer to be seen. For example, the number of people waiting for their first outpatient appointment increased by 15 per cent in the past year and there was a 99 per cent increase in the number of people waiting over 12 weeks. Scotland's health is not improving and significant inequalities remain, while general practice faces significant challenges, including recruiting and retaining GPs and low morale. In the face of this, NHS staff have helped maintain and improve the quality of care the NHS provides. Yet there are warning signs that maintaining the quality of care is becoming increasingly difficult. The findings in this year's report illustrate why the way healthcare is planned, managed and delivered at all levels in Scotland must change.

3 Healthcare is likely to look very different in future. Health and social care integration marks a significant change in how the different parts of the health and social care system work together and how the Scottish public will access and use services in future. Yet the scale, complexity, and interdependencies of health and social care make achieving the changes needed a highly complicated and long-term undertaking. A number of factors provide a positive basis on which to build. Scotland has had a consistent overall policy direction in health for many years and there is broad consensus on the aim that everyone will be able to live longer, healthier lives at home or in a homely setting. Staff remain committed to providing high-quality care and there is a continued focus on safety and improvement. Levels of overall patient satisfaction continue to be high and the Scottish public hold the NHS in high regard. There are also early signs that changes in the way services are planned and delivered are

the NHS faces increasing challenges and crucial building blocks to enable change still need to be put in place

beginning to have a positive impact. For example, delayed discharges have reduced in a number of areas and this provides opportunities for sharing learning across the country.

4 There is no simple solution to addressing the issues facing the NHS and achieving the changes required. Previous approaches such as providing more funding to increase activity or focusing on specific parts of the system are no longer sufficient. Attention needs to focus on overcoming a number of barriers to change. Managing the health budget on an annual basis is hindering development of longer-term plans for moving more care out of hospital. It is still not clear how moving more care into the community will be funded and what future funding levels will be required. A clear long-term financial framework is a critical part of setting out how change will happen and when. Culture change is an essential part of transforming health and social care services. A different way of involving the public and staff in how they access, use and deliver health and care services is needed to help make the necessary difficult decisions. More information about how the NHS is working and the impact changes have on different parts of the system would help. For example, there are indicators measuring access to acute care services, such as hospitals, but there is little or no monitoring of activity levels and still little public information about primary care, such as GP practices, and community care.

Recommendations

To provide the foundations for delivery of the 2020 Vision and changing the way healthcare services are provided:

The Scottish Government should (paragraphs 63–70):

- develop a financial framework for moving more healthcare into the community which identifies:
  - the anticipated levels of funding available for future years across the different parts of the healthcare system
  - how funding is anticipated to be used differently across NHS boards and integration authorities to change the way services are delivered
- develop a longer-term approach to financial planning to allow NHS boards and integration authorities flexibility in planning and investing in the longer-term policy aim of developing more community-based services.

The Scottish Government, in partnership with NHS boards and integration authorities, should (paragraphs 71–78):

- develop a capital investment strategy to ensure the NHS Scotland estate is appropriate for delivering more regional and community-based services
- continue to develop a comprehensive approach to workforce planning that:

  - reflects forecasts of future staffing and skills requirements to deliver changing models of healthcare provision at regional, local and community level
  - provides a clear breakdown of transitional and future costs to meet projected demand through additional recruitment and training.

To improve governance, accountability and transparency:

The Scottish Government should (paragraphs 61–62):

- develop a robust governance framework for the delivery of the *Health and Social Care Delivery Plan*. This should:
  - set out all the work currently under way and planned, and the interrelationships between them
  - move on from statements of intent to developing the specific actions, targets and timescales to deliver all of its workstreams and plans, to allow better oversight and progress to be assessed and reported publicly
  - simplify and make clear the lines of accountability and decision-making authority between the Health and Social Care Delivery Plan Programme Board and major work programme delivery oversight groups, regional boards, NHS boards and integration authorities
  - improve transparency by including measures of performance covering all parts of the healthcare system which include indicators of quality of care in addition to indicators of access.

The Scottish Government and NHS boards should (paragraphs 18–26):

- work together to develop a consistent way of measuring and reporting savings to ensure that it is clear how boards have planned and made savings, and what type of savings they have made.

To promote the culture change necessary to move to new ways of providing and accessing healthcare services:

The Scottish Government should (paragraph 87):

- work with the entire public sector to develop a shared commitment to, and understanding of their role and interrelationships in improving public health and reducing health inequalities.

The Scottish Government, NHS boards and integration authorities, should (paragraphs 83–84 and paragraphs 53–56):

- continue to work with the public, local communities and staff to develop a shared understanding and agreement on ways to provide and access services differently
- work together to embed the principles of 'realistic medicine' in the way they work, monitor progress in reducing waste, harm and unwarranted variation; and creating a personalised approach to care.

Introduction

Healthcare in Scotland needs to be delivered differently in future

1. The NHS in Scotland is 70 years old next year. The NHS was set up in 1948 to provide free healthcare at the point of need. In the intervening seven decades, the range of services it provides, the number of staff it employs, and the Scottish public's demand for its services have all grown considerably. At some point in their lives, everyone in Scotland will use a service provided or funded by the NHS, from dentists and GPs to hospital services such as maternity and orthopaedics. In 2016/17, the NHS in Scotland:

- employed almost 140,000 whole-time equivalent staff across 14 mainland and island health boards and eight national boards
- performed 1.5 million procedures in acute hospitals
- responded to 741,000 accident and emergency incidents
- conducted an estimated 17 million GP consultations
- had a budget of £12.9 billion for delivering healthcare.[1, 2, 3, 4, 5]

2. NHS staff are committed to their work and patient satisfaction is at an all-time high.[6] An increasing percentage of the overall Scottish budget is spent on health yet the NHS faces significant challenges in continuing to meet everything expected of it. Over the years, in our national and local audit work, we have highlighted these growing pressures. These include continuing increases in demand, a tightening financial environment, difficulties in recruiting staff, advances in expensive technology and medicines, and a demanding public and political environment. These features are common in many other countries around the world.

3. There is general consensus in Scotland that healthcare cannot continue to be provided in the same way but as we have reported previously, more progress needs to be made if transformational change is to happen. To help support this change, this annual overview of the NHS in Scotland focuses on two main areas:

- In Part 1, we examine how different parts of the healthcare system in Scotland currently perform and why healthcare needs to change.
- In Part 2, we identify the progress being made and the barriers which urgently need to be overcome to ensure the NHS can continue to provide high-quality care in the future.

the way healthcare is planned and delivered is changing

The Scottish Government has a consistent and long-standing vision of how it wants healthcare to look in the future

4. For well over a decade, successive Scottish Governments have had a policy of integrating health and care services to improve the health of the population.[7] A healthy population served by a high-quality healthcare system is central to the Scottish Government's ambition to create 'a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth'. In 2011, the Scottish Government published its 2020 Vision for transforming healthcare and the health of the population. Its aim is that everyone should live longer, healthier lives at home or in a homely setting by 2020.[8] Achieving this aim will mean that healthcare services will look very different in the future (Exhibit 1, page 9).

5. To achieve this vision, the way that people access and use health and social care services across Scotland will need to change, services will need to be delivered differently, and there will need to be a significant change in how people manage their own health. It is not possible to stop or pause services while these changes are made and the scale of the task should not be underestimated. This is an exceptionally large-scale, complex change involving not just structural, but also significant culture change, for the people providing care and the public. Attitudes towards the role and responsibilities of the NHS, the way health and social care services are accessed and delivered, the part the rest of the public sector has to play in improving Scotland's health, and how people manage their own health, will all need to change. This can only be achieved by involving and supporting the Scottish public, NHS and other public sector staff throughout this process. The NHS cannot achieve this vision alone. All parts of the public sector have a role to play, such as housing, sports and education, if the Scottish Government's vision for health is to be realised.

The way in which healthcare is planned is becoming more complex, with a mix of local, regional and national planning

6. Historically, health services in Scotland have been planned on a geographical health board basis with some services provided regionally and nationally. Health and social care integration and the move to greater regionalisation are changing this. Some services will now be planned on a much more local basis while others will be planned regionally (Exhibit 2, page 10).

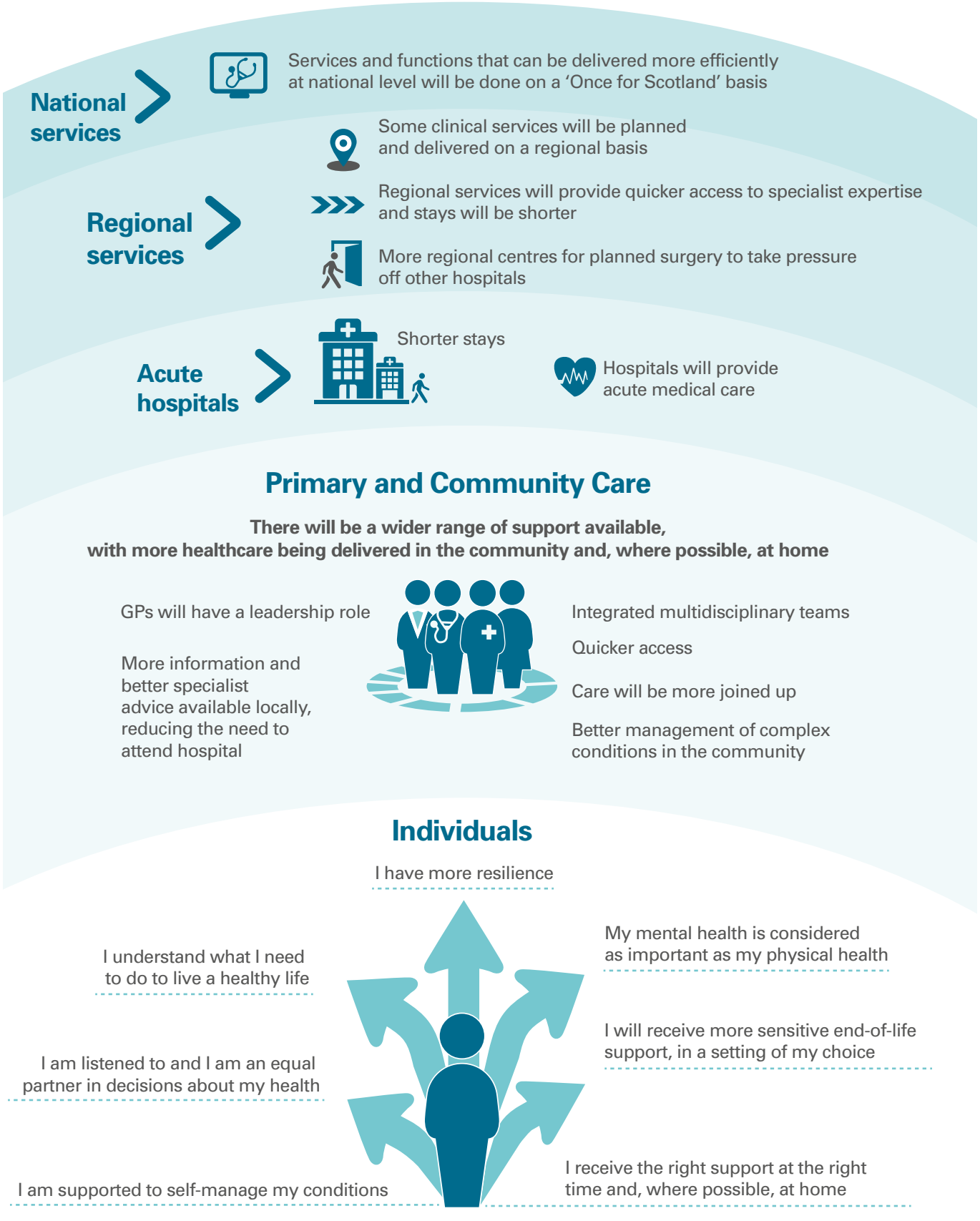
7. It is not yet clear how planning at each of the different levels will work together in practice. It is important that roles and responsibilities at each level, and how they link together, are well defined to ensure:

- there is clear accountability
- it is clear how public money is being used
- the public are easily able to access health and social care services that are joined up effectively.

Exhibit 1

The Scottish Government's vision for how healthcare will look in the future

The way people will access and use health and social care services is changing.

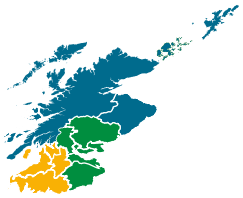
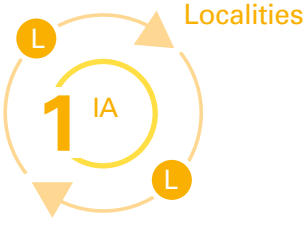


Source: Audit Scotland based on *Health and Social Care Delivery Plan,* Scottish Government, December 2016.

Exhibit 2

Planning levels in the Scottish health system

Multiple planning levels for healthcare are being developed.

Planning levels	Breakdown	Delivery
National planning 	The Scottish Government and eight national NHS boards 	Services that can be delivered more efficiently nationally will be done on a 'Once for Scotland' basis.
Regional planning 	3 regions North West East	Some specialist services will be planned and delivered on a regional basis. The aim is that services should be provided more quickly, will take pressure off other hospitals, and mean fewer delays for urgent or emergency care.
NHS boards 		These will continue to provide a range of acute services to their population.
Community Planning Partnerships (CPPs) 		Each CPP is responsible for improving outcomes and tackling inequalities of outcome in their area. Each CPP must identify smaller areas in their local authority which experience the poorest outcomes, known as localities, and develop a plan to improve outcomes in these areas.
Integration authorities (IAs) 		In control of a range of health services, for example primary care and adult social care. They are responsible for planning and commissioning services in their area. IAs are statutory members of CPPs.
Localities 	 Each integration authority must have at least two localities	Localities are responsible for planning how their IAs' resources will be spent to best meet the needs of the local population. These are not necessarily the same as the CPP localities

Source: Audit Scotland

Part 1

The NHS in Scotland in 2016/17

Key messages

1 In 2016/17, the health budget was £12.9 billion, 43 per cent of the total Scottish Government budget. Health funding continues to increase but NHS boards had to make unprecedented levels of savings in 2016/17, at almost £390 million, as operating costs also continue to rise. The lack of financial flexibility, with NHS boards required to break even at the end of each financial year, and lack of long-term planning are barriers to moving more care out of hospitals.

2 Demand for health services continues to rise but previous approaches of treating more people in hospital are no longer enough. People are waiting longer to be seen with waiting lists for first outpatient appointment and inpatient treatment increasing by 15 per cent and 12 per cent respectively in the past year. The majority of key national performance targets were not met in 2016/17 and wider indicators of quality suggest that the NHS is beginning to struggle to maintain quality of care.

3 The overall health of the Scottish population continues to be poor and significant health inequalities remain. Life expectancy is lower than in most European countries and improvements have stalled in recent years. Smoking rates have continued to reduce but drug-related deaths increased significantly in 2016/17 and are now the highest in the EU.

4 General practice is central to changing how health services are accessed and used, yet there are significant challenges. These include difficulties in recruiting and retaining GPs and low morale, and a lack of data on demand and activity.

health funding continues to increase but cost pressures are intensifying and health inequalities remain significant

Funding for the NHS continues to increase and accounted for 43 per cent of the Scottish Government budget in 2016/17

8. Health funding is the single largest area of Scottish Government expenditure. In 2016/17, the total Scottish Government health budget for spending on core services, known as the departmental expenditure limit (DEL), was £12.9 billion. This accounted for 43 per cent of the overall Scottish Government budget, an increase from 38 per cent in 2008/09.

9. The vast majority of the health budget is allocated to the 14 territorial health boards, £11.2 billion in 2016/17. The eight national NHS boards received £1.4 billion in 2016/17, and the remaining budget was for national programmes and

initiatives, such as health improvement and protection.[9] A significant percentage of territorial health boards' budgets, 45 per cent, £5 billion in 2016/17, is now allocated to Integration Authorities to fund delegated health services, such as primary care.

10. Between 2015/16 and 2016/17, the overall health budget increased by 5.7 per cent in cash terms. Taking into account inflation, the real terms increase was 3.6 per cent. This was made up as follows:

- Revenue funding, for day-to-day spending, increased by 3.1 per cent in cash terms from £12 billion to £12.4 billion, an increase of one per cent in real terms.

- Capital funding, for example for new buildings and equipment, increased from £203 million to £525 million, an increase of 159 per cent in cash terms, 154 per cent in real terms. The majority of this increase is due to changes in the way capital funding is accounted for, and excluding this the real terms increase was 35 per cent.[10]

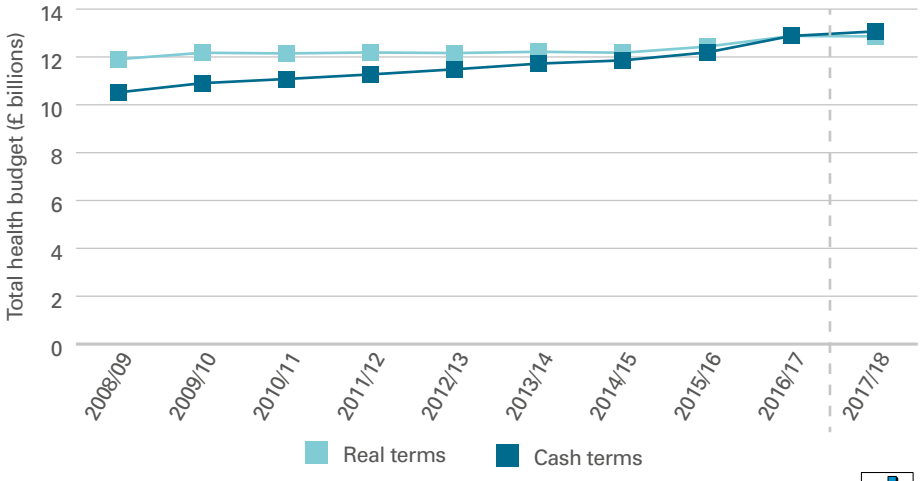
11. In 2016/17, the NHS budget included £250 million ring-fenced for social care funding for health and social care integration. Although this funding was for social care, it was included in the health budget and NHS boards were required to give this funding directly to Integration Authorities. Without this element of non-health funding, the health revenue budget decreased by one per cent in real terms between 2015/16 and 2016/17. It is important that it is clear what is included in budget figures to ensure transparency and to help scrutiny take place.

12. Between 2008/09 and 2016/17, the overall health budget increased by 8.2 per cent in real terms (Exhibit 3).[11] This has mainly been driven by funding increases in the most recent five-year period. Revenue funding increased by 5.7 per cent in real terms and capital funding by 9.2 per cent in real terms between 2012/13 and 2016/17.

Exhibit 3

Trend in the health budget in Scotland, 2008/09-2016/17, and budget figures for 2017/18

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



Source: Audit Scotland

13. The 2017/18 health budget is £13.1 billion, an increase of 1.5 per cent in cash terms, and a decrease of 0.1 per cent in real terms from 2016/17. This is due to an increase in the revenue budget of 2.5 per cent in cash terms, 0.8 per cent in real terms. The capital budget is projected to decrease by almost a quarter, from £525 million to £408 million, a 23 per cent reduction in real terms.[12] This is mainly due to Dumfries and Galloway Royal Infirmary and the Royal Hospital for Sick Children capital projects being close to completion.

Most territorial NHS boards moved closer to their target funding allocation in 2016/17

14. The Scottish Government allocates most funding to territorial NHS boards according to a formula developed by the NHS Scotland Resource Allocation Committee (NRAC). This is based on a number of factors including population size, age and gender profiles, and deprivation. Since the formula was introduced in 2009/10, the Scottish Government has been working towards ensuring that by 2016/17, no NHS board would be more than one per cent below their target allocation. In 2016/17, four NHS boards – NHS Grampian, Highland, Lanarkshire, and Lothian – remained more than one per cent below their target allocation, between 1.4 and 1.5 per cent below parity. Seven NHS boards received more than their target allocation, ranging from 0.3 per cent more in NHS Tayside to 9.4 per cent more in NHS Western Isles.[13] No board will be more than one per cent below their target funding allocation in 2017/18.

Lack of long-term planning and financial flexibility are barriers to moving more care into the community

15. NHS boards are required by the Scottish Government to achieve a balanced financial position at the end of each financial year, meaning they must spend no more than the limits of their revenue and capital budgets. All NHS boards broke even in 2016/17, achieving an overall surplus of £8 million.[14] A significant amount of work is carried out across the NHS to achieve financial balance each year. However, this is becoming harder to achieve each year and current approaches are unsustainable.

16. As with last year, the majority of NHS boards had to use short-term measures to break even. These included:

- receiving loans, known as brokerage, and late allocations from the Scottish Government
- reallocating capital funding to revenue funding to allow it to be used to cover increasing operational costs
- using reserves
- making one-off accounting adjustments, such as releasing surplus holiday pay accruals and insurance rebates.

17. NHS Tayside was the only board to require brokerage from the Scottish Government in 2016/17, receiving £13.2 million. We have prepared a separate report on *The 2016/17 audit of NHS Tayside*. Three NHS boards – NHS Highland, Orkney, and Western Isles – repaid all their outstanding brokerage ranging from £0.5 million to £1.1 million, and NHS 24 repaid £1.1 million from an existing balance of £20.4 million. NHS 24 is scheduled to repay the remaining loan over the next four years.

NHS boards made unprecedented levels of savings in 2016/17 but failed to meet the overall planned savings target

18. NHS boards need to make annual savings to achieve their financial targets of operating within their resource and capital limits and achieving financial balance at the end of each financial year. This is because there is a gap between the funding and income they receive and their expenditure, that is how much it costs them to deliver services. NHS boards are responsible for identifying and then making their own savings. This has become more complicated with the introduction of Integration Authorities (IAs). NHS boards now need to negotiate with their IAs to agree savings in primary care and other health services to contribute to their NHS board's savings target. NHS boards set out planned savings in their Local Delivery Plans (LDPs), which set out NHS board priorities. Savings targets are then revised through the year as revenue and capital resource limits change due to additional funding allocations from the Scottish Government.

19. NHS boards made £387.4 million savings in 2016/17 as reported in the external annual audit reports, 3.8 per cent of total revenue allocations to NHS boards. The level of savings made in 2016/17 was unprecedented, and was a third higher than the £291.3 million made in 2015/16. Despite this, the NHS did not meet its savings target of £406.3 million, falling short by 4.7 per cent, £18.9 million.

20. Although the overall target was missed, the majority of NHS boards did meet their individual savings targets in 2016/17. Five territorial boards – NHS Borders, Forth Valley, Highland, Lothian, Tayside – did not meet their savings targets despite almost all making higher levels of savings than in previous years. The shortfall ranged from NHS Lothian missing its original planned target by £9.8 million (28 per cent), to NHS Tayside which missed its original planned target by £1.3 million (three per cent). All the national boards reported that they achieved their savings targets.

21. It is becoming more difficult for NHS boards to identify the savings they need to make. In 2012/13, boards were unable to identify in their LDPs how they would make five per cent of their planned savings. In 2016/17, this had risen to 17 per cent. As a result, three NHS boards – NHS Ayrshire and Arran, Fife, and Tayside – projected in their 2016/17 LDPs that they would not achieve financial balance at year-end. In 2015/16, no territorial NHS boards predicted a deficit at year-end in their LDP.

22. NHS boards are also forecasting savings targets and financial break-even to be achieved at a later stage in the financial year than previously. In particular, more boards relied on making a greater amount of savings in the final month of the financial year in 2016/17 than in 2015/16:

- Twelve out of 14 territorial boards predicted that they would still be in a deficit position at February 2017, compared to nine boards in 2015/16.
- Between February and March 2016, NHS territorial boards recovered £35 million to move to a year-end surplus position. A year later, they had to recover almost double that amount, £61 million, to break even, and ended the financial year with a surplus of £8 million.

23. Forecasting in this way creates risks if planned savings do not materialise. For example, projects aiming to redesign services, that is providing them in new ways that may also cost less, may not be delivered on time. Then boards will be unable to recover any deficit in time to achieve financial balance.

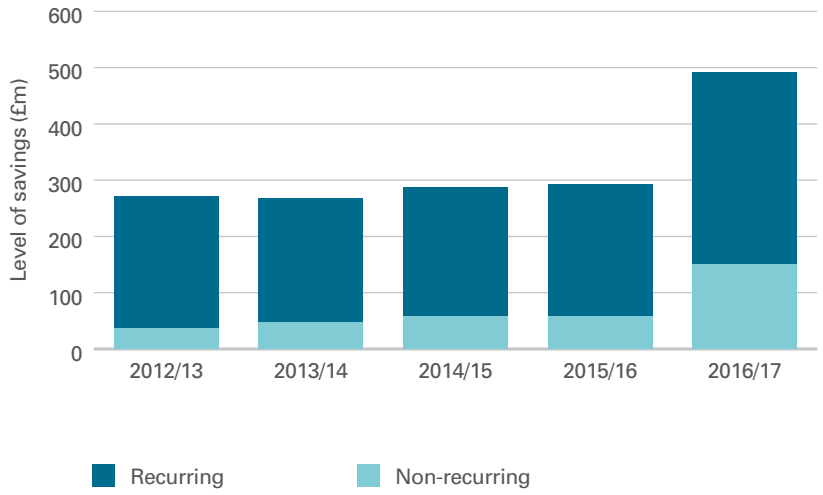
NHS boards' increasing use of one-off savings is unsustainable

24. The level of savings NHS boards have planned to make in their LDPs has increased significantly over the past five years, increasing by 81 per cent in cash terms, 71 per cent in real terms between 2012/13 and 2016/17 (Exhibit 4). NHS boards make savings in various ways and while they reduce expenditure and contribute to achieving financial targets, they do not necessarily demonstrate increased productivity or efficiency. Savings are classed as either recurring or non-recurring. The former recur year-on-year from that date, for example savings as a result of providing services in a different way. Non-recurring savings are one-off savings that do not result in ongoing savings after that financial year, for example selling a building or delaying filling a vacant post. The percentage of non-recurring savings planned by NHS boards in their LDPs has increased significantly over the past few years (Exhibit 4). Non-recurring savings accounted for 30 per cent of all savings planned in 2016/17, more than double the level of five years ago when they accounted for 13 per cent of planned LDP savings. The percentage of savings made up from non-recurring sources varied widely across the NHS in 2016/17. Among the territorial boards, as reported in the external annual audit reports, non-recurring savings accounted for seven per cent of total savings in NHS Forth Valley to 71 per cent in NHS Fife. Among the national boards they ranged from zero in NHS National Services Scotland to 86 per cent in The State Hospital.

Exhibit 4

Overall level of planned LDP savings by NHS boards between 2012/13 and 2016/17 split by planned recurring and non-recurring

The planned use of non-recurring savings has increased over the past five years.



Note: Figures are in cash terms.

Source: Audit Scotland using NHS board Local Delivery Plans 2016/17

25. We have stated previously that increasing reliance on non-recurring savings is unsustainable. This is because:

- it is becoming more and more difficult for NHS boards to identify areas in which they can make one-off savings
- boards that make high levels of one-off savings will have to find more savings in future years as they have less recurring savings to use

- non-recurring savings are typically short-term decisions rather than initiatives to change the way services are provided.[15]

26. Currently, NHS boards report their LDP savings target, and progress towards it, to the Scottish Government with savings categorised under set headings. In the course of our work we discovered differences between the level of planned and achieved savings NHS boards reported to the Scottish Government and that reported to their own boards. Given the scale of the savings NHS boards need to make, it is essential that it is clear how boards have calculated their savings and what types of savings are planned and then made, for example different types of recurring and non-recurring savings. It is also important that this is then reported in a consistent and clear way to ensure appropriate planning and scrutiny can take place.

27. The majority of NHS boards' financial plans cover three years or less. This is partly driven by one-year funding allocations from the Scottish Government, and the need to break even each year. However, a short-term approach to financial planning makes it difficult for boards to plan and invest in longer-term policy aims, such as developing more community-based services and treating people in homely settings. If services are to be transformed, NHS boards need to develop longer-term financial plans. To support boards to do this, the Scottish Government needs to consider giving NHS boards more financial flexibility. As we stated in our report, *NHS in Scotland 2015*, greater flexibility as part of good long-term financial planning can help boards respond better to local needs and priorities.[16] Even a small amount of flexibility at financial year-end, for example allowing NHS boards to manage their finances to within plus or minus 0.5 per cent of break-even, can make a difference. This is because increased flexibility can help in ways such as managing cost pressures over a longer period, provide opportunities for spend-to-save investment, and provide greater autonomy and responsibility of finances at a local level.

Rising operating costs continued to make it difficult for NHS boards to manage their finances in 2016/17

28. NHS boards must manage the cost of delivering services within the funding and income they receive. As discussed earlier, this is increasingly challenging for boards to do as costs have continued to rise in key areas. Exhibit 5 (page 17) sets out the main cost pressures boards faced in 2016/17. NHS boards face a high level of fixed costs, for example staff costs accounted for over half of all revenue expenditure in 2016/17. It is therefore important that NHS boards, IAs and the Scottish Government work together to ensure:

- spending on fixed costs is as economical as possible, for example managing utility costs by implementing energy-efficiency measures

- they minimise spending on areas within their control, such as staff agency spending or developing new healthcare facilities.

29. An example of this is the focus on reducing temporary staffing costs in many boards in 2016/17. Despite overall spending on agency medical locums increasing in the past year, six territorial boards reduced their expenditure between 2015/16 and 2016/17. They did this through a mix of filling vacancies, greater use of internal locums, and tighter controls on agency use.

Exhibit 5
Cost pressures in 2016/17

Most NHS boards overspent on their pay budgets and agency costs continued to be high

£6.5 billion was spent by NHS boards on staff in 2016/17 (57 per cent of revenue expenditure) and the majority of NHS boards overspent on their pay budget.[1]

In 2016/17, NHS boards spent £171 million on agency staff, an increase of 79 per cent in real terms over the past five years.[2] Spending decreased, however, by three per cent between 2015/16 and 2016/17.[3]

Boards reported spending £109 million on agency medical locums in 2016/17, an increase of six per cent in real terms on the previous year.[4]

Backlog maintenance costs have reduced but remain considerable

£511 million was spent by NHS boards on capital projects in 2016/17, with the majority, £465 million funded by the Scottish Government, and the remaining amount from asset sales and donations.[5]

70 per cent of the estate was rated in good physical condition in 2016/17, a slight increase from 66 per cent in 2015/16. There is wide variation across territorial boards, from 24 per cent of the estate rated good in NHS Orkney to 98 per cent in NHS Borders.[6]

NHS boards had a total backlog maintenance of £887 million in 2016/17, a slight decrease from £898 million in 2015/16. There has been a seven per cent increase in backlog maintenance classed as significant and high risk, to 47 per cent in 2016/17. There was wide variation across territorial boards, from 18 per cent of all backlog maintenance rated significant and high risk in NHS Forth Valley to 72 per cent in NHS Tayside. Over half, 56 per cent, of all backlog maintenance was accounted for by three boards: NHS Greater Glasgow & Clyde, Grampian and Tayside.[7]

Spending on drugs continues to rise

£1.68 billion was spent on drugs in 2015/16 (£1.26 billion in the community and £420 million in hospitals), an increase of £112 million in real terms (7.1 per cent) from 2014/15.[8]

Between 2014/15 and 2015/16, spending on drugs in hospitals increased at a higher rate (8.1 per cent in real terms) than spending on drugs in the community (6.8 per cent in real terms).

In the last five years, spending on drugs in hospitals rose by 34.4 per cent in real terms as opposed to a rise of 7.9 per cent in spending on drugs in the community.

Since 2014/15, the Scottish Government, via the New Medicines Fund (NMF), has provided £183 million additional funding to NHS boards to cover the costs of increasing patient access to treatment for very rare conditions and end-of-life medicines. The fund reduced from £85 million in 2015/16 to £53 million in 2016/17, placing further pressure on boards' drugs budgets. The amount available to boards from the NMF in 2017/18 is not yet known.[9]

Cont.

Exhibit 5 (continued)

The Scottish Government's Effective Prescribing Programme Board has been in place for two years. It is not yet known what savings have come from effective prescribing activities to date but it has contributed to a reduction in the annual increase in volume of community prescribing. Between 2013/14 and 2016/17 the quantity of drugs dispensed in the community increased by around two per cent or less, in comparison to annual increases of between 2.6 and 5.1 per cent between 2008/09 and 2012/13.[10]

Clinical negligence costs have increased

The way in which the amount of compensation in personal injury claims is decided has changed in the UK. The cash amount will now be higher which means that the amount boards set aside for claims increased from £330 million in 2015/16 to £582 million in 2016/17.[11]

Notes:
1. *NHS workforce planning*, Audit Scotland, July 2017.
2. *NHS Consolidated Accounts*, Scottish Government, July 2017.
3. Ibid.
4. Information provided to Audit Scotland by NHS boards, June 2017.
5. Ibid.
6. NHS Orkney's Balfour Hospital is in the process of being replaced with a new hospital.
7. *Annual State of NHS Scotland Assets and Facilities Report for 2016*, Scottish Government, July 2017.
8. 2015/16 is the most recent year figures are available. *Scottish Health Service Costs – drugs*, ISD Scotland, November 2016.
9. The New Medicines Fund is funded from rebate payments from the UK Pharmaceutical Price Regulation. Scheme (PPRS). The receipts for Scotland from this scheme have not yet been finalised for 2017/18.
10. ISD Scotland data provided to Audit Scotland, August 2017.
11. The lump sum compensation awarded to victims of life-changing injuries is adjusted according to the interest they could expect to earn by investing it. Courts use a calculation to work this out using a discount rate. The discount rate has been reduced by HM Treasury from 2.5 per cent to minus 0.75 per cent. This reduces the expected value of the future investment, making the cash value of the settlement higher.

Source: Audit Scotland

The financial outlook for NHS boards in the near future will be very challenging

30. NHS boards are predicting in their 2017/18 LDPs continuing cost increases year-on-year over the next three to five years across a wide range of areas:

- staff costs, including the annual one per cent pay uplift, pay rising as staff move up pay scales, the apprenticeship levy, and the impact of the living wage
- increases in spending on hospital drugs of between four and 16 per cent and increases in GP prescribing costs of around four per cent. The Healthcare Financial Management Association projected spending on drugs in hospitals as a proportion of all hospital costs will rise from 5.4 per cent in 2012/13, to 8.5 per cent in 2019/20 if they continue to grow at the rate they have done over the last four years.[17]
- business rate rises in 2017/18 of up to 27 per cent and energy increases of upwards of 2.5 per cent over the next three years.

31. Differences in anticipated funding from the Scottish Government and the cost of delivering services in 2017/18 means NHS boards are planning savings in their LDPs of £445 million. Case study 1 (page 19) gives an example of what these cost pressures mean financially for a territorial board over the next three years.

Case study 1

Financial pressures in NHS Grampian

NHS Grampian's cost assumptions between 2017/18 and 2019/20

In its draft 2017/18 Local Delivery Plan, NHS Grampian has set out its financial planning assumptions for the next three years based on its funding from the Scottish Government, cost increases and the net value of savings it will have to make to balance these. These are set out in the table below. NHS Grampian has estimated the figures for 2018/19 and 2019/20 as Scottish Government funding is confirmed for 2017/18 only. In setting out these projections, it has also assumed no funding for any further service investments or new posts within those services under the direct control of NHS Grampian.

	2017/18	2018/19	2019/20
	£m	£m	£m
New resources:			
Baseline increase in Scottish Government funding	13.2	18.9	19.4
Additional funding to achieve NRAC target allocation	3.0	-	-
Total	16.2	18.9	19.4
Less: allocation to Integration Joint Boards	(9.9)	(15.2)	(15.6)
Total new resources for NHSG direct services	6.3	3.7	3.8
Forecast expenditure: NHSG direct services			
Pay (including increments)	6.2	6.3	6.3
Secondary care drugs	6.3	6.0	6.0
Non-pay and planned developments	3.4	2.0	2.0
Impact of legislative changes (such as the apprenticeship levy and rates revaluation)	3.8	4.0	1.0
Other – depreciation reduction	(2.0)	(1.3)	(1.3)
Brought forward deficit	14.4	10.0	10.0
Impact of service investments, policy changes or national decisions (such as the Baird Family Hospital and Anchor Centre development)	0.9	1.0	1.0
Contingency	1.0	1.0	1.0
Sub total	(34.0)	(29.0)	(26.0)
Net additional cash efficiency challenge	(27.7)	(25.3)	(22.2)

Source: Audit Scotland using NHS Grampian's Local Delivery Plan 2017/18

Previous approaches of treating more people in hospital and speeding up treatment are not sufficient any more and a different approach is needed

32. There is no one indicator of demand for healthcare services. Historically, any analysis of demand has focused on the acute sector due to a lack of national data on primary and community care. This continues to be the case and makes it difficult to assess overall demand or to better understand changes in demand. Examining a range of different indicators, however, shows that demand is continuing to grow. In particular, demand for outpatient appointments and planned inpatient and day case treatment have risen significantly in the past five years (Exhibit 6).

Exhibit 6

Indicators of demand for NHS services, 2012/13-2016/17

Demand for NHS services continues to increase.

	Emergency admissions (A)	Number of procedures (A)	Number of people waiting for first outpatient appointment (C)	Number of people waiting for inpatient and day case treatment (C)	GP consultations (A)
Five year change	+3.5%	+11.4%	+43.4%	+33.5%	+4.6%
2016/17*	565,344	1,476,055	306,393	65,684	16,974,857
2012/13	546,258	1,325,111	213,694	49,191	16,236,010

Notes:
1. A= annual figure, C=March census figure.
2. Emergency admissions and number of procedures – figures are for 2015/16 as this is the most recent data available.
3. GP figure for 2016/17 is estimated using the same projection methods as in *Changing models of health and social care*, Audit Scotland, March 2016.

Source: Audit Scotland using ISD Scotland data at August 2017; *Changing models of health and social care*, Audit Scotland, March 2016.

33. In previous years, the NHS was able to partially offset growing demand by seeing more patients. However, there are signs that this is no longer sufficient and demand is beginning to back up in the acute system. For example:

Outpatients

- NHS boards see over one million people as outpatients every quarter, and over a third of these are new attendances. In the quarter to March 2017, the number of new attendances seen was 12 per cent higher than in the same period in 2013, meaning almost 39,000 more new people were seen. Most of this increase, however, was at the start of the five-year period, and the number seen since then has remained fairly static.

- Over the same period, waiting times have increased. The number of people that waited over the standard 12 weeks for their first appointment

increased by over 300 per cent (from 21,500 people waiting in the quarter to March 2013 to 87,500 people in the quarter to March 2017). Of these, the number of people that waited over 16 weeks for their first appointment increased ten fold, from 5,000 to almost 58,000 people.

- In the past year, the number of people waiting for their first outpatient appointment increased by almost 40,000, a 15 per cent increase.

Inpatients and day cases

- For planned inpatient and day case treatments, the number of people treated over the past few years has reduced while the length of time people are waiting, and the number of people waiting, have increased:
  - Around 74,500 people received planned inpatient or day case treatment in the quarter to March 2017, almost 13,500 fewer people (15 per cent less) than the peak in the quarter ending March 2014 where boards treated almost 88,000 people. In the past year, almost 4,400 fewer people were seen in the quarter to March 2017 compared with the same period in 2016 – a six per cent reduction.
  - At the same time, waiting times increased. The number who waited over the guaranteed 12 weeks for their treatment increased by over 800 per cent, from 1,450 in the quarter ending March 2013 to 13,300 in the quarter ending March 2017. The past year has seen a marked increase in people waiting longer than 12 weeks – an additional 7,500 people waited over 12 weeks in the quarter to March 2017 compared with the same period in 2016.
  - The number of people on the waiting list rose to almost 66,000 at the census point in March 2017, an increase of 12 per cent from March 2016 and 34 per cent higher than March 2013.[18]

34. Redesigning acute services to make them more efficient is one way in which NHS boards are trying to treat more patients. However, as we stated last year in our report, *NHS in Scotland 2016*, the NHS cannot continue to do everything within the current resources and needs to slow the rate of demand for hospital services. The NHS cannot do this on its own and needs to work with integration authorities and wider public services, to redesign primary and social care, and improve the general health of the wider population. This is discussed further in Part 2.

Current national performance standards do not measure quality of care across the whole healthcare system. They provide an indication of pressure in the acute sector, with the majority of targets not being met and performance declining

35. National NHS performance measures have been in place in Scotland for over a decade. Previously known as HEAT targets, since 2015 these have been referred to as Local Delivery Plan (LDP) standards. Most LDP standards are measures of access to acute healthcare services, for example the four-hour accident and emergency waiting time standard or the 12 weeks to first outpatient appointment standard. Acute services are only one part of the healthcare system and access is only one measure of the quality of that system. There are a lack of indicators providing information on quality of care, primary care and community care.

36. The existing measures do not provide a comprehensive, balanced assessment of the performance of our healthcare system. However, performance

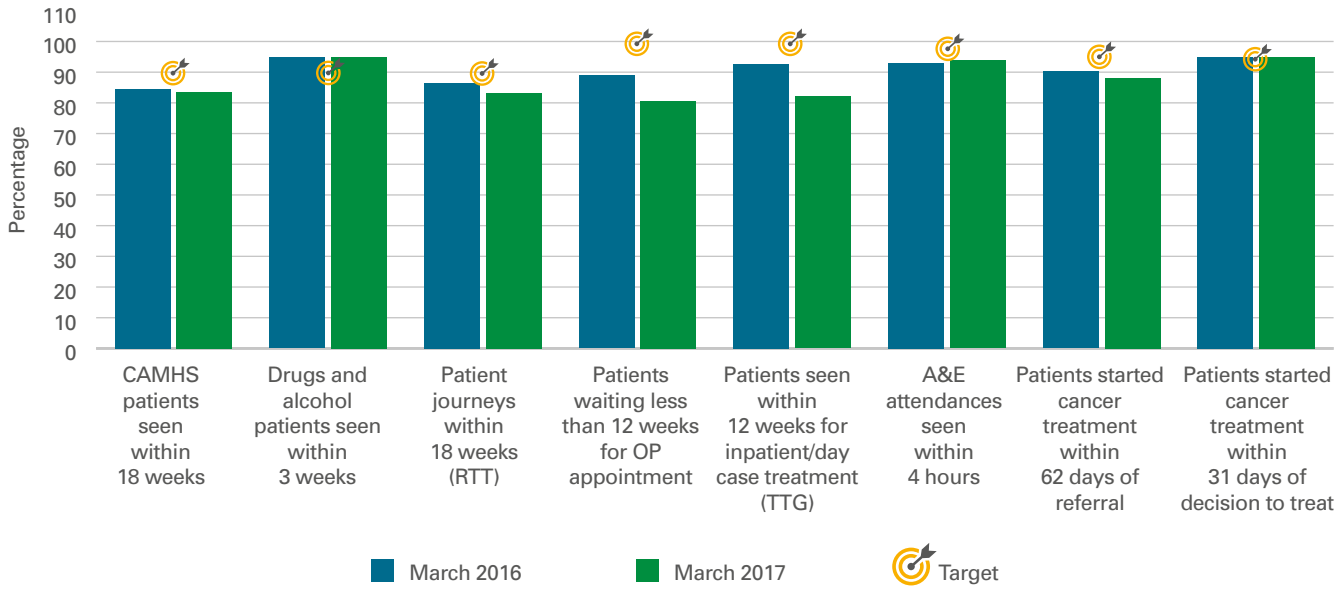
against LDP standards does indicate the pressure the healthcare system is under. An independent review of the national LDP standards is currently under way and an interim report was due to be published by August 2017.

37. As with last year, NHS Scotland failed to meet seven out of eight key performance standards in 2016/17 (Exhibit 7). Nationally, the NHS met its target of 90 per cent of patients referred for drug and alcohol receiving treatment within 31 days, at 94.9 per cent. The target of 95 per cent of patients starting cancer treatment within 31 days was missed by just 0.1 per cent, the same as in 2015/16. Appendix 3 shows performance against the national standards by NHS board. Over the past five years, overall performance has declined in six of the eight key performance standards and remained static in one, with performance only improving against the four-hour accident and emergency standard.

Exhibit 7

National performance against key national performance standards, 2015/16-2016/17

NHS Scotland did not meet the majority of key performance standards in 2016/17.



Notes:
1. CAMHS is Children and Adolescent Mental Health Services.
2. Figures are for month/quarter/census point ended March 2017 (Appendix 3).

Source: See Appendix 3 for sources

38. Overall performance dropped significantly between 2015/16 and 2016/17 in two key performance standards:

- Performance against the 12-week treatment time guarantee (TTG) for patients waiting on planned inpatient or day case procedures dropped by over 10 percentage points, from 92.7 per cent in the quarter to March 2016, to 82.2 per cent in the quarter to March 2017. This means that in 2016/17:
  - over 13,200 people were not seen within the 12-week standard, a 132 per cent increase in the number of people who waited over 12 weeks compared with the same period in 2016.

- Performance against the 12-week waiting time standard for first outpatient appointment dropped by over eight percentage points, from 88.9 per cent at the census point of March 2016, to 80.7 per cent at the same point in 2017. This means that over this period:
  - the number of people on the waiting list increased by 15 per cent, with almost 40,000 more people waiting
  - of those on the list, the number of people waiting over 12 weeks increased by 99 per cent, with over 29,000 more people waiting
  - of those on the list, the number of people waiting over 16 weeks increased by 108 per cent, with almost 22,500 more people waiting.

Achieving waiting time standards has been a top priority for the Scottish Government and NHS boards for a number of years. Approaches by the Scottish Government include providing additional funding to improve performance against individual standards and providing support teams in NHS boards. NHS boards continue to make extensive efforts to meet the targets. These efforts include redesigning processes and services, recruiting additional staff and using the private sector to increase short-term capacity. In our report *NHS in Scotland 2015*, we noted that these approaches may help meet targets in the short term but do not necessarily demonstrate value for money in achieving the longer-term aims and objectives of the NHS.[19] Our auditors reported in 2016/17 that NHS boards are increasingly struggling to improve performance against national targets while also achieving financial balance. The continuing effort being put into balancing these two priorities is detracting from the overall strategy of moving more care into the community.

There are signs that the NHS's ability to maintain quality of care is under pressure and this needs to be closely monitored

39. No single annual assessment is made of the overall quality of care provided by the NHS in Scotland by any organisation. Analysis of a range of measures indicates there were no significant weaknesses in the overall quality of care being provided by the NHS in 2016/17. Positive examples include the following:

- Inpatient satisfaction is at an all-time high. Ninety per cent of patients rated their care and treatment as good or excellent in 2016.[20]
- Patient safety indicators continued to improve: between 2007 and 2016, there was a reduction in the hospital standardised mortality ratio of 16.5 per cent, and a 21 per cent reduction in 30-day mortality due to sepsis.[21] [22]
- The Nuffield Trust's 2017 report, *Learning from Scotland's NHS*, found there was a strong culture of continuous improvement in the NHS in Scotland.[23]

40. There are signs, however, that the pressures described throughout this chapter may be beginning to impact on the quality of care staff are able to provide and this needs to be closely monitored. For example:

- one in five inpatients surveyed in the national inpatient experience survey in 2016, 20 per cent, said they had experienced problems during their hospital stay, such as infections, sepsis, bed sores or falls. A significant minority, 39 per cent, felt they were not involved in decisions about their care or treatment as much as they would have liked.[24]

- Patient complaints are increasing. Complaints to health boards increased by 41 per cent between 2012/13 and 2016/17, to 23,500.[25] NHS boards have worked to raise awareness of the complaints process, and make it easier for patients to make a complaint. This may account for at least some of this increase in complaint levels.

- Recent surveys of staff indicate pressures on maintaining quality of care. A 2016 British Medical Association (BMA) survey of GPs in Scotland found more than nine out of 10 GPs (91 per cent) believe their workload has negatively impacted on the quality of care given to patients. A 2017 survey of nurses and healthcare support workers by the Royal College of Nursing found that half of respondents in Scotland felt patient care was compromised on their last shift. The main reason respondents gave was a lack of registered nurses and healthcare support workers.[26]

Healthcare Improvement Scotland (HIS) provides public assurance about the quality and safety of healthcare by inspecting NHS and independent healthcare services. It has developed a new Quality of Care programme to support improvements in quality, underpinned by a framework. The framework provides guidance about what good-quality care looks like and how this can be measured and demonstrated. The framework is designed for use by service providers, but also as part of HIS assurance activities.

Scotland's health is not improving and significant inequalities remain

41. Scotland continues to be a country with significant health problems. There have been improvements in some areas in recent years, such as reducing smoking, but the majority of key trends show that Scotland's overall health is not improving, and in some areas is deteriorating:

- Average life expectancy, at 77.1 years for men and 81.1 years for women, is consistently lower than most European countries and has been static since 2012.[27]

- Healthy life expectancy, that is the number of years a person lives in good health, has remained almost the same since 2009, at 59.9 years for men and 62.3 years for women.[28]

- Overall mortality rates were higher in 2015 and 2016 than in 2014, although it is not yet clear the extent to which there is an emerging trend. Mortality rates from cancer and heart disease remain higher than the rest of the UK. [29,30]

- The number of drug-related deaths increased by 23 per cent between 2015 and 2016, from 706 to 867, and was double the number of deaths in 2006. Scotland now has the highest drug-death rate in the EU.[31]

- The proportion of adults in Scotland who are current smokers has reduced by five percentage points to 21 per cent between 2008 and 2016.[32]

- The average number of units of alcohol consumed per week for adult drinkers aged 16 and over fell from 16.1 units in 2003 to 12.2 in 2013 and has subsequently stayed at similar levels (12.8 in 2016).[33]

42. A recent study by the Scottish Public Health Observatory examined the burden caused by various diseases in Scotland. These are measured in disability-adjusted life years (DALYs) with one DALY equal to one lost year of healthy life. The conditions in Scotland causing the greatest loss of healthy life are heart disease, low back and neck pain, and depression. Comparing Scotland with other countries around the world shows that Scotland is less healthy (that is, it has more healthy years lost) compared to countries with similar socio-demographic profiles.[34]

43. Scottish health is still marked by significant health inequalities. These affect a wide range of groups, including people of different ages, gender, ethnicity, religion, sexual orientation, gender identity and levels of disability. For example:

- Mortality rates for chronic liver disease in 2015 were nearly twice as high for men than women (19 per 100,000 compared to 11 per 100,000) and stroke rates remain consistently higher for men than women across all age groups.[35]

- Scottish Government research based on the 2011 census found that gypsies/travellers had the worst overall health among ethnic groups, being more likely to report a long-term health problem or disability and more likely to report bad or very bad general health.[36]

- A 2015 Equality Network survey found that 21 per cent of LGBT respondents had personally experienced discrimination or poorer treatment in Scotland's healthcare services because of their sexual orientation or gender identity.[37]

44. A recent report by NHS NSS noted that while reliable data exists on age and gender in health, there continues to be a lack of data relating to disability, gender identity, religion, and sexual orientation. The report stated that 'without good data on inequalities in health it is impossible to plan and prioritise effective action or to monitor progress towards a more equal society' and that 'there is a need to collect equality data to directly improve the care and experience of individual service users…'[38]

45. People living in areas of deprivation are still much more likely to be in poorer health than those living in more affluent areas. The gap is not closing and in some measures is widening. People living in the most deprived areas of Scotland, compared to those living in the least deprived areas:

- are likely to die 8.6 years sooner if female and 12.2 years sooner if male, with the gap in life expectancy increasing as improvements in those living in the least deprived areas outpace those in the most deprived areas[39]

- spend an average of 11.5 years longer in ill health if female, and nine years longer if male[40]

- are most likely to be diagnosed with breast, colorectal and lung cancer at stage 4, the most advanced stage of the disease, whereas those living in the least deprived areas are most likely to be diagnosed at stages 1 or 2[41]

- are more than twice as likely to attend A&E, and are slightly more likely to then be admitted to hospital.[42]

General practice is central to the changes that are needed to the healthcare system but difficulties in recruiting and retaining GPs and low morale are among many challenges

46. Primary care is usually the first point of contact with the NHS and refers to services provided by health professionals in clinics and practices or in a patient's home. General practice is a key part of primary care and is central to the changes needed in how services are accessed and delivered. In 2016, there were 4,913 GPs in Scotland working in 963 practices.[43] Most GPs are independent contractors who run their own practices, known as 'partners', or are employed and paid by the partners running a practice. GPs are not normally employed by the NHS board area they work in, although their funding comes from NHS boards.

47. No up-to-date national information is available on levels of demand and activity for general practice in Scotland. From projections in our 2016 report, *Changing models of health and social care*, we estimated the number of GP consultations would increase by 4.6 per cent between 2012/13 and 2016/17, to 17 million consultations.[44] This is equivalent to every person in Scotland visiting their GP at least three times a year. In 2016 the Kings Fund analysed 177 practices in England (with a total of 30 million patient contacts). They found a 15 per cent increase in the number of consultations between 2010/11 and 2014/15.[45] Therefore it is possible that 17 million is an under-estimate.

48. Although data is lacking, evidence suggests that general practice in Scotland is struggling to meet demand and the pressure of this is, in turn, creating wider problems for the profession:

- The number of GP practices has fallen by three per cent in the past five years, to 963. Consequently, the average practice list size has increased to 5,881, an increase of six per cent. However, there has not been a corresponding increase in the number of GPs, whose numbers have only increased by one per cent in the last five years.[46] This means workload pressures are likely to have increased.

- Recruitment and retention data is not available nationally, however, a 2017 BMA survey of GPs in Scotland found that 26 per cent of practices had vacancies and of those vacancies, 73 per cent had been open for at least six months.[47] Workforce pressures are likely to continue increasing due to an ageing workforce. A third of all GPs and 42 per cent of GP partners were aged over 50 in 2016, and a BMA survey in December 2016 found that over a third of GPs planned to retire within the next five years.[48] [49]

- Due to reported recruitment difficulties and other issues such as retiring partners, locum costs, and premises issues, an increasing number of GP practices were taken over by their NHS board in 2016/17 compared to previous years. This means the GP partners running a general practice have handed their practice over to an NHS board and the practice is no longer run by GPs who are independent contractors. In 2016/17, 15 practices were taken over compared to 11 in 2015/16 and four in 2014/15.

- Morale is deteriorating. A BMA survey of GPs in Scotland in December 2016 found that over two-thirds of GPs, 70 per cent, felt they experienced significant work-related stress and 15 per cent felt their stress was unmanageable. More than half, 55 per cent, reported their workload had a negative impact on their commitment to being a GP.[50]

Part 2

Achieving change

Key messages

1 There is significant activity under way by the Scottish Government, NHS boards, and integration authorities to transform the healthcare system in Scotland and building blocks for moving more care out of hospital are being put in place. Integration authorities are beginning to have a positive impact, helped by the development of better primary care data. Initiatives to embed the 'realistic medicine' approach, that is putting people at the centre of their own healthcare decisions, are also beginning to be developed.

2 There are a number of key areas that need addressed as a priority, however, if meaningful change is to be achieved. A key action is developing a financial framework to set out how existing and future funding will be used to move more care into the community. Improvements in planning the future healthcare estate, and the workforce are also needed.

3 Successfully changing how services are accessed and used is dependent not just on NHS boards, but many other partners working together. Gaining GP agreement to the new GP contract is critical to changing how primary care works. Improving people's health means doing more to involve local communities and individuals in decisions, and a commitment across the public sector to improve public health.

significant activity is under way to transform healthcare but a number of key areas need addressed as a priority

The national Health and Social Care Delivery Plan sets out the main ways the Scottish Government aims to achieve change

49. The Scottish Government published a *Health and Social Care Delivery Plan* (the Delivery Plan) in December 2016 to set out how the 2020 Vision will be achieved. Its aim is to 'increase the pace of improvement and change within Scotland's health and care system'.[51] The Delivery Plan brings together four major existing programmes of work and cross-cutting initiatives:

- health and social care integration
- the National Clinical Strategy
- public health improvement
- NHS board reform.

The Delivery Plan sets out the main activities that are currently being undertaken or are planned in each of the four areas and sets out timescales for achieving these ranging from 2017 to 2021.

Integration authorities are beginning to have a positive impact but challenges remain

50. 2016/17 was the first year all integration authorities (IAs) were fully operational. Controlling a budget of £8.2 billion, they are responsible for a wide range of health services, including primary care, mental health, accident and emergency, and adult social care. Their role is to coordinate health and social care services, and to commission NHS boards and councils to deliver services in line with a strategic plan. Our first report on health and social care integration, *Health and social care integration*, published in December 2015, sets out the structure and requirements of IAs in more detail.

51. IAs published their first annual performance reports in July 2017. IAs are expected to set out their performance against a set of national performance indicators and provide information on their work to move more healthcare into the community and improve patient outcomes, such as better health. It is not possible to identify changes in performance across years and IAs from these reports due to a lack of clarity in how the national measures have been presented. Examples provided in the reports, however, indicate that IAs are beginning to have a positive impact in some areas (Case study 2, page 29).

52. There are still challenges to be overcome in how NHS boards and IAs work together. These include the following:

- Budget-setting: our report, *NHS in Scotland 2016*, highlighted there had been difficulties in agreeing IA 2016/17 budgets, mainly due to differences in when local authorities and NHS boards finalise their budgets. This was still the case in 2017/18. Only 17 IAs agreed budgets by March 2017, and these were based on indicative NHS budget offers.

- IAs and NHS boards are still developing clinical governance processes.

- Developing agreed financial reporting timescales: the majority of NHS auditors reported that IAs submitted late financial information to NHS boards for the 2016/17 accounts process. Therefore relevant financial information was not available to boards and auditors at the appropriate time for inclusion in the draft accounts.

We will examine progress in integrating health and social care services in more detail in our second report on integration, due to be published in 2018.

Progressing 'realistic medicine' will support the culture change necessary to transform healthcare

53. Realistic medicine is described as putting the person receiving health and care services at the centre of decision-making, creating a personalised approach to their care and promoting responsibility for looking after one's own health. It aims to reduce harm, waste (in terms of interventions, or treatments, that do not add value for patients) and unwarranted variation in practice and patient outcomes, all the while managing risks and innovating to improve.

Case study 2

Examples of how integration authorities are beginning to change the way services are accessed and delivered

- Nationally, there are early signs of improvement in delayed discharges. In March 2017 there was an average of 1,338 beds occupied per day by a delayed discharge, 14 per cent fewer bed days than six months earlier in October 2016.
- Aberdeen City Health and Social Care Partnership has made improvements in delayed discharges, with a 22 per cent reduction in the number of people delayed in hospital at the end of the first full partnership year. This was achieved through initiatives such as ensuring social work staff are part of hospital discharge processes and the use of intermediate care beds, which allow patients and their families more time to consider care options.
- In East Dunbartonshire the Integrated Care Fund funded the Red Cross to provide transport home from A&E for older people, and provide support to settle them back home. In 2016, 118 people were helped by this service, which avoided unnecessary hospital admissions.
- Edinburgh Health and Social Care Partnership worked with Edinburgh Leisure to develop a 'Fit for Health' physical activity programme, to help people manage their long-term conditions. Seventy-eight per cent of participants reported greater wellbeing, including weight loss and improved sleep.
- Orkney Health and Care commissioned NHS Orkney to expand foot care provision through the use of the third sector to provide an alternative service. This has reduced waiting times.

Source: Audit Scotland using ISD Scotland data and IAs' annual performance reports

54. The concept of realistic medicine was introduced by the Chief Medical Officer in her 2014/15 annual report. A vision and strategy were developed the following year, that by 2025 everyone who provides healthcare in Scotland will demonstrate their professionalism through the approaches, behaviours and attitudes of realistic medicine. Actions set out in the Delivery Plan to achieve the vision include the following:

- refreshing the 'Making It Easy' health literacy plan to help everyone in Scotland to live well with any health condition they have
- reviewing the consent process for patients in Scotland – a key element in transforming the relationship between individuals and medical professionals
- incorporating the principles of realistic medicine as a core component in medical education and into medical professionals' working practice

- commissioning a collaborative training programme for clinicians to help them to reduce unwarranted variation

- developing a Single National Formulary to further tackle health inequalities by reducing inappropriate variation in medicine use and cost; and reducing the overall cost of medicine.[52,53]

A realistic medicine policy team is currently being put in place to take forward these actions. The Scottish Government has yet to set out how it will measure progress in achieving realistic medicine, for example how it will monitor progress in reducing waste, harm and unwarranted variation and creating a personalised approach to care.

55. A range of realistic medicine initiatives are already happening in NHS boards across Scotland. These range from posters in waiting rooms asking patients to think ahead about the questions they should ask doctors in NHS Borders to using data about acute admissions to change practice. An example of the latter includes standardising diabetic foot care processes to reduce variation in NHS Forth Valley. Case study 3 (page 31) illustrates an example of realistic medicine in NHS Lothian.

56. Part of the culture change involved in realistic medicine is reducing unwarranted variation in clinical procedures. A person-centred healthcare system means that variation will always exist, but it is important to identify and reduce variation that does not improve patient outcomes and cannot be explained. ISD Scotland, part of NHS National Services Scotland, examines activity data across a range of clinical scenarios to identify potential savings. This work shows a range of potential savings to the NHS. For example:

- If all NHS boards achieved an average length of inpatient stay in line with those operating in the upper quartile of performance, an estimated 91,444 bed days could be saved annually, equating to £31.4 million.

- Reducing the number of inpatient admissions from a set list of procedures and moving them to a day case setting could potentially save £19.8 million annually.

- Some procedures should only be considered when specific thresholds have been met to ensure that they add value to a patient's outcomes. Reducing the number of these procedures, such as tonsillectomies and minor skin lesions, could potentially reduce admissions by almost 21,000 annually, or £39 million.[54]

The data needed to transform healthcare is beginning to be put in place

57. It is essential that reliable and comprehensive information is available to support moving more care into the community and to support efforts to manage acute sector demand. We have reported previously that there is a major gap in information about demand and activity for most community health services, including general practice.[55] Two initiatives are under way to try and address this, called 'Source' and LIST.

58. The 'Source' project, managed by ISD Scotland, aims to support integration authorities' strategic planning by improving data sharing across health and social care. The project links anonymous individual-level data on health and social care

Case study 3

Realistic medicine activity in NHS Lothian

The Renal Department at NHS Lothian has been practising principles of shared decision-making and person-centred care since 2008. People with end-stage kidney failure often have other health problems and their quality of life is variable; for some the burden of treatment is too much. In 2008, stemming from discussions with patients, the renal service in Edinburgh began to offer an alternative option of conservative care. It was adopted as a culture for all staff. The service runs open evenings every couple of months for those approaching end stages of kidney failure to give them a chance to learn about the different options. It was evolved so that patients now do much of the speaking, with clinical staff in the background. The service has two conservative care nurses that act as a point of contact and support for patients. Patient and family reports are very positive about the service and research has shown that those opting to receive treatment are, on average, likely to live three months longer than those opting not to receive treatment.

Source: Audit Scotland and NHS Lothian

activity (excluding general practice data), costs, and demographic information to enable IAs to understand how individuals, groups of people, and communities interact with services and how resources are being used. 'Source' is designed to be flexible enough to include additional datasets, for example housing and homelessness data, and there are plans to include GP data from participating practices in the future.

59. ISD Scotland is also providing data and analytical support to IAs through the Local Intelligence Support Team (LIST) initiative. This has placed information specialists from ISD Scotland with IAs to build local capacity and capability, facilitate access to national information and expertise, and share methods and results across Scotland. Working jointly with the central ISD Scotland teams, work is driven by local priorities. Examples of work include:

- forecasting service demand and impact of service changes
- examining how individuals and groups move between services
- identifying individuals who most frequently attend accident and emergency departments, to help focus preventative care.

The LIST team also provides some support to community planning partnerships, the third sector, and other organisations. The LIST service is being expanded in 2017/18 to offer support to GP clusters.

60. To specifically address the lack of data on general practice in Scotland, NHS NSS is currently rolling out a new system called the Scottish Primary Care Information Resource (SPIRE). SPIRE extracts patient information from GP records in a standardised and secure way and will:

- be used by the NHS in Scotland and researchers to learn more about the health needs of the population, better plan services and support research into new treatments for particular illnesses

- assist GPs by providing tools for practices such as a flu vaccination dashboard and statistics on patients with more than one long-term condition.

SPIRE data will not, however, be automatically linked to the 'Source' data being used by IAs. It is up to individual GP practices to decide if they want their information to be used by IAs. This means there is potential for IAs to plan services without key information on their population and for there to continue to be a lack of reliable and comprehensive data on demand and activity at a national level on general practice.

Action is needed as a priority in several key areas if meaningful change is to happen

Governance arrangements for overseeing activity and scrutinising progress need finalised

61. As we set out in Part 1, the Scottish Government is attempting a change programme that is exceptionally large in scale, difficult, and long term. It is essential that a robust governance framework is in place to oversee the work.

62. The Health and Social Care Delivery Plan National Programme Board was established to 'provide strategic oversight and operational assurance of the delivery of the Health and Social Care Delivery Plan'.[56] The Programme Board contains representation from across the public sector, including directors from the Scottish Government Health and Social Care Directorate, NHS board Chief Executives and Chairs, COSLA, Integration Authorities and NHS staff representatives. It met for the first time in April 2017. At August 2017, governance arrangements that still need to be addressed:

- Lines of accountability and authority with existing governance structures: the current major work programmes have their own governance arrangements, for example health and social care integration has a Ministerial Strategic Group. Decision-making authority and lines of accountability between these existing structures and the Programme Board are not yet clear and there is potential for duplication and lack of clarity about connections to the work of other groups.

- How to assess progress: the Delivery Plan sets out the government's intention to develop a robust, integrated performance framework for the different components of the delivery plan by early 2017. At August 2017, the Scottish Government was still developing this framework. The Delivery Plan does not set out in detail how the changes described in it will be achieved and many of the actions contained in it are statements of intent rather than actions. Therefore it is important that the performance framework sets out clearly what work is being done and how progress will be measured.

- How to oversee activity: a mapping exercise is currently being carried out of all the work currently under way or planned across the multiple areas of work and programme boards. Completing this exercise will help ensure

there is no duplication across workstreams and will allow the Programme Board to prioritise activity and assess the impact of different activities and decisions on other areas.

A financial framework is needed to show how moving healthcare into the community will be funded

63. It is not clear how moving to new ways of providing healthcare will be funded. In our report *NHS in Scotland 2016* we recommended that the Scottish Government should develop long-term funding plans for implementing the changes set out in the 2020 Vision and the National Clinical Strategy. The Delivery Plan stated that a financial plan would be developed to support the delivery plan. It added that 'the components within the delivery plan will be financially and economically assessed at key stages in their development…to create a comprehensive assessment of affordability and sustainability'. A financial plan has not yet been developed and it is not clear how, and when, the main work programmes will be assessed.

64. A financial framework is needed to show how moving more healthcare into the community will be funded, addressing questions such as:

- What levels of funding are likely to be available in future years, and how does this compare to the likely levels of funding that will be needed in different parts of the system?
- How will existing funding be used differently to deliver health and social care in new ways? Where and when will money be spent or stop being spent?

65. Previously we have commented that shifting the balance of care will require either:

- reducing spending on acute services, such as hospital care, to move funding into the community, or
- investing more money in the community to develop and establish new models of care while maintaining spending on acute services.

66. Neither are straight forward to achieve financially. Community health services need to be capable of looking after patients before resources can be shifted from acute services. This effectively means double-running services, which requires additional funding. The Scottish Government has announced additional funding in the Delivery Plan of £500 million in primary care by 2021. However, it is not clear how much of this will be new investment or reallocated funding from other areas.

67. Currently, there is little indication that the balance of funding between acute and community services will shift in coming years. In 2016/17, NHS boards' funding from integration authorities was almost exactly the same as the budget they initially provided.[57] Analysis of NHS boards' 2017/18 LDPs shows that only eight territorial boards plan to increase cash funding to their integration authorities between 2017/18 and 2019/20. The Nuffield Trust in their 2017 report, *Learning from Scotland's NHS*, examined a sample of NHS board LDPs and found little evidence of multi-year plans to move funding and reduce the number of acute beds. Our own analysis of all territorial NHS board LDPs supports this. The majority of 2016/17 LDPs only discussed the current year's funding and only a

minority of NHS boards have high-level financial plans for five years. The Ministerial Strategic Group for Health and Community Care is currently considering how it can help integration authorities and NHS boards to shift funding.

68. Long-term financial planning is currently difficult, because scenarios which set out potential future demand are still being developed and the financial implications of this for the acute and community sectors are unknown. Future demand for acute services will be influenced by a range of factors. These include:

- how effective community healthcare is in lowering or slowing demand for acute services
- the fact that healthcare needs are not static and will continue to increase as Scotland's population ages
- the impact of efforts to improve the health of the Scottish population.[58]

69. The financial consequences of future demand will similarly be influenced by a wide range of factors. These include:

- The level of savings that can be realised from investment in community services. A survey of integration authorities in 2016 by the Health and Sport Committee found only one example in the responses provided of specific savings resulting from investment (North Ayrshire Health and Social Care Partnership provided a specific example of a £600,000 investment in its care at home reablement service that was estimated to have saved 4,710 acute bed days).[59]
- The level of resources that can be freed up in the acute hospital setting given the high levels of fixed costs involved.
- The extent to which structural redesign, such as increased regional planning and management of health services and using national elective centres, results in delivering more efficient services and financial savings.

70. A recent submission by the IJB Chief Finance Officers Group to the Health and Sport Committee on the draft budget 2018/19 stated that 'there is emerging evidence which indicates that the current level of resources is less than that required to meet current cost and demand pressures'.[60] An example cited is a funding gap of £30 million that North Ayrshire Health and Social Care Partnership identified over the next two financial years. North Ayrshire stated in its own submission that 'it is unlikely that transformation alone will bridge the gap, and service reductions within community based, preventative services will be required, which is in direct opposition to what the partnership is seeking to achieve'.[61] The lack of financial flexibility NHS boards have and their limited planning horizons makes it difficult for NHS boards, and subsequently integration authorities, to make long-term decisions to redesign health and care services. If the Scottish Government is to achieve its aim of moving more care into the community, it needs to work with NHS boards, integration authorities and local authorities to set out a clear medium and long-term framework for how shifting the balance of care will be funded.

The Scottish Government does not yet have a strategic approach to capital investment and developing health and social care facilities

71. The estate, that is the facilities and buildings needed to provide health and social care services in Scotland, is likely to change significantly as these services become more focused on communities. As integration authorities develop their understanding of their local communities and the services needed, they will identify what primary care and community assets they need. Regional and national planning will also change the estate as services are delivered differently in different locations. A particular example is the development of regional elective centres, which will carry out procedures such as hip, knee and cataract treatments. To ensure the right assets are in the right place at the right time, it is essential that capital investment plans fully support service planning.

72. NHS boards have had asset management plans for a number of years and detailed national information is available on the NHS estate and other capital assets, such as equipment and vehicles. However, there is no national capital investment strategy that sets out how capital investment by the Scottish Government and NHS boards supports the aim of moving more care into the community.

73. A range of factors make it important that the Scottish Government develops a strategic approach to capital investment in future years. For example:

- There is no national-level information available on how much it would cost to fully fund NHS boards' capital programmes in future years. We have estimated that around £2 billion would be required over the next five years. It is not known what level of funding will be available from the Scottish Government, therefore there is the potential for a funding gap.

- The continuing high level of backlog maintenance, £887 million in 2016/17, and the likely future need for investment in primary care facilities mean there is an opportunity to change the type, location, and size of healthcare facilities.

Workforce planning needs to improve urgently and staff need to be involved in designing changes to the way they work

74. Comprehensive workforce planning across all staffing groups is essential if the appropriate numbers of skilled staff are to be in the right place at the right time as services are provided in new ways. It has become significantly more complex to plan the health workforce due to the integration of health and social care, and regional and national planning arrangements. Integration authorities are now responsible for identifying their local workforce needs in primary and social care and working with NHS boards and local authorities to ensure this links to their respective workforce plans.

75. In July 2017, we published *NHS workforce planning: The clinical workforce in secondary care*, the first report in our two-part audit on the NHS workforce. We found the following:

- Urgent workforce challenges face the NHS in Scotland. These include continuing recruitment and retention difficulties, an ageing workforce, greater use of temporary staff, and the changing demands of an ageing population that is living longer.

- The Scottish Government and health boards have not planned effectively for the long term and responsibility for workforce planning is confused.

- The Scottish Government has not yet adequately estimated what impact increasing and changing demand for NHS services could have on the workforce or skills required to meet this need.

76. The Scottish Government aimed to publish a single national workforce plan in early 2017. This became three plans. The first, *National Health and Social Care Workforce Plan - Part 1*, published in June 2017, covers the NHS workforce.[62] The second plan, covering the social care workforce is due to be published in autumn 2017, and the third, covering primary care is due to be published by the end of 2017. Part 1 is not a detailed plan to address immediate and future issues, rather it is a broad framework to consider future workforce planning challenges. The Scottish Government is likely to find it challenging to provide any more detail in the next two plans. This is due to a lack of national data on the primary care and social care workforces and the fact that integration authorities are still in the early stages of identifying their workforce needs in their areas.

77. In our report, we recommended that the Scottish Government:

- improves understanding of future demand to inform workforce decisions, including carrying out scenario planning on the future populations' health demand and workforce supply changes

- provides a clear breakdown of the costs of meeting projected demand through additional recruitment across all healthcare staff groups

- sets out the expected transitional workforce costs and expected savings associated with implementing NHS reform; this includes collating transitional costs attached to greater regional and national working, costs in relation to moving staff into elective centres and into the community, and savings through increased efficiencies.

We will publish a second report on the community-based NHS workforce, including those employed by general practices as part of our future work programme.

78. Change to the way services are delivered has significant implications for the NHS workforce. How people do their job, where they work, and the types of work they undertake will change in future years. And it is not just staff in the community that will be affected; embedding realistic medicine principles will change how everyone works. NHS boards currently work with staff in a range of ways, including staff forums, newsletters and by using social media. It is essential staff are fully involved in designing changes to services and roles or change will not be successful.

Agreeing a new GP contract is critical to delivering more care in the community

79. The Scottish Government and BMA are currently negotiating a new GP contract. This was expected to be completed by April 2017 but is now scheduled for April 2018 depending on GPs voting to agree the new contract in December 2017. The contract aims to set out a new role for GPs, agree a new payment scheme, and agree measures to resolve current challenges relating to GP premises, and recruitment and retention. Delivering primary care in different ways and moving more care into the community is dependent on the agreement reached in the new contract.

80. Recent work at a national level has set out the Scottish Government's aim to make GPs the lead clinical decision-maker in the community, working with a multi-disciplinary team. This will involve other professions, such as physiotherapists and nurses taking on some of the current responsibilities of GPs (Case study 4).[63]

Case study 4

Future role of the GP within a wider multidisciplinary team

In February 2016, the Scottish Government's *A National Clinical Strategy for Scotland* proposed a revised role for the GP. This will see the GP as the senior clinical decision-maker in a wider community multi-disciplinary team, who will focus on:

- the complex care and management of people in the community
- people attending the practice with the first presentation of illness.

Alongside this is the introduction of GP clusters – typically made up of between four and eight practices covering 20,000 to 40,000 patients. This will see GPs directly involved in improving the quality of all health and social care provided to patients in their area, including secondary care. Two roles have been created within the clusters:

- cluster quality lead – a GP from the cluster with responsibility to provide a continuous quality improvement leadership role. The cluster quality lead liaises with practices, the board and the integration authority on quality improvement issues.
- practice quality lead – a GP from each practice who has responsibility to link with the cluster quality lead. Practice quality leads in a cluster will meet regularly to discuss the quality of care in their area.

Other health and care professionals in the multidisciplinary team will take on a greater role in the care of patients to alleviate some of the workload pressures on GPs. For example:

- Pharmacists' role will be considerably enhanced, with their expertise ensuring that people with complex medication regimes have their care optimised.
- Advanced physiotherapists will work within GP practices to provide enhanced care for those patients with musculoskeletal issues.
- Advanced nurse practitioners will take on more routine tasks usually carried out by a GP.

Source: Audit Scotland using *A National Clinical Strategy for Scotland*, February 2016; *Improving Together: A National Framework for Quality and GP Clusters in Scotland*, January 2017

81. A range of work is currently ongoing as part of, and related to, the contract negotiations to identify ways to resolve the challenges facing general practice as set out in Part 1. This includes the following:

- Modelling future demand scenarios to identify workforce requirements for both GPs and the wider primary care workforce.

- Identifying options for how to plan and manage GP facilities. The Cabinet Secretary for Health and Sport is currently considering findings from a working group set up by the Scottish Government and BMA to examine this issue.

- Additional investment in primary care by the Scottish Government. A £500 million investment in primary care by 2021 announced in October 2016, included £71.6m to be invested in 2017/18 to improve GP recruitment and retention, stabilise GP pay and make general practice a more attractive profession. The GP recruitment and retention fund is increasing from £1 million in 2016/17 to £5 million in 2017/18 to fund GP training bursaries, expand the GP returners scheme and increase the GP retainer reimbursement scheme.

Open and regular involvement with local communities about the NHS will be needed to develop options for delivering services differently

82. NHS boards have had legal duties to involve the public in designing services for a number of decades. More recently, the Public Bodies (Joint Working) (Scotland) Act 2014 also placed duties on Integration Authorities. The Community Empowerment (Scotland) Act 2015 (the Act) marked a significant shift in the Scottish Government's expectations of how the Scottish public should be involved in decisions that affect them. NHS boards, integration authorities, and local authorities all have legal duties placed on them by the Act. The Act:

- provides a statutory basis for community planning partnerships and places duties on them for the planning and achievement of local outcomes. NHS boards and integration authorities have a legal duty to participate in community planning.

- means that community groups can make a request to a public body, such as an NHS board, to get involved in trying to make services better. The public body must agree to the request unless there are reasonable grounds for refusing it.

- gives communities greater rights to buy land and to request asset transfers for any land or buildings which a public body owns, or rents from someone else. Public bodies must agree to the asset transfer request unless there are reasonable grounds for refusing it.[64]

83. Proposals to change the way health services are delivered attract considerable attention. As we noted last year, NHS boards can face considerable public and political resistance to proposed changes to local services.[65] The Scottish Government's transformation programme is based on changing the way services are delivered. It is therefore critical that NHS boards and integration authorities are able to do this. This means working with the public to develop a shared understanding and agreement on the need for, and benefits of, change, and then to develop and agree ways to provide services differently.

84. NHS boards and integration authorities are working with their local populations in a range of ways. A review of a sample of integration authorities' annual reports for 2016/17 found examples such as a public participation forum

used by Scottish Borders Health and Social Care Partnership to engage directly with members of the public. This meets six times a year to make decisions about local services. East Renfrewshire Integration Authority has held team-building days involving young people, elected members and senior managers. NHS boards are also working with their local populations, for example through media campaigns and involving patient representatives on working groups. The Scottish Government has set up a citizens' panel with 1,300 members of the public from across Scotland and developed 'Our Voice' framework to help involve people in improving health and social care.

85. National Standards for community engagement have been in place since 2005. These were revised in 2016 and are good practice principles for organisations to use when working with communities. It is important that NHS boards and integration authorities refer to these to ensure their work with the public is meaningful and achieves the desired outcome.

More information will help to involve staff and communities in developing the future of healthcare

86. It is important the public, staff, and elected officials are able to easily access information about how the NHS and integration authorities are performing. This is so that they can get involved with and hold these bodies to account. Our audit work has identified a range of areas where transparency could improve. Examples are as follows:

- Not all NHS boards or integration authorities publish all board and committee meeting papers and minutes on their websites.
- The public are not able to attend committee meetings in some NHS boards.
- Regular data is lacking in some areas of the NHS. For example:
  - Currently no data is published on most aspects of primary care such as how many consultations are undertaken and the types of conditions seen. There is little reliable information on the primary care workforce, for example staff employed by general practices, such as nurses and Allied Health Professionals, including physiotherapists and podiatrists.
  - Public information is lacking in areas such as waiting lists for inpatient and outpatient specialties in NHS boards. Most NHS boards do not publish information on the length of their waiting lists or inform patients of their likely wait to be seen.

All parts of the public sector need to have a shared commitment to, and clear actions on, improving the health of the public in Scotland

87. Although public health has traditionally been seen as the domain of the NHS, as little as ten per cent of a population's health and wellbeing is linked to access to healthcare. Factors such as the local environment, housing, transport and employment all affect people's health.[66] It is therefore important that, across all parts of the public sector, there is a shared understanding of, and commitment to, improving the health of the public in Scotland.

88. Improving people's health is a key part of the Scottish Government's vision for transforming health and social care. A healthier population is likely to reduce the future burden on health and social care services as fewer people develop conditions stemming from unhealthy lifestyles. Yet it will not be a quick process

and may take decades before any meaningful financial savings can be identified. The BMA's submission to the Health and Sport Committee's investigation into the prevention agenda in 2016 illustrates this point. It noted that measures that reduced obesity in children and young adults might not lead to financial savings in health services until they reached middle to older age. This was when weight-related complications would otherwise be more likely to occur.[67]

89. As part of the Delivery Plan, the Scottish Government committed to developing a public health strategy and creating a new single, national public health body. The Scottish Government has been working with COSLA to agree a joint set of public health priorities by the end of 2017. The new public health body will come into existence at the start of 2019 and a Public Health Reform Oversight Group has been set up by the Scottish Government to oversee its development. It will bring together the existing functions of Health Scotland and Health Protection Scotland and potentially ISD Scotland which is currently part of NHS National Services Scotland. Work to take forward the national public health priorities at a local level will be started once the new body is in place.

Endnotes

1 *Overall NHS Scotland workforce summary by staff grouping*, ISD Scotland, June 2017.

2 Procedures data is for 2015/16 and provisional (this is the most recent data available); *Number and types of procedures carried out by health board*, ISD Scotland, 2017.

3 *Annual Report and Accounts for Year ending 31 March 2017*, Scottish Ambulance Service, 2017.

4 GP consultations data is an estimate based on actual data at 2012/13 from our report, ***Changing models of health and social care***, Audit Scotland, March 2016.

5 *NHS Consolidated Accounts for financial year 2016/17*, Scottish Government, 2017.

6 *NHS Scotland Staff Survey 2015 National Report*, Scottish Government, December 2015; *Scottish Inpatient Experience Survey 2016 Volume 1: National Results*, Scottish Government, August 2017.

7 This vision has its roots as far back as 2000, with the publication of the joint futures agenda. See ***Reshaping care for older people***, Audit Scotland, February 2014, Exhibit 3 (page 12) for a policy summary.

8 *2020 Vision: Strategic Narrative*, Scottish Government, September 2011.

9 *Revenue and Capital expenditure limits, NHS Consolidated Accounts*, Scottish Government, July 2017.

10 Real terms increase excluding accounting changes – source is *Draft budget 2016/17: Health and Sport*, SPICe Briefing , December 2015.

11 This includes the £250 million social care funding for integration authorities in 2016/17.

12 *Draft budget 2017/18*, Scottish Government, December 2016.

13 Information provided by Scottish Government, July 2017.

14 *NHS Consolidated Accounts for financial year 2016/17*, Scottish Government, 2017.

15 ***NHS in Scotland 2016***, Audit Scotland, October 2016.

16 ***NHS in Scotland 2015***, Audit Scotland, October 2015.

17 *Medicines Costs in Scotland,* Healthcare Financial Management Association Briefing, July 2017.

18 *Inpatient, Day Case and Outpatient Stage of Treatment Waiting Times*, ISD Scotland, August 2017.

19 ***NHS in Scotland 2015***, Audit Scotland, October 2015.

20 *Scottish Inpatient Experience Survey 2016 Volume 1: National Results*, Scottish Government, August 2016.

21 The hospital standardised mortality ratio (HSMR) is based on all acute inpatient and day case patients admitted to all specialties in hospital. The calculation takes account of patients who died within 30 days from admission and includes deaths that occurred in the community as well as those occurring in hospitals. HSMR is equal to observed deaths divided by predicted deaths.

22 *Scottish Patient Safety Programme Acute Adult End of Phase Report*, Healthcare Improvement Scotland, August 2016.

23 *Learning from Scotland's NHS*, The Nuffield Trust, July 2017.

24 *Scottish Inpatient Experience Survey 2016 Volume 1: National Results*, Scottish Government, August 2016.

25 *NHS Scotland Complaints Statistics 2016/17*, ISD Scotland, October 2017.

26 *Survey of GPs*, BMA, 2017; *Draft budget 2018-19 submission*, RCN, 2017.

27 *Table 1: Expectation of life, by sex and selected age, Scotland 1861 to 2015*, National Records for Scotland, September 2016.

28 *Healthy life expectancy: key points*, Scottish Public Health Observatory, December 2016.

29 *Table 1: All ages age-standardised death rates for all causes and certain selected causes, Scotland, 1994 to 2016; Age-standardised death rates calculated using the European Standard Population*, National Records of Scotland, August 2017.

30 *Scotland's Population 2016 – The Registrar General's Annual Review of Demographic Trends*, National Records of Scotland, August 2017.

31 National Records of Scotland report that differences in coding, coverage and under-reporting in some countries means that the comparison between Scotland and other countries should be viewed with caution. *Drug-related deaths in Scotland in 2016*, National Records of Scotland, August 2017.

32 *Scottish Health Survey 2016*, Scottish Government, October 2017.

33 Ibid.

34 *The Scottish Burden of Disease Study 2015*, the Scottish Public Health Observatory, July 2017.

35 *Table 1: Chronic Liver Disease: Deaths rate (EASR) per 100,000 population, for Scotland by gender, calendar years of registration of death 1982-2015*, Scottish Public Health Observatory, December 2016; *Scottish Stroke Statistics Publication Summary*, ISD Scotland, February 2017.

36 *Gypsy/Travellers in Scotland: A comprehensive analysis of the 2011 census*, Scottish Government, 2015.

37 *The Scottish LGBT Equality Report*, Equality Network, July 2015.

38 *Measuring use of health services by equality group*, NHS National Services Scotland, 2017.

39 *Scotland's Population 2016 – The Registrar General's Annual Review of Demographic Trends*, National Records of Scotland, August 2017.

40 Between 2009 and 2013, the most recent data available, healthy life expectancy among those living in the least deprived areas in Scotland was 72.7 years for men and 74.1 years for women, compared to 51.1 years for men, and 65.3 years for women living in the most deprived areas. *Health life expectancy: deprivation deciles*, Scottish Public Health Observatory, December 2015.

41 The highest proportion, 29.4 per cent, of patients living in the most deprived areas were diagnosed at stage 4. Of those living in the least deprived areas, the highest proportion, 28.6 per cent, were diagnosed at stage 2. *Detect cancer early staging data: Year 5*, ISD Scotland, July 2017.

42 *Who attends Emergency Departments*, ISD Scotland, September 2015.

43 *GP Census*, ISD Scotland, December 2016.

44 Actual data for 2012/13 is from *GP Practice Team Information*, ISD Scotland, October 2013. Data for 2016/17 is estimated using the same projection methods as in ***Changing models of health and social care***, Audit Scotland, March 2016.

45 *Understanding pressures in general practice*, The Kings Fund, 2016.

46 *GP Census*, ISD Scotland, December 2016.

47 *Vacancy survey shows GP recruitment problems*, News Release, BMA, June 2017.

48 *GP Census*, ISD Scotland, December 2016.

49 *Survey shows pressures on GPs in Scotland*, News Release, BMA, December 2016.

50 Ibid.

51 *Health and Social Care Delivery Plan*, Scottish Government, December 2016.

52 Ibid.

53 A formulary specifies the drugs GPs and other prescribers should use for different conditions based on their clinical effectiveness, safety, and cost effectiveness. There are currently ten formularies in Scotland.

54 Data supplied by ISD Scotland, July 2017. Data is standardised for age, gender, and deprivation. The savings opportunities identified may not necessarily be cash-releasing. They may instead provide opportunities to reinvest or address new demands. The figures stated should not be added together as the savings may span a number of clinical areas.

55 ***NHS in Scotland 2016***, Audit Scotland, October 2016.

56 *Health and Social Care Delivery Plan*, Scottish Government, December 2016.

57 ***NHS in Scotland 2016***, Audit Scotland, October 2016. Comparable 2017/18 data was not available at the time of writing.

58 *Draft Budget 2018-19 Submission to Health and Sport Committee*, Scottish Parliament, BMA Scotland, 2017.

59 *Health and Social Care Integration Budgets, 2nd Report 2016 (Session 5), Health and Sport Committee*, Scottish Parliament, November 2016.

60 *Draft Budget 2018-19 Submission to Health and Sport Committee*, Scottish Parliament, CIPFA IJB Chief Finance Officer Section and CIPFA, July 2017.

61 *Draft Budget 2018-19 Submission to Health and Sport Committee*, Scottish Parliament, North Ayrshire Health and Social Care Partnership, 2017.

62 *National Health and Social Care Workforce Plan - Part 1 a framework for improving workforce planning across NHS Scotland*, Scottish Government, June 2017.

63 See the *National Review of Primary Care Out-of-Hours Services*, November 2015; *A National Clinical Strategy for Scotland*, February 2016; *Health and Social Care Delivery Plan*, December 2016.

64 *Community Empowerment (Scotland) Act 2015*, Scottish Parliament, July 2015.

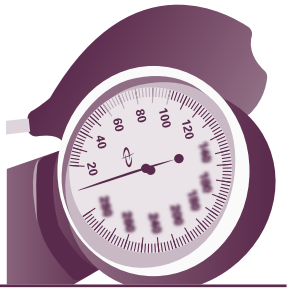
65 ***Changing models of health and social care***, Audit Scotland, March 2016.

66 *What makes us healthy?*, The Health Foundation, June 2017.

67 *Submission on Preventative Agenda, Health and Sport Committee*, Scottish Parliament, BMA, 2017.

Appendix 1

Audit methodology



This is our annual report on how the NHS in Scotland is performing. Our audit assessed how well the NHS managed its finances and performance against targets in 2016/17 and how well the NHS is adapting for the future.

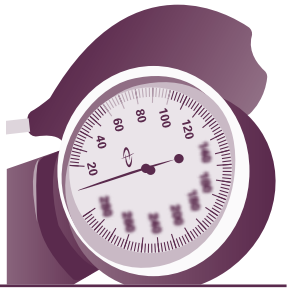
Our findings are based on evidence from sources that include:

- the audited annual accounts and auditors' reports on the 2016/17 audits of the 22 NHS boards
- Audit Scotland's national performance audits
- NHS boards' Local Delivery Plans (LDPs), which set out how boards intend to deliver services to meet performance indicators and targets, as well as indicative spending plans for the next three years
- activity and performance data published by ISD Scotland, part of NHS National Services Scotland
- publicly available data and information on the NHS in Scotland including results from staff and user surveys
- interviews with senior officials in the Scottish Government, professional bodies, and a sample of NHS boards and integration authorities.

We reviewed service performance information at a national and board level. Our aim was to present the national picture and highlight any significant variances between boards. We focused on a sample of key targets and standards, covering some of the main activities of the NHS. Where we have used trend information, we have selected a time period where information is most comparable. Information about the financial performance of the NHS is included in Appendix 2 (page 45).

Appendix 2

Financial performance 2016/17 by NHS board

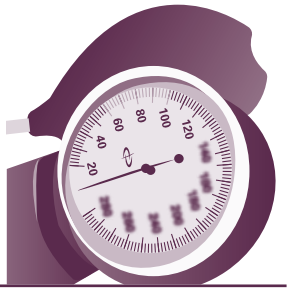


Board	Core revenue outturn (£m)	Total savings made (£m) Annual Audit Report	Non-recurring savings in Annual Audit Report	NRAC: distance from parity
Ayrshire and Arran	743.7	25.4	20%	0.7%
Borders	220.5	8.1	53%	2.3%
Dumfries and Galloway	311.1	12.7	43%	4.6%
Fife	665.6	30.8	71%	-0.2%
Forth Valley	532.5	23.8	7%	-1.0%
Grampian	983.0	26.5	43%	-1.4%
Greater Glasgow and Clyde	2273.7	69.0	33%	1.6%
Highland	664.4	22.1	60%	-1.5%
Lanarkshire	1204.3	45.9	20%	-1.5%
Lothian	1457.1	24.5	16%	-1.5%
Orkney	52.8	2.2	47%	0.6%
Shetland	54.8	4.2	54%	-0.9%
Tayside	803.1	45.5	49%	0.3%
Western Isles	80.1	4.0	43%	9.4%
Healthcare Improvement	27.6	1.9	61%	
National Services Scotland	394.5	18.1	0%	
National Waiting Times Centre	65.1	4.4	11%	
NHS 24	71.6	3.3	2%	
NHS Education for Scotland	436.0	2.6	26%	
NHS Health Scotland	19.1	0.9	9%	
Scottish Ambulance Service	221.1	9.9	45%	
State Hospital	32.1	1.8	86%	
Mental Welfare Commission	4.3			

Note. The Mental Welfare Commission does not provide savings figures.

Appendix 3

NHS performance against key LDP standards by NHS board in 2016/17



Measure	Child and Adolescent Mental Health Services (CAMHS), patients seen within 18 weeks	Drug and alcohol treatment, patients seen within 3 weeks	Referral to treatment (RTT), patient journeys within 18 weeks	Referral to outpatient appointment, patients waiting less than 12 weeks
	standard = 90%	standard = 90%	standard = 90%	standard = 100%, interim 95%
Ayrshire and Arran	93.8	96.8	73.6	82.6
Borders	98.4	94.4	90.0	90.8
Dumfries and Galloway	100.0	97.1	89.5	92.0
Fife	84.5	96.6	89.1	95.5
Forth Valley	99.7	98.7	79.4	81.6
Grampian	45.2	93.3	74.5	72.6
Greater Glasgow and Clyde	98.0	96.8	89.7	86.0
Highland	96.0	84.0	78.2	63.4
Lanarkshire	87.2	99.8	78.7	83.4
Lothian	47.8	83.3	79.1	72.7
Orkney	100.0	100.0	94.3	67.8
Shetland	100.0	88.9	84.2	68.1
Tayside	95.2	96.7	86.7	86.0
Western Isles	100.0	94.2	95.6	95.6
National total	**83.6**	**94.9**	**83.2**	**80.7**

Key	Green = Standard met
	Red = Standard missed

Measure	Inpatient / day case treatment time guarantee (TTG), patients beginning treatment within 12 weeks	A&E, Patients seen within 4 hours	Cancer referral to treatment, patients beginning treatment within 62 days	Cancer decision to first treatment, patients beginning treatment within 31 days
	standard = 100%	standard = 98%, interim 95%	standard = 95%	standard = 95%
Ayrshire and Arran	86.6	93.7	92.8	99.7
Borders	95.7	93.2	95.1	98.3
Dumfries and Galloway	86.3	93.7	96.3	96.5
Fife	91.2	95.2	80.5	97.8
Forth Valley	63.5	97.2	89.3	96.6
Grampian	74.4	96.1	86.2	92.2
Greater Glasgow and Clyde	87.2	90.7	83.3	93.9
Highland	75.8	96.8	87.2	97.8
Lanarkshire	66.7	90.0	95.9	96.9
Lothian	81.4	95.7	90.6	93.6
Orkney	90.3	97.5	84.6	100.0
Shetland	98.1	97.1	94.1	100.0
Tayside	81.2	98.6	89.6	93.1
Western Isles	100.0	99.3	85.0	100.0
National total	**82.2**	**93.8**	**88.1**	**94.9**

Sources:
CAMHS Waiting Times – Number of patients seen during the month by health board, Quarter ending March 2017; ISD Scotland, September 2017
Drugs and alcohol – Waiting times for referral to treatment, quarter ending March 2017; ISD Scotland, September 2017
18 weeks referral to treatment (RTT), Month ending March 2017; ISD Scotland, August 2017
New Outpatient Appointment: Waiting Times for Patients waiting at Month end, Census date at 31 March 2017, August 2017
Inpatient or day case admission: waiting times for patients seen, Quarter ending March 2017; ISD Scotland, August 2017
Accident and Emergency: attendances and time in department by NHS board and month, Month ending March 2017; ISD Scotland, July 2017
Performance against the 62 day standard from receipt of an urgent referral with suspicion of cancer to first treatment by NHS board, Quarter to March 2017; ISD Scotland, September 2017
Performance against the 31 day standard from date decision to treat to first cancer treatment by NHS board, Quarter to March 2017, ISD Scotland, September 2017.

NHS in Scotland 2017

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WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 14 March 2018

Subject: Complaints Handling Procedures – Confirmation of Compliance

1. Purpose

1.1 To present the Audit Committee with confirmation from the Scottish Public Services Ombudsmen that the approved Health & Social Care Partnership Board Complaints Handling Procedure is fully compliant with the requirements of the Scottish Government and Associated Public Authorities Model CHP.

2. Recommendation

2.1 The Partnership Board is recommended to note the Scottish Public Services Ombudsmen's confirmation of compliance.

3. Background

3.1 As members will recall, the Integration Scheme confirms that for the functions delegated to the Partnership Board both the Health Board and the Council retain separate complaints policies reflecting their distinct statutory requirements: specifically the Patient Rights (Scotland) Act 2011 making provisions for complaints about NHS services; and the Social Work (Scotland) Act 1968 making provisions for the complaints about social work services.

3.2 The Public Services Reform (Social Work Complaints Procedure) (Scotland) Order 2016 (the Order) brought social work complaint handling into line with other local authority complaints handling, by bringing it under the remit of the Public Services Reform (Scotland) Act 2010 (the Act). Under the Act, the SPSO has the authority to lead the development of model complaints handling procedures across the public sector.

3.3 In line with changes brought in through the Public Services Reform (Social Work Complaints Procedure) (Scotland) Order 2016, every authority that provides social work services was required to adapt and adopt the model Social Work Complaints Handling procedure for implementation on 1st April 2017. Consequently, a new local social work complaints handling procedure was prepared and approved by the Partnership Board at its March 2017 meeting for application from the 1st April 2017.

3.4 In parallel with that process, a new NHS model Complaints Handling Procedure has been developed through a partnership approach - led by a Steering Group involving the Scottish Public Services Ombudsman (SPSO) and representatives from across NHS Scotland – for implementation on 1st April 2017. Consequently, a new complaints policy for NHS Greater Glasgow& Clyde has been prepared and presented for approval by the Health Board at its meeting of 21st February 2017 (Appendix 2). In addition, there is a separate statutory requirement for all Integration Joint Boards to approve, make available and comply with a robust procedure with respect to

complaints that may be raised against them in relation to the particular functions and duties that they have responsibility for, as detailed within the Public Bodies (Joint Working) Act and the Integration Scheme.

3.5 West Dunbartonshire HSCP engaged and worked with both the SPSO and Scottish Government to develop a template Complaints Handling Procedure for use by all Integration Joint Boards; and consequently a local complaints handling procedure for the Partnership Board was prepared and approved at its March 2017 meeting for application from the 1st April 2017.

4. Main Issues

4.1 The Scottish Public Services Ombudsmen (SPSO) has assessed the local social work complaints handling procedure against the requirements of the Social Work Model complaints handling procedure.

4.2 The SPSO has separately assessed the Partnership Board's Complaints Handling Procedure against the requirements of the Scottish Government and Associated Public Authorities Model Complaints Handling Procedure. The IJB template Complaints Handling Procedure was developed from this Model Complaints Handling Procedure, and both have been used as the standard on which to base the SPSO's assessment.

4.3 The SPSO has separately written to the Chief Officer to confirm that:

- The local social work complaints handling procedure has been assessed as fully compliant against the requirements of the Social Work Model complaints handling procedure (appendix 1).
- The West Dunbartonshire Partnership Board has been assessed as fully compliant with the requirements of the Scottish Government and Associated Public Authorities Model complaints handling procedure (appendix 2).

5. People Implications

5.1 There are no people implications associated with this report.

6. Financial Implications

6.1 There are no financial implications associated with this report.

7. Professional Implications

7.1 There are no professional implications associated with this report.

8. Locality Implications

8.1 There are no locality implications associated with this report.

9. Risk Analysis

9.1 The SPSO has emphasised that local complaints handling procedures should not diverge from the national models to the extent that their purpose or substance is changed in away which does not reflect their key aims.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

12. Strategic Assessment

12.1 The approval and application of effective complaints handling procedures supports the commitment to continuous quality improvement and the delivery of the best possible quality of health and social care that is articulated within the Strategic Plan.

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Appendices: Letter from SPSO – July 2017

Letter from SPSO – September 2017

Background Papers: West Dunbartonshire Social Work Complaints Handling Procedure

West Dunbartonshire Health & Social Care Partnership Board Complaints Handling Procedure

The Social Work Model Complaints Handling Procedure http://www.valuingcomplaints.org.uk/complaints-procedures/local-authority-model-chp/social-work-complaints/

Scottish Government, Scottish Parliament and Associated Public Authorities in Scotland http://www.valuingcomplaints.org.uk/complaints-procedures/scottish-government-scottish-parliament-and-associated-bodies/

Wards Affected: All

SPSO Scottish Public Services Ombudsman

4 Melville Street
Edinburgh
EH3 7NS
Tel **0800 377 7330**
Fax **0800 377 7331**
Web **www.spso.org.uk**

26 July 2017

CONFIDENTIAL
Keith Redpath
Chief Officer
West Dunbartonshire HSCP
Council Offices
Garshake Road
Dumbarton
G82 3PU

Dear Mr Redpath

Compliance with The Social Work Model Complaints Handling Procedure

Thank you for providing me with your Social Work Complaints Handling Procedure (CHP), together with your statement of compliance and self-assessment of compliance.

As explained in the 'Guide to Implementation'[1] I have assessed your CHP against the requirements of the Social Work Model CHP. West Dunbartonshire HSCP has been assessed as:

Fully compliant with the requirements of the Social Work Model CHP.

Ongoing compliance with the Social Work Model CHP will be monitored by the SPSO, in conjunction with existing reporting mechanisms through Audit Scotland.

Yours sincerely

John Stevenson
Head of Complaints Standards Authority

[1] The Social Work Model Complaints Handling Procedure (Model CHP) Guide to Implementation

SPSO Scottish Public Services Ombudsman

4 Melville Street
Edinburgh
EH3 7NS
Tel 0800 377 7330
Fax 0800 377 7331
Web www.spso.org.uk

8 September 2017

CONFIDENTIAL
Ms Beth Culshaw
Chief Officer
West Dunbartonshire HSCP
Council Offices
Garshake Road
Dumbarton
G82 3PU

Dear Ms Culshaw

Compliance with the Scottish Government and Associated Public Authorities Model Complaints Handling Procedure

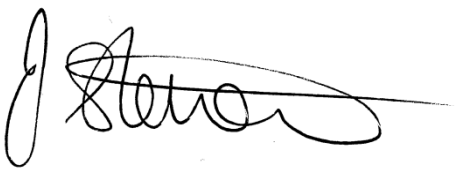
Thank you for providing me with your Integration Joint Board (IJB) Complaints Handling Procedure (CHP), together with your statement of compliance and self-assessment of compliance.

I have assessed your CHP against the requirements of the Scottish Government and Associated Public Authorities Model CHP. The IJB template CHP was developed from this Model CHP, and both have been used as the standard on which to base our assessment. West Dunbartonshire IJB has been assessed as:

Fully compliant with the requirements of the Scottish Government and Associated Public Authorities Model CHP.

Ongoing compliance will be monitored by the SPSO, in conjunction with existing reporting mechanisms.

Yours sincerely



John Stevenson
Head of Complaints Standards Authority

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee – 14 March 2018

Subject: Care Inspectorate Reports for Older People's Residential Care Services Operated by West Dunbartonshire Health and Social Care Partnership

1. Purpose

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

2. Recommendations

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

3. Background

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

3.2 The services covered in this Audit Committee report are :

- Boquhanran House
- Frank Downie House
- Mount Pleasant House

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

4. Main Issues

4.1 Boquhanran House was inspected on 29th September 2017.

4.1.1 The inspector commented that they found the care home to be calm and relaxed and saw residents were very much at ease in the company of staff.

Care Plans were of a good standard and provided a very detailed record of residents care and support needs. Sections 'things I would like you to know about me' and 'how I like to spend my day' provided a very detailed picture of residents likes, dislikes and preferences and there were good falls prevention measures in place to help keep people safe.

4.2 The inspection awarded the following grades:

- Quality of Care and Support - **Grade 5 – Very good**
- Quality of Environment - **Not Assessed**
- Quality of Staffing - **Grade 4 – Good**
- Quality of Management & Leadership - **Not Assessed**

4.3 There were no requirements from the September 2017 inspection.

4.4 The tables below sets out the grades for this care home over the last two full inspections.

Boquhanran House: 18th May 2016	
Care & Support	**5**
Environment	**4**
Staffing	**Not Assessed**
Management & Leadership	**Not Assessed**

Boquhanran House: Current Grades 29th September 2017	
Care & Support	**5**
Environment	**Not Assessed**
Staffing	**4**
Management & Leadership	**Not Assessed**

4.5 The table below summarises the movement in grades for the service over their last two inspections.

	18th May 2016						**29th September 2017**					
Boquhanran House	**Previous Grades**						**Current Grades**					
	1	**2**	**3**	**4**	**5**	**6**	**1**	**2**	**3**	**4**	**5**	**6**
• Care & Support • Environment • Staff • Management & Leadership				✓	✓					✓	✓	

4.6 Frank Downie House was inspected on 11th October 2017.

4.7 The inspector commented that the management and staff had created a very homely and welcoming atmosphere and they observed excellent interaction between staff, residents and visiting relatives. Care plans were of a good standard and person centred.

Both managers have completed My Home Life training which promotes putting residents at the heart of care home life and they sought to put residents at the centre of everything they do. The service places high

importance on consulting residents about service developments and residents had very good opportunities to have their views heard and regular consultation took place.

4.8 The inspection awarded the following grades:

- Quality of Care and Support - **Grade 5 – Very good**
- Quality of Environment - **Grade 4 - Good**
- Quality of Staffing - **Grade 4 – Good**
- Quality of Management & Leadership - **Not Assessed**

4.9 There were no requirements from the October 2017 inspection.

4.10 The tables below sets out the grades for this care home over the last two full inspections.

Frank Downie House : 21st December 2016	
Care & Support	**5**
Environment	**Not Assessed**
Staffing	**Not Assessed**
Management & Leadership	**5**

Frank Downie House : Current Grades 11th October 2017	
Care & Support	**5**
Environment	**4**
Staffing	**4**
Management & Leadership	**Not Assessed**

4.11 The table below summaries the movement in grades for the service over their last two inspections.

	21st December 2016						**11th October 2017**					
Frank Downie House	**Previous Grades**						**Current Grades**					
	1	**2**	**3**	**4**	**5**	**6**	**1**	**2**	**3**	**4**	**5**	**6**
• Care & Support					✓						✓	
• Environment										✓		
• Staff										✓		
• Management & Leadership					✓							

4.12 Mount Pleasant House was inspected on 21st December 2017

4.12.1 The inspector commented that the service was making good progress since the last inspection. They observed very good staff interaction with resident's and had a very good knowledge of each resident's care and support needs. On the whole, resident's care plans were of a good standard, but they could see areas where they could improve. Good team working was observed throughout the visit and there was a very pleasant atmosphere in the home.

4.13 The inspection awarded the following grades:

- Quality of Care and Support - **Grade 4 Good**
- Quality of Environment - **Grade 4 Good**
- Quality of Staffing - **Grade 4 Good**
- Quality of Management & Leadership - **Grade 4 Good**

4.14 There was one requirement from the inspection on 21st December 2017.

The provider must ensure that all care plans and related documentation is accurate, up-to-date, signed and dated, and reflective of the care needs and outcomes to be achieved for each resident.

This requirement was carried forward from the previous inspection report. The inspector states Care Plans had improved but more remains to be done.

4.15 An Action Plan relating to this requirement is attached.

4.16 The tables below set out the grades for this care home over the last two full inspections.

Mount Pleasant House : 19th July 2017	
Care & Support	**3**
Environment	**3**
Staffing	**3**
Management & Leadership	**3**

Mount Pleasant House : 21st December 2017	
Care & Support	**4**
Environment	**4**
Staffing	**4**
Management & Leadership	**4**

4.17 The table below summaries the movement in grades for the service over their last two inspections.

	19th July 2017						**21st December 2017**					
Insert Care Home	**Previous Grades**						**Current Grades**					
	1	**2**	**3**	**4**	**5**	**6**	**1**	**2**	**3**	**4**	**5**	**6**
• Care & Support			✓							✓		
• Environment			✓							✓		
• Staff			✓							✓		
• Management & Leadership			✓							✓		

5. People Implications

5.1 There are no people implications associated with this report.

6. Financial and Procurement Implications

6.1 There are no financial implications associated with this report.

7. Risk Analysis

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

8. Equalities Impact Assessment (EIA)

8.1 Equalities impact assessment has been undertaken for service and is reviewed on basis of change process being undertaken. The assessment has determined there is no discrimination against any group within the service, or redesign process, nor equalities impact of any sort.

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Appendices: Audit Committee Action Plan Update February 2018

Background Papers: None

Wards Affected: All

Mount Pleasant House: Audit Committee Action Plan Update February 2018			
Requirement (1)	**The provider must ensure that all internal areas of the home are maintained to a good standard at all times.**		**Date of Completion**
Action	Programme of works to be undertaken in respect of following: - Painting to walls in common areas - Painting to walls in bedrooms - Replacement of floor coverings in some bathroom areas - Replacement of some furnishings in common areas		October 2017
Progress	This requirement was met at the December 2017 visit		December 2017
Requirement (repeat) (2)	**The provider must ensure that all care plans and related documentation is accurate, up-to-date, signed and dated, and reflective of the care needs and outcomes to be achieved for each resident.**		
Action		**By Whom**	
	Further training and development sessions have been arranged to ensure staff have relevant knowledge and appropriate skill levels are developed to ensure accurate recording of care needs and outcomes for each resident.	Care Home and Quality & Service Development Managers	ongoing
Progress	Improvement was noted at the recent inspection, however, this requirement has been continued. The inspector felt some further improvements were needed to ensure support was provided consistently.		

WEST DUBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 14 March 2018

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

1. Purpose

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

2. Recommendations

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

3. Background

3.1 The Care Inspectorate assesses registered providers of care services in relation to four quality themes: care & support; environment; staffing; and management & leadership.

3.2 In 2015, any residential care home which has been awarded Grade 2 (i.e. weak) or less and/ or has requirements placed upon them following a full inspection will usually receive a follow-up visit within twelve weeks. These follow-up visits allow the Care Inspectorate to track improvement and gain assurance that services are making the right changes. The Care Inspectorate do not intend to make further requirements or revise grades on these follow up visits (although Inspectors have some discretion to do so if they consider that sufficient evidence is evident).

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

3.4 The independent sector Care Home reported within this report is:

- Castle View Nursing Home

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

4. Main Issues

Castle View Nursing Home

4.1 Castle View Nursing Home is owned and managed by is owned and managed by HC-One Limited. The home is registered with the Care Inspectorate for a maximum of 60 residents. As of 14 November 2017 there were 46 West Dunbartonshire residents supported within the care home.

4.2 The care home was inspected on 14 November 2017 and the report was published on the 28 November 2017, grades awarded as follows:

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

4.3 There were no requirements detailed in the inspection report.

4.4 The chart below summarises the movement in grades awarded to Castle View Nursing Home over the last 3 inspections.

5. People Implications

5.1 There are no people implications associated with this report.

6. Financial Implications

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

6.2 The National Care Home Contract also accounts for providers receiving low grades of 1/Unsatisfactory or 2/Weak in their Care Inspectorate Inspection report. If either of these grades are awarded it may trigger the withdrawal of

the quality funding component, resulting in a reduction of £20 per resident per week from the weekly fee payable.

6.3 The Inspection Reports for Castle View Nursing Home has financial implications for the HSCP. The service again received the grade of 5/Very Good for the theme of Quality of Care & Support and 5/Very Good in at least another one of the other three thematic areas in their inspection reports; thereby they will continue to receive the enhanced weekly rate for every resident the HSCP has placed in the homes.

6.4 As detailed at point 6.3 above Castle View Nursing Home will continue to receive the enhanced weekly rate for Nursing Homes of £3.00 per resident per week from the date of their inspection. This means the HSCP will pay Castle View Nursing Home an additional £2,331.00 from 14/11/17 to 09/04/18, if all residents remain in the home until the end of this financial year. The increase does not apply to residents who only receive a Free Personal and/or Nursing Care payment from the HSCP.

6.5 These additional payments will remain in place until either the National Care Home Contract terms are renegotiated or the Care Inspectorate reduces the grades awarded to Castle View Nursing Home following inspection.

7. Professional Implications

7.1 There are no professional implications associated with this report.

8. Locality Implications

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

9. Risk Analysis

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

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

12. Strategic Assessment

12.1 The Strategic Plan 2016 -19 emphasises the importance of quality assurance amongst independent sector providers of care; and the HSCP's commitment to work with independent sector providers within an agreed assurance framework.

Author: Brian Gardiner - Contracts & Commissioning Officer

Date: 06 February 2018

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Telephone: 01389 776837

Appendices: None

Background Papers: All the inspection reports can be accessed from http://www.scswis.com/index.php?option=com_contenttaskviewid7909Itemid727

Wards Affected: All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 14 March 2018

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

1 Purpose

1.1 To provide Members with information regarding the most recent inspection report for Craigellachie Residential Children's House.

2 Recommendations

2.1 The Committee are asked to note the content of this report and the work undertaken to ensure grades awarded reflect the high quality levels expected by the HSCP.

3. Background

3.1 The service covered in this report is Craigellachie Residential Children's House which was inspected on the 22nd of September 2017. As with the previous inspection the focus was on a combination of two thematic areas:

- Quality of Care
- Quality of staff

3.2 Copies of the above inspection report can be accessed on the Care Inspectorate web-site; www.scswis.com

4 Main Issues

4.1 The grades awarded for the 2 themes inspected are as follows:

• Quality of Care	**Grade 4**	**Good**
• Quality of Staff	**Grade 4**	**Good**

4.2 There was one requirement from this inspection. The requirement was in relation to notification to the Care Inspectorate when the service went over the registered number of young people. Please see Appendix 1.

4.3 This is to comply with SS1 2011/28 Regulation 4 (1) (b) - Any matters the provider must notify from time to time to Social Care and Social Work Inspection Scotland (SCSWIS) whilst the service is registered.

4.4 The service did notify the inspector of this temporary change in numbers however the notification was received late. The service has since addressed

this issue and all managers have been advised of the requirement for immediate notification to the Care Inspectorate. This will be monitored by the external Manager for the service Frank McCollum at his regular meetings with the Unit Managers.

4.5 The service had been experiencing an unsettled period leading up to this inspection. The behavioural presentation of some young people had impacted upon the lives of other young people and similarly on the staff team, who had been managing the evolving circumstances, resulting from such behaviours. The absence of key staff, including the manager had contributed to the circumstances experienced by young people and staff.

4.6 As a result of this additional supports were provided to Craigellachie to enable staff to build resilience, as individuals and as a team and to ensure the young people and their families continued to receive, high levels of care and support. In her report the inspector noted this and commented.

4.7 The inspector commented that:

'young people told us that they had very good relationships with staff and felt that they could approach them if they needed support. Young people said that staff were respectful and "did their best to make Craigellachie "a good place to live".

4.8 The grades awarded for this inspection reflect a continuum of 'Good' across the quality themes inspected in line with the previous inspection in February 2017.

4.9 The table below highlights the grades assessed over the past two inspections:

Craigellachie Residential Children's House	**Previous Grades**						**Current Grades**					
	1	**2**	**3**	**4**	**5**	**6**	**1**	**2**	**3**	**4**	**5**	**6**
					Feb 2017						September 2017	
Quality of Care and Support				**X**						**X**		
Quality of Staffing				**X**						**X**		

5 People Implications

5.1 There are no people implications.

6 Financial Implications

6.1 There are no financial implications.

7 Risk Analysis

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

8 Equalities Impact Assessment (EIA)

8.1 Not required for this report.

9 Consultation

9.1 Not required for this report.

10 Strategic Assessment

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

Jackie Irvine
Head of Children's Health, Care and Criminal Justice
Chief Social Work Officer

Date: 12 February 2018

Person to Contact:
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Appendices: Action Plan

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

Wards Affected: All

eForms Document

Inspection Action Plan

Craigellachie

November 2017

Requirements

Details of the following entries are included in the Appendix at the end of this document along with blank forms for adding new entries.

Quality Theme Quality Statement Requirement Number
Management And Leadership 1 1

Please enter responses for each of the requirements listed below
1 record
Quality Theme Management & Leadership

Quality Theme/Statement No 1
Requirement Number 1

The provider must ensure that the Care Inspectorate is notified when it breaches the conditions of registration for the service. This is to comply with SS1 2011/28 Regulation 4 (1) (b) - Any matters the provider must notify from time to time to Social Care and Social Work Scotland (SCSWIS) whilst the service is registered.

Timescale: immediate.
Action Planned:

If the service goes over their registered numbers through an emergency placement we will ensure that the Care Inspectorate are notified at the earliest opportunity
Timescale:

This will start with immediate effect

Responsible Person:

Sandy Begg / House Manager

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 14 March 2018

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

1. Purpose

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

2. Recommendations

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

3. Background

3.1 The Care Inspectorate assesses registered providers of care services in relation to four quality themes: quality of care and support; environment; staffing; and management & leadership.

3.2 In 2015, the Care Inspectorate amended their inspection process. Where any building based service has been awarded a Grade 2 (i.e. weak) or less and/ or has requirements detailed following a full inspection, their next inspection may be a 'follow up' inspection. The follow up inspection will focus on the requirements made in the previous inspection instead of covering the four quality themes. The grades awarded at the previous inspection may change if the Inspector has evidence to support any adjustment. Follow up inspections will allow the Care Inspectorate to track improvement and gain assurance that services are making the right changes.

3.3 The independent sector support service inspections reported here are for:

- The Adolescent Children's Trust - the service is provided in family homes to children and young people from throughout the West Dunbartonshire Council area.
- Living Ambitions Limited, Glasgow North and West - the service is provided across West Dunbartonshire Council area.
- Neighbourhood Networks in Scotland Limited - the service is provided in the Clydebank and Old Kilpatrick area.
- National Fostering Agency (Scotland) Limited - the service is provided across West Dunbartonshire Council area.
- Carers Direct Limited - the service is provided across West Dunbartonshire Council area.
- Trust Housing Association Ltd. - Branch 2 - the service is provided in the Clydebank and Old Kilpatrick area.
- Share Scotland - Glasgow - the service is provided across West Dunbartonshire Council area.

3.4 Some providers operate multiple services across Scotland and register groups of their services with the Care Inspectorate on a 'Branch' basis rather than as individual services. In this report Neighbourhood Networks in Scotland Ltd., Trust Housing Association Ltd. - Branch 2 and Share Scotland - Glasgow operate in this manner.

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

4. Main Issues

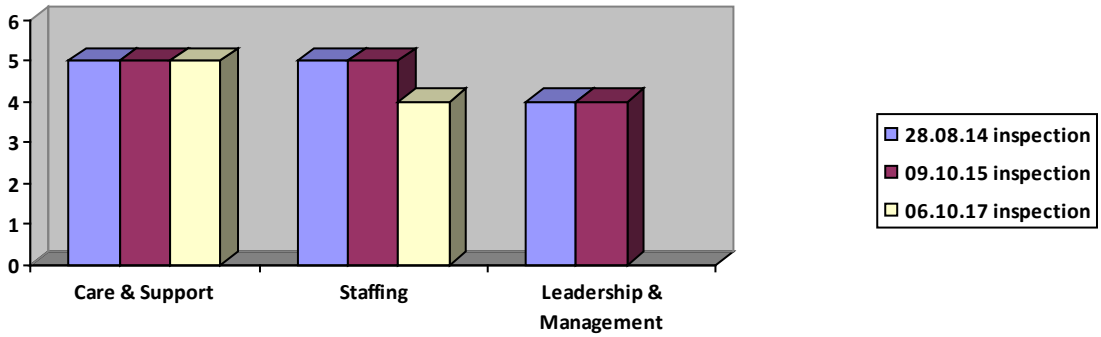
The Adolescent Children's Trust

4.1 The Adolescent Children's Trust provides a Fostering Service. The service offers a fostering and family placement service for children and young people from birth to 18 years of age. The service was inspected on 6 October 2017 and the report published on 28 November 2017. The following grades were awarded:

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

4.2 There were no requirements detailed in the inspection report.

4.3 The chart below summarises the movement in grades awarded to The Adolescent Children's Trust from inspections over the last 3 inspections.



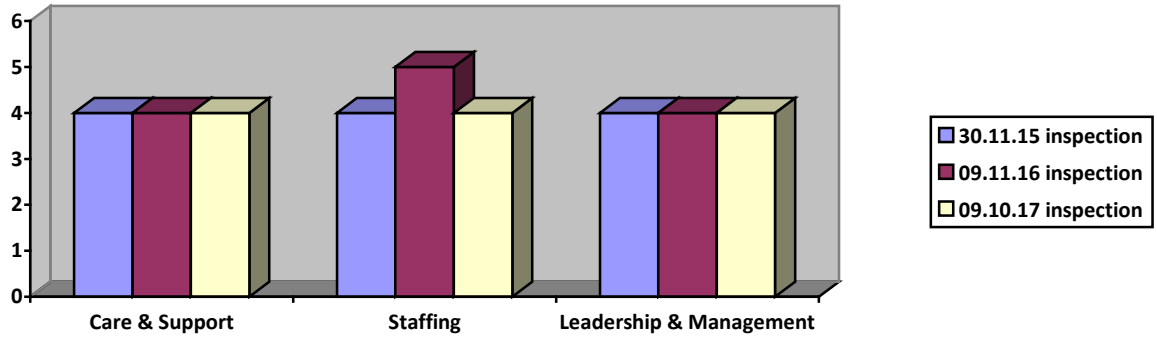
Living Ambitions Limited, Glasgow North and West

4.4 Living Ambitions Limited, Glasgow North and West is a Combined Housing Support and Care at Home service provided to people with learning and physical disabilities. The service was inspected on 9 October 2017 and the report published on 28 November 2017. The following grades were awarded:

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

4.5 There were no requirements detailed in the inspection report.

4.6 The chart below summarises the movement in grades awarded to Living Ambitions Limited, Glasgow North and West over the last 3 inspections.



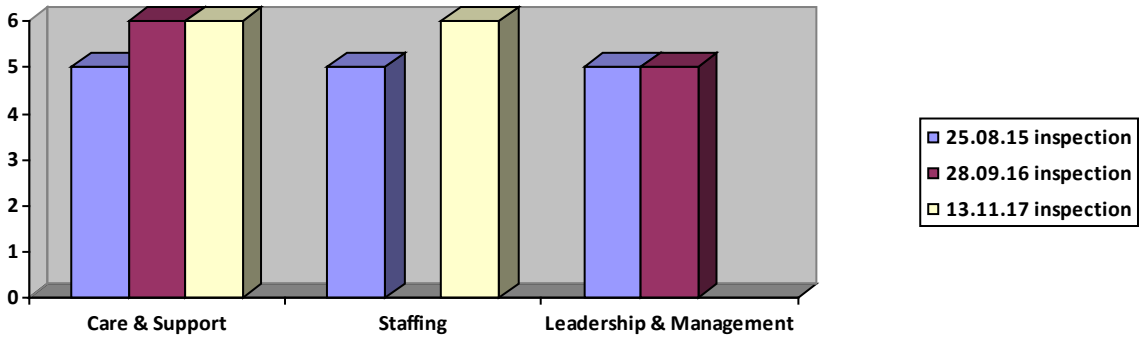
Neighbourhood Networks in Scotland Limited

4.7 Neighbourhood Networks in Scotland Limited is a Housing Support Service. The service supports vulnerable or excluded people living in their own homes who require lower levels of support to develop life skills, increase self-esteem, build new friendships and reduce isolation. The service was inspected on 13 October 2017 and the report published on 27 November 2017. The following grades were awarded:

- For the theme of Care & Support - Grade 6/Excellent.
- For the theme of Staffing - Grade 6/Excellent.

4.8 There were no requirements detailed in the inspection report.

4.9 The chart below summarises the movement in grades awarded Neighbourhood Networks in Scotland Limited over the last 3 years.



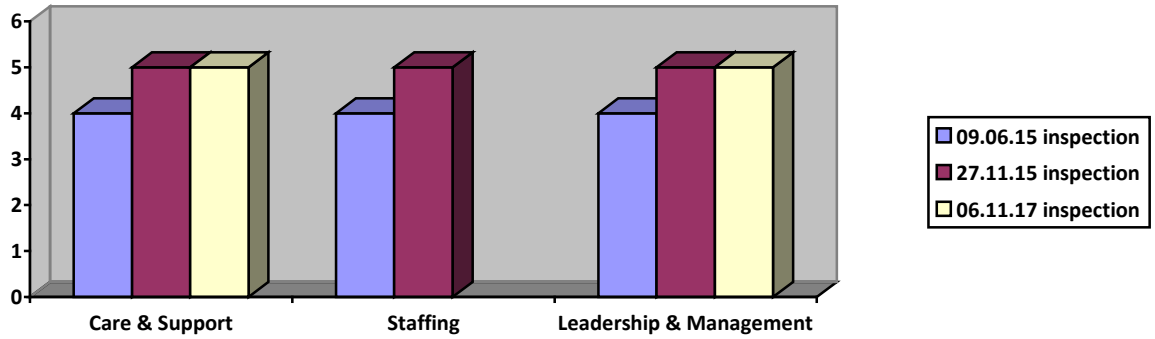
National Fostering Agency (Scotland) Limited

4.10 National Fostering Agency (Scotland) Limited provides a Fostering Service. The service offers a fostering and family placement service for children and young people from birth to 18 years of age. The service was inspected on 6 November 2017 and the report published on 30 November 2017. The following grades were awarded:

- For the theme of Care & Support - Grade 5/Very Good.
- For the theme of Management & Leadership - Grade 5/Very Good.

4.11 There were no requirements detailed in the inspection report.

4.12 The chart below summarises the movement in grades awarded to National Fostering Agency (Scotland) Limited from inspections over the last 3 inspections.



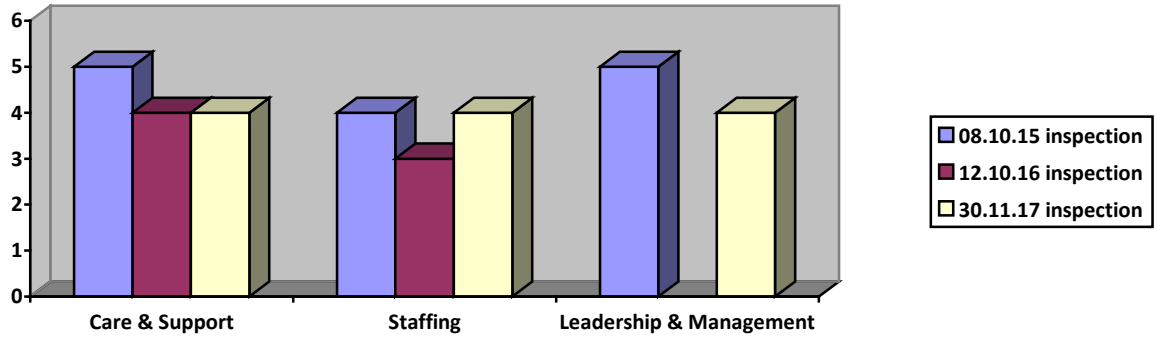
Carers Direct Limited

4.13 Carers Direct Limited provides a Care at Home Support Service to elderly people in their own homes. The service was inspected on 30 November 2017 and the report published on 8 December 2017. The following grades were awarded:

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

4.14 There were no requirements detailed in the inspection report.

4.15 The chart below summarises the movement in grades awarded to Carers Direct Limited from inspections over the last 3 inspections.



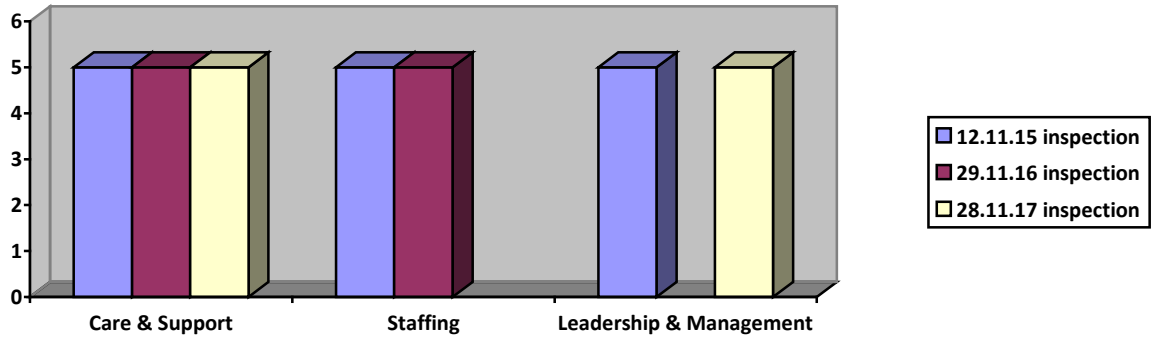
Trust Housing Association Ltd. - Branch 2

4.16 Trust Housing Association Ltd. - Branch 2 is a Housing Support service provided to older people. The service was inspected on 28 November 2017 and the report published on 14 December 2017. The following grades were awarded:

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

4.17 There were no requirements detailed in the inspection report.

4.18 The chart below summarises the movement in grades awarded to Trust Housing Association Ltd. - Branch 2 over the last 3 inspections.



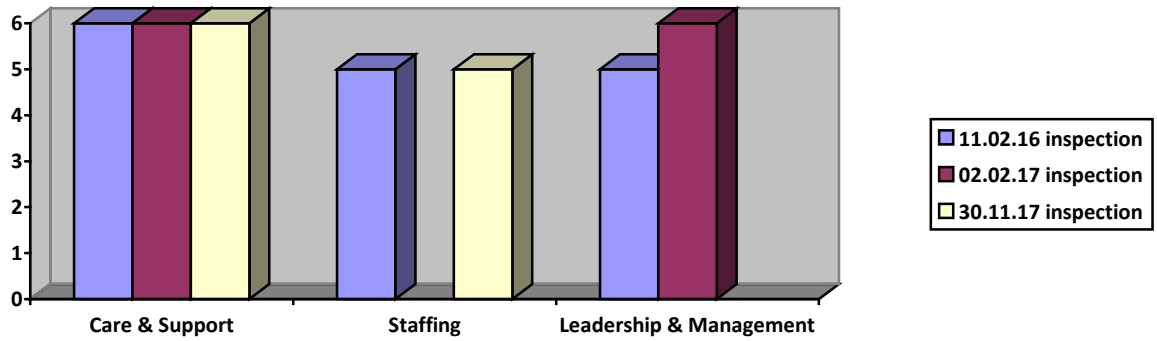
Share Scotland - Glasgow

4.19 Share Scotland - Glasgow is a housing support service. The service provides housing support to adults with complex learning and physical needs in the community, within their own accommodation either alone or within larger units with other service users. The service was inspected on 30 November 2017 and the report published on 5 January 2018. The following grades were awarded:

- For the theme of Care and Support - Grade 5/Very Good.
- For the theme of Staffing - Grade 5/Very Good.

4.20 There were no requirements detailed in the inspection report.

4.21 The chart below summarises the movement in grades awarded to Share Scotland - Glasgow over the last 3 inspections.



5. People Implications

5.1 There are no people implications associated with this report.

6. Financial Implications

6.1 There are no financial implications associated with this report.

7. Professional Implications

7.1 There are no professional implications associated with this report.

8. Locality Implications

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

9. Risk Analysis

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

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

12. Strategic Assessment

12.1 The Strategic Plan 2016 -19 emphasises the importance of quality assurance amongst independent sector providers of care; and the HSCP's commitment to work with independent sector providers within an agreed assurance framework.

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Date: 06 February 2018

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Appendices: None

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

Wards Affected: All

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Health & Social Care Audit Committee: 14 March 2018

Subject: Work Undertaken to Improve Grades at Dunn Street Respite Service

1. Purpose

1.1 To present the Audit Committee with and update of the work being undertaken to support the improvement of Care Inspectorate Grades at Dunn Street Respite Care Unit Clydebank.

2. Recommendations

2.1 The Audit Committee is asked to note the work being undertaken to support Quarriers to make improvements with their clinical and care governance processes processes and standards of care delivery.

3. Background

3.1 Dunn Street is a 6 bed unit in Clydebank used to provide respite support for residents of West Dunbartonshire who have a Learning Disability.

The property at Dunn Street is leased by West Dunbartonshire from Knowes Housing Association. Quarriers are the service provider currently commissioned to deliver support services.

Discussion has been ongoing with the management team at Quarriers regarding several underpinning issues contributing to a lack of improvement in Care Inspection Grades over the past year. In order to support Quarriers with the improvement process, a multi-disciplinary care core group, comprising multi-agency professionals, was established by Learning Disability services and has met monthly since March 2017 to identify key areas for improvement. An improvement work plan has been formulated in an attempt to support Quarriers raise their standards imminently across the service.

4. Main Issues

4.1 Recent Care Inspections have graded the service poorly and there has been little improvement in grades despite Quarriers management providing assurances of improved practice to achieve this.

Further issues have included a lack of robust governance arrangements, inaccurate medication recording and errors in the delivery of care associated with not following patient care plans. There has been frequent senior staff changes resulting in a lack of overall leadership and management and there has been an increase in the amount of Adult Support and Protection referrals.

5. People Implications

5.1 A requirement for Quarriers management and staff engagement in the improvement plan is essential to ensure action points for improvement are implemented, with robust monitoring processes in place.

6. Financial Implications

6.1 The current commissioning contract between West Dunbartonshire HSCP and Quarriers is due for review. Given the difficulties Quarriers may have in improving and sustaining care standards across the service the procurement process may have to be considered to identify alternative care providers.

7. Professional Implications

7.1 The Care Inspectorate continues to be fully involved in the improvement planning for Dunn Street. The HSCP Pharmacy team have also been included in work plan action planning to support staff with medication issues.

8. Locality Implications

8.1 Dunn Street is the only available learning disability respite resource available to residents of West Dunbartonshire and demand for the service is high. The HSCP expectation is for Quarriers to make significant improvements across clinical and care governance areas if the contract is to be continued.

9. Risk Analysis

9.1 Current risk issues are being managed through the Improvement action plan.

10. Impact Assessments

10.1 None required

11. Consultation

11.1 Consultation with Quarriers remains ongoing.

12. Strategic Assessment

12.1 The Keys to Life Strategy (The Keys to Life – Improving quality of life for people with learning disabilities, June 2013) emphasises the requirement for care to be provided to the highest standards of quality and safety. The National Care Standards (published in June 2017 with implementation from April 2018) set out headline outcomes such as the requirement of high quality care and support and also having “confidence in the people who support and care for me”. The West Dunbartonshire Strategic Plan 2016 – 2019 further

recognises the importance of providing high quality Learning Disability services.

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Date: 12 February 2018

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Appendices: Copy of Dunn Street Work plan January 2018

Background Papers: None

Wards Affected: All

MULTI AGENCY ACTION PLAN (Version 15th January 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
1	**Management and Leadership**					
1.1	Fully utilise quality assurance systems to assess and monitor the quality of service provision.	Brian Gardiner/ Sarah Perry/ Louise Fee	**COMPLETED**	03/07/2017		**GREEN**
1.2	Policies and procedures on staff supervision, Team Meetings, PDP Planning are in place and are implemented.	Brian Gardiner/ Sarah Perry/ Louise Fee	**COMPLETED**	13/04/2017		**GREEN**
1.3	Copies of policies and procedures on staff supervision, training, development available to the staff group.	Brian Gardiner/ Sarah Perry/ Louise Fee	**COMPLETED**	04/04/2017		**GREEN**
1.4	There is a process for issues/concerns about staff skills to be recorded in supervision sessions and personal development plans.	Brian Gardiner/ Sarah Perry/ Louise Fee	**COMPLETED**	30/05/2017		**GREEN**

MULTI AGENCY ACTION PLAN (Version 15th January 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
1.5	Evidence of information in relation to any changes in care needs being passed to staff.	Brian Gardiner/ Sarah Perry/ Louise Fee	**COMPLETED**	ONGOING		**GREEN**
2	**Training provided for management team**					
2.1	All managers have undertaken leadership and management training.	Jude Grant	*SSC Qualification will be completed with 3 years of recruitment.* ***Dates still required.***	ONGOING		**GREEN**
3	**File Management**					
3.1	File management system to be implemented and up to date.	Brian Gardiner/ Sarah Perry/ Jude Grant	** New tracker in place to ensure target dates are met for auditing of files. *AWI Section 47 certificates required*	15/01/2018	****Lists of AWI Certificates still required***	**AMBER**
3.2	Process to be put in place to ensure files are kept up to date by staff.	Brian Gardiner/ Sarah Perry/ Jude Grant	**Operational audit in place. *Files of 2 x staff and 2 x respite users audited each month *Internal audit implemented.*	ONGOING		**GREEN**
4	**Staffing levels and staff turnover**					
4.1	Ensure all staff suitably qualified and registered with the SSSC. (This is cross referenced ensuring a review of training needs of staff).	Brian Gardiner/ Jude Grant	**** List if staff SSSC renewal dates*** **** Usage of Outlook calendar to alert staff to renewal date***	16/02/2018		**GREEN**

MULTI AGENCY ACTION PLAN (Version 15th January 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
4.2	Ensure rota is set on a 4-6 weekly basis.	Brian Gardiner/ Jude Grant	***Staff Rota in place until 18/2/18 * Manager periodically reviewing rota***	ONGOING		**GREEN**
4.3	Achieve a frequency of agency workers used within the service to below 7% of total staff.	Jude Grant	***TO BE CONFIRMED***	ONGOING		**AMBER**
4.4	Establish if agency staff are suitably qualified and registered with the SSSC?	Brian Gardiner/ Louise Fee	**COMPLETED**	04/04/2017		**GREEN**
4.5	Establish the absence levels within the last year.	Brian Gardiner/ Jude Grant	***No absence at this point.***	15/01/2018		**GREEN**
4.6	Establish the turnover of staff within the last year, monthly vacancy list to be provided to this group.	Brian Gardiner/ Jude Grant	***Recruitment ongoing *A total of 55 hours vacant.***	ONGOING		**GREEN**
5						
5.1	There is a requirement for 4 to 6 weekly meetings to take place alongside Senior Staff at Dunn Street/Marie Malt/LD Staff? (This will facilitate supporting Dunn Street staff with the planning of respite.)	HSCP Staff/ Quarriers	***COMPLETED Dates arranged into 2018*** .	ONGOING		**GREEN**

MULTI AGENCY ACTION PLAN (Version 15th January 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
5.2	To monitor the service user mix/dependency levels.	Marie Malt/ Quarriers	** Update Meetings continue every 4 weeks.* **Agenda Template to next meeting*	15/01/2018		**AMBER**
5.3	Face to face meetings with carers	Lorraine Bell	****Phone Contact,*** ****Attendance at reviews*** ****Open Day***	ONGOING		**AMBER**
5.4	Pre & Post visit questionnaires	MM/BG Quarriers	****Log for post questionnaire implemented. *Pre visit questionnaire design agreed.***	ONGOING		**GREEN**
6	**Staff Training**					
6.1	Undertake a review of the training needs of staff taking into account the health, welfare and safety needs of service users.	Brian Gardiner/ Louise Fee	****Staff Development Day * Medication Workshop***	Mar-18		**GREEN**
6.2	The training provided by external agencies should be recorded and system to put in place to ensure this is implemented.	Brian Gardiner/ Louise Fee	**COMPLETED**	ONGOING		**GREEN**
6.2.1	Develop a recording tool multi-agency training and feedback	HSCP Staff/ Quarriers	**COMPLETED**	ONGOING		**GREEN**
6.3	Issues in relation to staff training to be linked back to supervision.	Quarriers	**** Staff Supervision occurring 4-5 weekly*** ****Observations of staff practice by manager regularly occurring***	ONGOING		**GREEN**
7	**Skills and knowledge of how to communicate with individuals**					

MULTI AGENCY ACTION PLAN (Version 15th January 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
7.1	Key worker system in place in order to ensure knowledge, consistency and communication with service users.	Nicola Wightman/ Brian Gardiner/ Louise Fee Quarriers	**COMPLETED**	ONGOING		**GREEN**
7.2	Systems to be put in place to ensure effective communication, with individuals, carers and external agencies.	Brian Gardiner/ Quarriers	* *New handover process implemented.* * *Staff Communication Diary.* * *Respite Users Questionnaire.*	ONGOING		**AMBER**

MULTI AGENCY ACTION PLAN (Version 15th January 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
7.3	Establish a process for recording and distributing information provided by external agencies.	Brian Gardiner/ Louise Fee Quarriers	**COMPLETED**	ONGOING		**GREEN**
7.4	Develop a system for updating service users care plans with any relevant changes or information.	Brian Gardiner/ Louise Fee Quarriers	**** Historical Support plans have been reviewed and updated. *Care Plan updates are now ongoing***	ONGOING		**GREEN**
8						
8.1	Analyse how much time kitchen prep is taking away from care provision.	SP/NW	**** Analyse every 2 weeks Fri-Mon quarterly.***	ONGOING		**AMBER**
8.2	Establish how often the training kitchen is being used as a meaningful activity for service users to participate in.	SP/NW	**** Refurbishment of kitchen required to ensure it's fit for purpose.***	31/03/2018		**AMBER**
8.3	Ensure staff are aware of the nutritional care of adults with a learning disability is being used.	SP/NW	**** Dates for training to be identified.***	31/03/2018		**AMBER**
8.4	Review the food planner in place to evidence choice is being offered to guests at mealtime.	SP/NW	**COMPLETED**	01/10/2017		**GREEN**

MULTI AGENCY ACTION PLAN (Version 15th January 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
9	**Staff handover and planning meetings**					
9.1	Confirm there is a protocol/policy in place in relation to staff handover meetings to ensure effective communication.	BG/ Quarriers	**COMPLETED**	01/10/2017		**GREEN**
9.2	Establish frequent staff meetings and ensure an action note is taken and distributed.	BG/ Quarriers	** 4 weekly Staff Team Meetings.*	31/03/2018		**GREEN**
9.3	A process in place to confirm staff not in attendance of the outcomes of staff meetings	BG/ Quarriers	**COMPLETED**	01/11/2017		**GREEN**
9.4	Confirm communication methods in place for managers to pass information to the staff group.	BG/ Quarriers	** Staff must read folder in place*	ONGOING		**GREEN**
10	**In house quality assurance for auditing care plans**					
10.1	Establish whether the staff group have easy access to pictorial information provided in current working care plan?	SP/NW/ BG	**COMPLETED**	01/10/2017		**GREEN**
11	**Staff following external advice**					
11.1	A process is in place for recording all contact with external services.	BG/ Quarriers	***Review of existing telephone lines and equipment completed.***	ONGOING		**GREEN**
12	**Clothing and belongings**					

MULTI AGENCY ACTION PLAN (Version 15th January 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
12.1	There is a checklist of belongings at the start of respite and the checklist is signed off at the end of respite.	Quarriers	**COMPLETED**	15/01/2018		**GREEN**
13	**Moving and Handling**					
13.1	There is a protocol in place to supervise any moving & handling procedures.	RU/ Quarriers	**COMPLETED**	04/04/2017		**GREEN**
13.2	The staff group are fully trained and competent in relation to moving and handling procedures.	RU/ Quarriers	**COMPLETED**	01/10/2017		**GREEN**

MULTI AGENCY ACTION PLAN (Version 15th January 2018)

	Actions	Lead	Progress	Target Date	Risks / Barriers to achievement	RAG Status
14	**Provision of medication**					
14.1	Review the medication recording system in place is safe, up to date and accurate. Review the record of medicines held on premises for use by service users.	BG/DF Quarriers	***Covering letters to accompany new medication sheet to carers.** ***Lorraine draft a letter for next meeting**	15/01/2018		**AMBER**
14.2	Establish if there is a process in place when there is a medication discrepancy e.g. when care plan is different to medication labelling.	BG/RM Quarriers	**COMPLETED**	01/12/2017		**GREEN**
14.3	Establish there is a process in place for recording errors in administering medication.	BG/RM Quarriers	***Medication return regarding errors and staff involved to be implemented**	01/12/2017		**GREEN**

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 14 March 2018

Subject: Are they involving us? Integration Authorities' engagement with stakeholders - A Report by the Scottish Parliament Health and Sport Committee Report

1. Purpose

1.1 To bring to the Audit Committee's attention a recent report published by the Scottish Parliament Health and Sport Committee, and the Cabinet Secretary's formal response to it.

2. Recommendation

2.1 The Partnership Board is recommended to note this recent report published by the Scottish Parliament Health and Sport Committee, and the Cabinet Secretary for Health and Sport's formal response.

3. Background

3.1 The remit of the Scottish Parliament Health and Sport Committee is to consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Sport. The nature of this role means that it considers and scrutinises the Scottish Government's policies and expenditure in relation to a variety of matters of interest to the Partnership Board and its Audit Committee, including the overall health and social care integration agenda.

4. Main Issues

4.1 As part of its current work programme, the Committee prepared and published in September 2017 a report titled "Are they involving us? Integration Authorities' engagement with stakeholders" (Appendix 1).

4.2 In November 2017 the Cabinet Secretary's published her formal response to this report (Appendix 2).

4.3 Officers are giving consideration to the substance of this report as part of ongoing activities to continually strengthen good governance of the Partnership Board (as previously reported to the Audit Committee and Partnership Board). This will be reflected upon and assessed as part of the next annual review of the Local Code of Good Governance.

4.4 It is noteworthy that the Cabinet Secretary's response specifically highlights West Dunbartonshire HSCP's approach to engaging with communities and the third sector as an example of best practice.

5. People Implications

5.1 None associated with this report.

6. Financial Implications

6.1 None associated with this report.

7. Professional Implications

7.1 None associated with this report.

8. Locality Implications

8.1 None associated with this report.

9. Risk Analysis

9.1 None associated with this report.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

12. Strategic Assessment

12.1 The evidence and insights provided by the appended documents will provide important evidence and context for the on-going development of local engagement arrangements in support of integration.

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Date: 31st October 2017

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Appendices: Are they involving us? Integration Authorities' engagement with stakeholders (September 2017).

	Letter from the Cabinet Secretary for Health and Sport to the Convenor of the Scottish Parliament Health and Sport Committee (November 2017).
Background Papers:	None
Wards Affected:	All

Published 12 September 2017
SP Paper 188
11th Report (Session 5)

The Scottish Parliament
Pàrlamaid na h-Alba

Health and Sport Committee
Comataidh Slàinte is Spòrs

Are they involving us? Integration Authorities' engagement with stakeholders

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All documents are available on the Scottish Parliament website at:
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Health and Sport Committee

To consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Sport.

http://www.scottish.parliament.uk/parliamentarybusiness/CurrentCommittees/health-committee.aspx

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Introduction

1. Integration Authorities (IAs) are a key area of scrutiny for the Health and Sport Committee. To date our primary focus has been on the mechanisms of budget setting by IAs. An issue raised in this process has been IAs' approach to engagement with their stakeholders. As all IAs are now into at least their second full year of operation we decided we could reasonably consider this issue further.

2. Our short inquiry has sought to assess the extent to which stakeholders (including the public, the service users, the third sector and the independent sector) are being involved effectively in the work of IAs.

3. We issued a general call for written views to patient and carers representatives, NHS and social care staff and third sector organisations. We received 51 responses.

4. This was followed by oral evidence at two meetings. On 25 April 2017 we heard from both stakeholders and integration authority representatives. On 13 June 2017 we took evidence from the Cabinet Secretary for Health and Sport.

5. We are very grateful to all those who have given up their time to provide us with information and evidence on this inquiry.

Background

6. The Public Bodies (Joint Working) Act 2014 (the Act) sets out the legislative framework for integrating health and social care.

7. During passage of the Act the then Cabinet Secretary for Health and Well-being stated “the third and independent sectors will be embedded in the process as key stakeholders in shaping the redesign of services" . [1]

8. The Act sought to achieve this vision by placing a duty on integration authorities to ensure stakeholders were fully engaged in the preparation, publication and review of strategic commissioning plans.

9. Scottish Government guidance on strategic planning states services should be "planned and led locally in a way which is engaged with the community (including those who look after service users and those who are involved in the provision of health and social care)". [2]

10. The guidance details that the aim is to ensure a wide and diverse engagement results in a strategic commissioning plan that is not simply controlled by the small number of people on the Strategic Planning Group but rather the population that will be affected by its findings. The guidance advises that this should include the involvement and engagement of existing representative fora, such as joint planning groups, advocacy organisations, locality planning groups and those involved in local community planning. [3]

11. The guidance to involve and engage is not explicit beyond the strategic planning stage. However, the duty to involve, inform and consult is embedded in the twelve integration principles which underpin the approach IAs should take in improving the wellbeing of service users. A number of IAs have produced participation and engagement or communication strategies. These strategies set out the respective IAs vision and shared principles with respect to participation and engagement of its stakeholders.

12. The Scottish Government has produced a Communications Toolkit which contains practical resources and information to help IAs to communicate the purpose and outcomes of health and social care integration. Healthcare Improvement Scotland also runs iHub which is expressly about supporting health and social care integration.

13. We considered a series of reports, from Audit Scotland, the Alliance and the Coalition of Carers, that indicate IAs engagement with stakeholders may not be working as well as it could. These reports, along with the written and oral evidence we have received, highlight challenges that need to be overcome to ensure the vision of stakeholders being embedded in IAs and ultimately service design is being realised.

14. Our report highlights some of the issues around the meaningful involvement of stakeholders by IAs which we consider need to be addressed.

How can public awareness of Integration Authorities be improved?

15. A recurring issue raised during the course of our inquiry was the lack of public awareness about the establishment of IAs.

16. Diabetes Scotland highlighted that people in its network of local groups had limited understanding of the structures, process and outcomes of IAs. [4]

17. Inclusion Scotland felt there was little awareness of the engagement carried out by IAs. It suggested there was a tendency for IAs to engage with organisations already known to health boards and local authorities rather than to seek to engage new or seldom heard groups. [5]

18. In oral evidence, North Ayrshire Health and Social Care Partnership acknowledged that, to date, there had been limited work done to promote (to the public) the existence of IAs and improve knowledge of IAs' responsibility to shift the balance of care. [6]

19. North Ayrshire suggested whilst there was a local responsibility to share information about IAs to the public, there was also a role for a national campaign to help support this work. [7]

20. **The Scottish Government has emphasised integration is one of the biggest changes in the way health and social care services are run in decades.**

21. **However, knowledge of this fundamental change in the way parts of the healthcare system operates does not appear to be high amongst the general population.**

22. **To ensure health and social care integration is a success it will require the support of the populations they serve. There is an onus on each individual IA to make sure their communities know of their existence and role. However, the reconfiguration of services is a change that is of national, as well as local, importance. We therefore recommend the Scottish Government take every opportunity to promote IAs and the shift in the balance of care at a national level. We also believe IAs, health boards and local authorities have an important role to promote integration at a local level.**

How can engagement be meaningful?

Avoiding a box-ticking exercise

23. We heard that stakeholders' experiences of engagement with IAs on local service planning were very mixed. A common theme was that engagement with stakeholders needed to be meaningful rather than a 'box-ticking' exercise. By that we mean engagement should be done with a purpose and a desire to involve stakeholders in meaningful decision making before such decisions are determined. Public involvement should be embedded.

24. We received some examples of good practice, where engagement seemed to be working fairly well, for example in South Lanarkshire. Voluntary Action South Lanarkshire explained the third sector fed into the different structures within the IA. This included being represented by the Chief Executive on the IA.

25. Fife Health and Social Care Partnership also suggested going forward it was looking at a "genuine co-production model with our partners". This included recruiting a mix of service users, staff and carers to look at the options for change around urgent care in Fife. It had also held a redesigning care together event with the independent sector in order to help shape investment in new models of care in Fife. [8]

26. These examples suggest that when engagement is meaningful, it can help create a system of 'co-production' with the third sector and other stakeholders on the IA.

27. However, this approach did not appear to be universal, with many stakeholders telling us they were finding it hard to contribute to local service planning.

28. The term used repeatedly by witnesses during the course of our inquiry was that engagement was 'tokenistic' and was not delivering the co-production that was required. [9] Witnesses commented that IAs needed to do more than just consult others for views. For co-production to be achieved stakeholders need to be involved at the start of the process.

29. Alzheimer Scotland told us about an occasion where they had attended meetings at which resourcing decisions were discussed by members of the IA. However it was made clear Alzheimer Scotland's role was to communicate decisions rather than to contribute to the decision making process. Alzheimer Scotland commented "engagement is about bringing people with you and doing things with them, rather than just communicating decisions that have already been made". [10]

30. The Coalition of Carers in Scotland also raised similar concerns about IAs' approach to engagement. It gave the specific example of an IA producing three options for a revised approach to mental health services but only consulting on one. This resulted in carers being unhappy that ultimately the new approach to mental health services appeared to have been agreed before consultation began. [11]

31. Whilst some witnesses suggested that the acute sector and medical staff had more prominence in IAs than other stakeholders, the Royal College of Physicians of

Edinburgh raised concerns about the extent to which clinician input was valued. Experience had been mixed, however it felt there is "no real sense that the IA or Integrated Joint Board are taking action to recognise or acknowledge the clinical voice". [12] In oral evidence the Royal College suggested the approach taken by IAs could be "overly top down" and the experiences of front-line clinicians are not being allowed to influence the approach being taken. [13]

32. RCN Scotland presented a similar picture for its members. In its written submission it stated "At present, the RCN has found that nurse board members, nurses and the RCN as an organisation have not always been fully engaged or listened to by all IAs." [14]

Improving transparency of information

33. Meaningful engagement is also made more difficult where there is a lack of transparency about how IAs operate and where information on the aims and work of the IA is not forthcoming. This can make it difficult for stakeholders to know how to contribute their views.

34. Diabetes Scotland told us it had found involvement with the IAs at a strategic and a locality level to be "somewhat challenging" and IAs' "communication channels to be a bit abstract and opaque". [15]

35. Diabetes Scotland also found it hard to obtain information from IAs on their priorities for diabetes. Many IAs were non responsive. Ultimately Diabetes Scotland had had to issue FOI requests to IAs for the information. Even then, the information received from the FOI requests had been mixed. [16]

Case study- Petition PE1628

36. Petition PE1628 raised another example where engagement with stakeholders had been considered not to have been meaningful.

37. During our work on the inquiry we took the opportunity to look at the petition as a case study of how engagement could be improved.

38. The Petition related to Argyll and Bute IA and the decision of its Locality Planning Group to change the use of a residential care home (Struan Lodge) to a reablement facility. According to the IA, this decision would reduce the number of care home beds but increase the capacity for people to remain independent and in their own homes for longer.

39. The Petitioner and a dedicated local group did not support this decision and argued consultation was inadequate. They raised concern the process of consultation for the integration of health and social care was not clear

40. In evidence Argyll and Bute IA noted the challenges it faced in helping people to understand the case for shifting the balance of care. One of the issues that arose

was that individual facilities rather than a bigger picture of overall services became the focus of the discussion in the local community. Argyll and Bute IA discussed the need to build communities' confidence in community services. [17]

41. In the case of Struan Lodge, Argyll and Bute IA conceded it had not taken the time to consult with stakeholders regarding the service changes. The IA explained they had "apologised and said to the community that we did not get it right. There was an absolute error in judgement in the making of decisions that were very focused on budget". [18]

42. The IA told us as a result it had paused the changes for six months. It had held community engagement events and issued questionnaires which had resulted in the Struan Lodge Development Group producing an action plan offering different approaches to the future of the care home. Although no consensus had been reached, the IA indicated it would take account of the feedback it had received when determining its future approach.

Scottish Government views

43. We raised the question of how to achieve meaningful engagement with the Scottish Government. The Cabinet Secretary for Health and Sport indicated the importance of engagement by IAs both at the strategic planning and the locality level. She told us "those who know best how services should be delivered are those who receive the services and those who provide them". [19]

44. However she emphasised this approach should not be a barrier to ensuring integration authorities engage fully and widely with all stakeholders. [20]

45. She said there were examples of good practice in relation to IA engagement, however she acknowledged the situation was "still work in progress". Some IA had improvements to make to ensure engagement resulted in stakeholders being placed at the centre of planning and decision making. [21]

46. The Cabinet Secretary discussed the Scottish Government's role in sharing IAs best practice through the provision of guidance and support. She also emphasised the role for the Scottish Government in highlighting the merits of IAs adopting a co-production approach.

47. **The case studies brought to our attention have demonstrated the importance of having meaningful engagement by IAs. This engagement must not be a tick box exercise. We were concerned to hear there had been occasions where organisations, keen to engage with an IA, had to resort to issuing FOI requests to receive basic information about the approach the IA was taking to service delivery. There is a clear need for greater public transparency around this sort of information.**

48. **Integration offers an opportunity to improve the involvement of communities in decisions around the shift in the balance of care.**

49. **We understand at times there will be challenging decisions to be made involving competing priorities and it may not always be possible to satisfy all the wishes of community representatives. However at the very least it is important the reasons for a decision are properly explained, even if the decision itself might not be supported. This can also be helped by communities having a feeling of involvement in the entire process. At present there does not appear to be a mechanism or guidance in place to facilitate this.**

50. **IAs must make sure communities are fully involved and have confidence in the engagement being undertaken. IAs must learn from occasions where engagement has clearly not worked as well as it should have to date. We believe IAs must involve relevant stakeholders in consultation planning. We also believe IAs should work with stakeholders on the evaluation of engagement and public involvements activities. IA need to ensure they take account of the time and resource implications for individual and third sector stakeholders in this work.**

Reducing the costs and complexity of engagement

The costs associated with engaging

51. We heard evidence of some practical barriers which were hindering engagement with IAs.

52. Some witnesses raised concerns carers and service user representatives on IAs were incurring costs as a result of their engagement. The Coalition of Carers in Scotland explained there were instances where carers were not getting their transport and replacement care costs fully reimbursed for attending meetings. [22]

53. Corinne Curtis, Service User Representative on the Strategic Planning Group in Orkney felt it was unfair public representatives on IAs should be expected to volunteer their time without compensation. She believed no one should be at a financial disadvantage as a result of being a public representative. Corinne Curtis called for a standard Scotland-wide approach to be taken to address the issue. For example the self-employed could be paid a day rate for attendance at meetings and carers given additional paid care hours. [23]

54. The Alliance said “If we truly value public involvement in the boards, we need to pay for it and budget for it, and ensure that people are able to attend and are financed to do so.” [24]

55. The Cabinet Secretary, in response to concerns about the costs incurred by some representatives to participate in the work of IAs, agreed they should not be disadvantaged. She explained “We expect the integration authorities to ensure that those who participate in the process can do so without detriment, and I would be concerned if that were not the case.” [25]

Making the process of engagement less complex

56. We also received evidence that the complexity and length of meeting papers for IA and sub-group meetings presented challenges for carers and service user representatives in engaging with the work of the IA. Meeting papers often did not take into account their needs. The papers contained inaccessible language, for example.

57. There was also a high volume of paperwork with papers often only available shortly before a meeting. This meant representatives had little time to consider the papers and even less time to confer and debate issues raised in the papers with other organisations prior to meetings. [26]

58. The way some meetings were conducted was also noted as a barrier for stakeholder engagement. Some meetings could be quite ‘high level’ and hard to follow. [27] There was also variation in the approach taken by different IAs to

stakeholders being able to put items on the agenda for consideration at meetings. In some instances there was no mechanism to do this. [28]

59. However, we received some examples of good practice. The Coalition of Carers highlighted examples of additional resources being provided to support the carers and service user representatives on IAs. It highlighted some IAs holding development sessions with Carer Reps every other month, between formal Board meetings. [29]

60. **We are concerned there are instances where there appears to be a lack of support for individuals and third sector organisations to mitigate the time, resource and money required to be properly involved in local planning.**

61. **We agree with the Cabinet Secretary no one should be financially disadvantaged as a result of engagement with an IA. However we are concerned by reports that people have incurred financial costs associated with their participation in IAs. We ask the Cabinet Secretary for details of how she intends to address these concerns, noting her comments representatives should be able to participate without detriment.**

62. **Whilst there are examples of IAs ensuring that the additional needs of carers and service users are taken into consideration to facilitate meaningful engagement, we do not believe there is consistency across IAs in meeting these needs. We expect the additional support and accommodations needed to ensure the barriers to involvement to be provided across all IAs. We call upon the Scottish Government to indicate how it will ensure this is achieved.**

Changes needed to IA governance?

63. One issue raised with us was whether changes to the voting rights on IA boards might help increase the influence of stakeholder representatives, and improve the equality of the relationship between participants on IAs.

64. Currently third sector organisations and carers representatives do not have voting rights on IAs.

65. The Coalition of Carers highlighted expanding voting rights on IAs was something they had lobbied for when the relevant legislation was being scrutinised by the Scottish Parliament.

66. The Alliance told us at the IA governance level, the relationship between the statutory sector and the third sector, the independent sector and people who use supporting services is "inherently unequal, because of the nature of voting rights and the number of people on the boards". [30]

67. However, we also heard that, for many organisations, the key objective was not voting rights but the ability to influence the approach taken to the provision of services, prior to this decision-taking stage. Some witnesses also highlighted that with voting rights came the possibility of seeming to endorse a decision they did not agree with. Ultimately not being able to vote could provide more freedom. [31]

68. The Cabinet Secretary acknowledged the debate about the voting rights of individual board members. She explained the reasoning for the approach taken "The conclusion was that it was proper for voting rights on use of such significant public budgets to be held only by board members who are publicly accountable- in other words, elected council members and non-executive member of health boards." [32]

69. **We are concerned that the relationships between board members at IA governance level are 'unequal'. We note the call by some witnesses to extend voting rights to other members of IA boards to address these concerns. However we also note the challenges which changes in governance relationships would pose if voting rights were extended to board members who are not publicly accountable like council and non-executive members of health boards. We conclude that at this stage other approaches should be prioritised to address this perceived inequality before considering changes to IA governance arrangements. In this report, we have outlined improvements which could be made.**

Improving engagement at a locality level

70. There are lots of ideas regarding how to facilitate and achieve engagement at a local level. We heard evidence about the goodwill and strong desire by stakeholders to be involved in the work of IAs but concerns these were being frustrated by the current system.

71. We received evidence about the important work being undertaken by representatives of carers and the third sector on IAs. However, we also heard about the challenges in ensuring these representatives truly reflect the range of views being expressed at a local level.

Challenges

72. Corinne Curtis, Service User Representative on the Strategic Planning Group in Orkney expressed frustration with her role—

> "As a service user representative— I cannot represent, because I do not have a network to feed back to or to get information from. [….] Now that I have attended a few meetings, I have come to the realisation that my job is to act not as a representative but as someone who monitors public participation." [33]

73. The Coalition of Carers explained for the carer on the IA board to operate as an effective representative there needed to be a community of other carers for them to communicate and engage with. [34]

74. Some IAs had adopted, or were considering adopting, the approach of having an elected representative from the third sector on the IA. We heard from East Lothian Health and Social Care Partnership this was an approach they were giving some consideration to. [35]

75. Corinne Curtis' experience however, suggested only a (small) minority of people were willing, able and could afford to participate as service user representatives. Her view was that an election process may not result in the individual being any more representative. [36]

Role of Third Sector Interfaces

76. We heard the use of Third Sector Interfaces (TSIs) could provide another way for IAs to access the views of a wider range of local views.

77. As set out in the Public Bodies (Joint Working) (Scotland) Act 2014, TSIs have a key role as an advocate in relation to the role of the third sector and the integration of health and social care. "TSIs are positioned to act as the conduit for the third sector in relation to integration activities." [37]

78. We heard some evidence the approach to the IAs' use of TSIs was developing in some areas.

79. Voluntary Action South Lanarkshire commented that whilst it was impractical to expect the 1,600 community groups and organisations in South Lanarkshire to sit round the table together it viewed the TSI as the "conduit for passing out information". [38]

80. However some witnesses noted there was variation in the approach taken by TSIs across the country, which resulted in variation in their effectiveness. Some suggested there were challenges for national organisations to engage with TSIs in some areas. Alzheimer Scotland stated "there is great variation in the capacity and willingness of the TSIs to work with their members-particularly those of us that are national organisations". [39]

81. A Marie Currie written submission suggested TSIs were facing a difficult task to "represent a sector that is simply not representable, due to its size, shape and nature". It explained the needs of a large charity with a significant local presence delivering a frontline service in healthcare were considerably different to those of a small, local based charity delivering support services in social care. [40]

82. The Scottish Government highlighted the funding it had made available to TSIs to provide local support to the third and voluntary sectors to engage with integration. The Scottish Government explained £8m had been made available until March 2018 and a further £4m to September. [41]

Role of the Scottish Health Council

83. We also explored the question as to whether the remit of the Scottish Health Council (SHC) should be formally expanded to assist IAs with their engagement. Currently its role is to support health boards with their public engagement.

84. The Scottish Health Council highlighted in its written submission that whilst its current role did not formally extend into social care, it had been working with IAs to support their public engagement activities through its Our Voice framework.[Scottish Health Council and Healthcare Improvement Scotland written submission]. This framework, initiated by the Scottish Government, aims to enable people who use health and social care services, carers and the public to engage purposefully with health and social care providers in order to continuously improve services.

85. Diabetes Scotland suggested, given the SHC's current role with health boards, the SHC could develop best practice for engagement and involvement for IAs. [42]

86. North Ayrshire Health and Social Care Partnership suggested a similar role for a national body like the SHC or Alliance to distil and share good practice regarding engagement across all IAs. [43]

87. Diabetes Scotland suggested the focus should be on ensuring there were engagement channels up from the local networks. Diabetes Scotland emphasised the need for a 'menu of communications' for people to engage rather than there being "just one mechanism and one organisation". [44]

88. The Coalition of Carers also emphasised the need to support local engagement. It believed there was a small role for national support but as things developed it expected the role of engagement at a local level to strengthen. [45]

89. Several organisations emphasised the real opportunity to influence and engage lay people at the locality level. In its written submission Arthritis Care Scotland explained "key investment is more likely to be at locality level and this needs to be prioritised when looking at systems that support consultation with service users". [46]

90. Some submissions called for a specific role for an individual responsible for public engagement within each IA. In its written submission Marie Curie suggested it had been considerably easier to engage with those IAs where the IA had appointed staff with stakeholder engagement in their remit and titles. It called for consideration to be given to all IAs to adopting this approach. [47]

91. Harold Massie, a former Patient and Service User Representative on the Shetland Integration Authority recommended in his written submission there should be a full time, paid support worker employed by the SHC. He called for the individual to have responsibility for maintaining public representation and supporting public consultations at locality and IA area level. [48]

92. We received views from an engagement event involving service users, carers and third sector representatives who sit on IAs. This had been facilitated by the Alliance and the SHC, in collaboration with the Coalition of Carers in Scotland. Some people at the event had suggested the introduction of legislation to require national standards for IAs to ensure accountability. They also supported the idea of a dedicated staff member in post with responsibility for ensuring meaningful engagement at all levels across localities and communities.

Conclusions on engagement at a locality level

93. **When discussing the delivery of meaningful public involvement emphasis is often placed on the importance of a local presence and the need for direct involvement with individuals and local groups.**

94. **We recognise there are challenges in ensuring representatives of carers and the third sector on IAs truly reflect the range of views being expressed at a local level. We also recognise the challenges TSIs face in assisting IAs to obtain the views of community organisations. Clearly there are variations in how TSIs have been operating. There are difficulties inherent in trying to capture views from a broad range of organisations, some of which operate nationally whilst others operate on a small-scale local level. The diversity of the third sector means it cannot be treated as a single homogenous group, which makes designing an approach to third sector engagement particularly challenging.**

95. **We note the Scottish Health Council's current role remains under review and we expect revisions to the SHC's role to be made reflecting the changed health and social care landscape.**

96. **In addition, we can see the advantages in identifying within each IA a single individual taking responsibility for public involvement and engagement. While we do not wish to see accountability for this diluted and passed to a single individual many organisations have argued such a role would improve the profile of public engagement and support others in carrying out this work. We are attracted to the idea of a dedicated community development staff member in each IA or TSI. Their explicit role would be to link and co-ordinate public and stakeholder engagement. The post holder could also seek to identify and mitigate some of the practical barriers to engagement. We recommend that each IA appoint a dedicated community development staff in their IA or TSI accountable directly to the chief officer. We ask the Scottish Government how it could encourage and support such an approach to be taken by IAs.**

Overall conclusion

97. **Health and social care integration is a fundamental change to the way health and care services are planned and delivered. For IAs to achieve this change they require not only the population at large to understand and support the approach taken to local service delivery, but ultimately for them to be involved in driving the changes forward.**

98. **Engagement of stakeholders should be done with a purpose and desire to involve them in meaningful decision making before such decisions are determined. We have found evidence of a willingness and strong desire from stakeholders to achieve this co-production.**

99. **However whilst we have found examples where stakeholder engagement has been working well this is not consistent across all IAs. Stakeholders are not embedded in decision-making processes across all IAs and at all stages in determining the approach taken to delivering local services. This must be improved. All IAs are now into at least their second full year of operation and this piecemeal approach to engagement with stakeholders cannot continue. For IAs to be a success this core issue of co-production must be addressed.**

100. **We also recognise that at times there will be challenging decisions to be made by IAs involving competing priorities, the priorities of the local community, financial proprieties and the priority to deliver the shift in the balance of care. In the Scottish Government's response to this report we request it provide further information on the guidance and assistance it provides to IAs in supporting their navigation through these often competing priorities. We ask the Scottish Government to provide further detail on the extent to which Scottish Government guidance is directed at shifting the balance of care and examples of this approach in operation. We also ask the Scottish Government how the shift in the balance of care is being measured and how it is to be specifically reported allowing the shift to be identified and collated.**

Annex A - Minutes of meeting

15th Meeting, 2016 (Session 5) Tuesday 13 December 2016

1. Work programme (in private): The Committee considered and agreed its work programme.

4th Meeting, 2017 (Session 5) Tuesday 07 February 2017

2. Integration Authorities Consultation with Stakeholders (in private): The Committee considered and agreed its approach.

11th Meeting, 2017 (Session 5) Tuesday 25 April 2017

2. Integration Authorities Engagement with Stakeholders: The Committee took evidence from—

- Claire Cairns, Coordinator, The Coalition of Carers in Scotland, representing The National Carer Organisations;
- Heather Petrie, Future & Specialist Delivery Team Leader, Voluntary Action South Lanarkshire;
- Linda McGlynn, Regional Engagement Manager Scotland, Diabetes Scotland; and
- Sonia Cottom, Director, Pain Association Scotland;

and then, in roundtable format, from—

- Christina West, Chief Officer, Argyll and Bute Health and Social Care Partnership;
- Michael Kellet, Chief Officer, Fife Health and Social Care Partnership;
- Amy Dalrymple, Head of Policy, Alzheimer Scotland;
- Margaret McKeith, National Lead, Partners for Integration, Scottish Care;
- Corinne Curtis, Service User Representative (Orkney Integration Authority Strategic Planning Group;
- Dr Marion Slater, Consultant Geriatrician and elected member of the Council, Royal College of Physicians of Edinburgh;
- Jo Gibson, Principle Manager, North Ayrshire Health and Social Care Partnership;
- Andrew Strong, Assistant Director (Policy and Communications), Health and Social Care Alliance Scotland (the ALLIANCE); and
- David Small, Chief Officer, East Lothian Health and Social Care Partnership.

6. Integration Authorities Engagement with Stakeholders (in private): The Committee considered the main themes arising from the oral evidence heard earlier in the meeting and agreed to invite the Scottish Government to give evidence at a future meeting.

16th Meeting, 2017 (Session 5) Tuesday 13 June 2017

12. Integration Authorities Engagement with Stakeholders and Draft Budget 2017-18: The Committee took evidence from—

- Shona Robison, Cabinet Secretary for Health and Sport;
- Geoff Huggins, Director for Health and Social Care Integration; and
- Christine McLaughlin, Director of Health Finance

all Scottish Government

14. Integration Authorities Engagement with Stakeholders and Budget 2017-18 (in private): The Committee considered the evidence heard earlier in the meeting.

18th Meeting, 2017 (Session 5) Tuesday 5 September 2017

5. Integration Authorities Consultation with Stakeholders (in private): The Committee considered and agreed a draft report.

Annexe B - Evidence

Written Evidence

- Amy Anderson
- Arthritis Care Scotland
- CHAS
- Diabetes Scotland
- Alex Stobart
- Heidi Tweedie
- Alzheimer Scotland
- Ayrshire Independent Living Network
- British Lung Foundation Scotland
- Pain Association Scotland
- Corinne Curtis - Orkney
- Harold Massie
- Law Society of Scotland’s Health and Medical Law Sub-committee
- The Alliance
- National Carers Organisation
- P3 (Patient Partnership in Practice)
- Colin Angus
- Royal College of Physicians of Edinburgh
- Volunteer Scotland
- Accord Hospice
- Inclusion Scotland
- Marie Curie
- Sue Ryder
- North Lanarkshire Partnership for Change
- West Dumbartonshire CVS

- Ardgowan Hospice
- Coalition of Care Providers in Scotland
- Moira Robertson
- Royal National Institute of Blind People Scotland
- Scottish Care
- Scottish Health Council and Healthcare Improvement Scotland
- SCVO
- St Columbas Hospice
- Voluntary Action South Lanarkshire
- Royal College of Nursing Scotland
- Fife Voluntary Action
- PAMIS
- Sport Aberdeen
- Care Inspectorate
- Paths for All
- ALLIANCE and the Scottish Health Council on behalf of service user and carer Integration Joint Board representatives
- Parkinson's UK Scotland
- Kenny Matheson
- Patient Opinion Scotland
- Andrew Muir
- Max Barr
- Chest Heart & Stroke Scotland (CHSS)
- Anonymous
- Camphill Scotland
- Hamish Greig
- Argyll and Bute Health and Social Care Partnership

Official Reports of Meeting

Tuesday 25 April - Evidence from stakeholders

Tuesday 13 June - Evidence from the Cabinet Secretary

1 Health and Sport Committee. *Official Report, 1 October 2013*, Col 4401.

2 Scottish Government. (2015) Strategic Commissioning Plans Guidance

3 Scottish Government. (2015) *Strategic Commissioning Plans Guidance*

4 Diabetes Scotland. Written submission

5 Inclusion Scotland. Written submission.

6 Health and Sport Committee. *Official Report 25 April 2017*, Col 45.

7 Health and Sport Committee. *Official Report 25 April 2017*, Col 45.

8 Health and Sport Committee. *Official Report, 25 April 2017* , Col 24.

9 Health and Sport Committee. *Official Report, 25 April 2017*, Col 21.

10 Health and Sport Committee. *Official Report, 25 April 2017*, Col 25.

11 Health and Sport Committee. *Official Report, 25 April 2017*, Col 12.

12 Royal College of Physicians of Edinburgh. Written submission.

13 Health and Sport Committee. *Official Report, 25 April 2017*, Col 28-29.

14 RCN Scotland. Written submission.

15 Health and Sport Committee. *Official Report, 25 April 2017*, Col 4-5.

16 Health and Sport Committee. *Official Report, 25 April 2017*, Col 4-5.

17 Health and Sport Committee. *Official Report, 25 April 2017*, Col 41-43.

18 Health and Sport Committee. *Official Report, 25 April 2017*, Col 42.

19 Health and Sport Committee. *Official Report, 13 June 2017*, Col 22.

20 Health and Sport Committee. *Official Report, 13 June 2017*, Col 23.

21 Health and Sport Committee. *Official Report, 13 June 2017*, Col 23.

22 Health and Sport Committee. *Official Report, 25 April 2017*, Col 3-4.

23 Corinne Curtis. Written submission.

24 Health and Sport Committee. *Official Report, 25 April 2017*, Col 37.

25 Health and Sport Committee. *Official Report, 13 June 2017*, Col 24.

26 Alzheimer Scotland. Written submission.

27 Health and Sport Committee. *Official Report, 25 April 2017*, Col 3-4.

28 Health and Sport Committee. *Official Report, 25 April 2017*, Col 11.

29 The National Carer Organisations. Written submission. Health and Sport Committee .*Official Report, 25 April 2017*, Col 6.

30 Health and Sport Committee. *Official Report, 25 April 2017*, Col 21.

31 Health and Sport Committee. *Official Report, 25 April 2017*, Col 11-12, Col 34.

32 Health and Sport Committee. *Official Report, 13 June 2017*, CoL 23.

33 Health and Sport Committee. *Official Report, 25 April 2017*, Col 23.

34 Health and Sport Committee. *Official Report, 25 April 2017*, Col 4.

35 Health and Sport Committee. *Official Report, 25 April 2017*, Col 22.

36 Health and Sport Committee. *Official Report, 25 April 2017*, Col 23.

37 Scottish Government.(2015) The Role of Third Sector Interfaces.

38 Health and Sport Committee. *Official Report, 25 April 2017*, Col 23.

39 Health and Sport Committee. *Official Report, 25 April 2017*, Col 7 , Col 33.

40 Marie Currie. Written submission.

41 Health and Sport Committee. *Official Report, 13 June 2017*, Col 24.

42 Health and Sport Committee. *Official Report, 25 April 2017*, Col 16-17.

43 Health and Sport Committee. *Official Report, 25 April 2017*, Col 32.

44 Health and Sport Committee. *Official Report, 25 April 2017*, Col 7.

45 Health and Sport Committee. *Official Report, 25 April 2017*, Col 7.

46 Arthritis Care Scotland. Written submission.

47 Marie Curie. Written submission.

48 Harold Massie. Written submission.

Cabinet Secretary for Health and Sport
Shona Robison MSP

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Mr Neil Findlay MSP
Convener
Health and Sport Committee
Scottish Parliament
Edinburgh

Our ref: H&SC-Eng
15 November 2017

Dear Neil

Thank you for the Committee's constructive report on Integration Authorities' engagement with stakeholders. I welcome the report and fully agree that stakeholders, including service users and carers, must be at the heart of planning services and decision making to drive forward improvement.

I have been considering the key findings and I am now responding on the main issues and recommendations highlighted within the report on which the committee sought further information and clarification from Scottish Government. For ease of reference the main issues are in bold with the paragraph number from the report included at the end.

The Scottish Government take every opportunity to promote Integration Authorities and the shift in the balance of care at a national level. We also believe Integration Authorities, Health Boards and Local Authorities have an important role to promote integration at a local level. (22)

The Committee is aware that the integration of health and social care is one of the most significant reforms of public services in Scotland since the establishment of the NHS. Integration Authorities have brought together Health Boards, Local Authorities and others to ensure the delivery of efficient, integrated services which are commissioned in response to the needs and choices of people and communities, based on real local understanding and flexibility. To ensure that this is taken forward successfully we must create the right conditions nationally that will support this change at a local level. Integration is one of the four major programmes of activities within the Health and Social Care Delivery Plan, and focuses on reducing inappropriate use of hospital services; shifting resources to primary and community care; and supporting capacity of community care.

I agree that in order for health and social care integration to be a success, local populations must be thoroughly involved. As demand for services increases, and complexity and acuity grow, delivering the current levels of service as we have done in the past is not sustainable.

It is clear that in order to make progress in this area some Integration Authorities must be more transparent, accountable and easier to contact with greater interaction and a clearer understanding of the aims, objectives and whom to contact. There is inconsistency in people's ability to find and access information about those who sit on the Integration Joint Boards, how the boards operate, meeting papers minutes, and contact details for members, and how to become involved in the decision making process.

Progress has been made, with all 31 Strategic Commissioning Plans, Integration Schemes, and Annual Performance Reports available to the public on-line and accessible through the new Scottish Government web pages. I acknowledge though that there is further work to be done. At a local level we are aware that the Integration Authorities Chief Officer network has recently started to look at how they can work jointly to improve their profiles with the general public. This has included an audit of their web presences to ensure that all Integration Authorities are working towards a postion where the public get the best possible information relating to the integration of health and social care and the work that is underway within their local communities. Already many Integration Authorities have established their own websites and publish a range of accessible information on these, including all papers and agendas of the Integration Joint Board. Others have dedicated pages on either Local Authority or Health Board websites, where they currently publish information.

We are concerned that people have incurred financial costs associated with their participation in Integration Authorities, We ask the Cabinet Secretary for details of how she intends to address concerns, noting her comments representatives should be able to participate without detriment. (61)

Ensuring that all members of an Integration Authority do not suffer financial detriment for engaging in the process of health and social care Integration is very important. I have instructed my officials to liaise with the Chief Officer network to establish what Integration Authority members are entitled to claim expenses for and to ascertain the extent of this issue. It is important that we understand why this is occurring and whether variation in what can be claimed is occurring between local areas.

Ultimately, if required, I will ensure through guidance that all Integration Authority members are reimbursed for all reasonable travel and subsistence costs and any reasonable dependant-carer expenses incurred whilst undertaking duties and for support required to help you carry out their duties effectively.

Whilst there are examples of Integration Authorities ensuring that the additional needs of carers and service users are taken into consideration to facilitate meaningful engagement, we do not believe there is consistency across Integration Authorities in meeting these needs. We expect the additional support and accommodation needed to ensure the barriers to involvement to be provided across all Integration Authorities. We call upon the Scottish Government to indicate how it will ensure that this is achieved. (62)

The Public Bodies (Joint Working) (Scotland) Act 2014 places a duty on Integration Authorities - either Integration Joint Boards, or Health Boards and Local Authorities in a lead agency arrangement – to involve a range of service providers, service users and their carers, representative bodies, and professionals in the strategic commissioning process.

A key principle of the commissioning process is that it should be equitable and transparent, and therefore open to influence from all stakeholders via an on-going dialogue with people

who use services, their carers, providers, local communities and professionals. However we are aware that meaningful engagement with service users and their carers is variable across Scotland.

We are already working with Integration Authorities through the Chief Officers network to review progress on the strategic commissioning of new services, and to share good practice and lessons learned. Additionally, Healthcare Improvement Scotland is providing direct support to partnerships as integration beds in. Though this work we will look for opportunities to identify engagement best practice and share this learning across Integration Authorities.

We also hold development days with Chairs and Vice-Chairs of Integration Joint Boards. The issue of barriers to equal participation was raised at the most recent session on 31 October. We have undertaken to explore this further with this group, to identify and share areas of good and inclusive practice, particularly where carer and service user representatives have been provided with clear and accessible information in advance of board meetings in such ways as to enable to them to participate fully in board activity.

We recommend that each Integration Authority appoint a dedicated community development staff in their Integration Authority or Third Sector Interface accountable directly to the Chief Officer. We ask the Scottish Government how it could encourage and support such an approach to be taken by Integration Authorities (96)

Whilst we fully agree that improving the profile of public engagement should be a priority for Integration Authorities, we believe that this responsibility for this should lie more widely than with a single dedicated staff member. The Scottish Government believes that the responsibility for public involvement and engagement lies across Integration Authorities at all levels, and that the biggest impact on improvement in this area could come from Integration Authorities supporting staff at all levels to work collaboratively to improve public engagement.

Under the Public Bodies Act (Scotland) 2014 Local Authorities and NHS Boards have a duty to provide a range of support services to Chief Officers. We understand that the current levels of support provided vary across the country and would wish to seek a clearer understanding of this variation before supporting this recommendation.

The third sector has a vital role to play if the national outcomes for integration are to be achieved. It is important to recognise that the sector is vast, working across multi-disciplinary areas, with all ages, and is well placed to reach people and communities, which public sector partners are less able to reach. This is essential if we are to achieve truly co-produced health and social care services.

The role of the Third Sector Interface (TSI) is a very important one in terms of engagement with localities and Integration Joint Boards and ensuring third sector representation in decision making.

West Dunbartonshire is a good example of this, where they have Local Engagement Networks (LENs) which allows for both targeted and general engagement across localities supported by the Integration Authority and Community Voluntary Service in a partnership approach. Another example is from South Lanarkshire, where the TSI and Third Sector were fully engaged in the development of strategic plans and information collected from people at several events was used to prioritise the key themes under strategic commissioning.

The Scottish Government is working in partnership with the Scottish Health Council, CoSLA, Healthcare Improvement Scotland and The Health and Social Care Alliance to develop the Our Voice Integration Network. One of the aims of the Our Voice framework is to support people to engage meaningfully in decisions about local services. The Our Voice Integration Network is being developed to provide an opportunity for staff working in integration roles, and for service user, carer and third sector representatives, to share experiences and learning about good engagement practice across the integrated landscape. Three learning events for staff within Health and Social Care Partnerships who have engagement responsibilities are being held in November, in Glasgow, Inverness and Dundee. These events will provide opportunities to build relationships and share and celebrate good practice in engagement.

We also recognise that at times there will be challenging decisions to be made by Integration Authorities involving competing priorities, the priorities of the local community, financial proprieties and the priority to deliver the shift in the balance of care. In the Scottish Government's response to this report we request it provide further information on the guidance and assistance it provides to Integration Authorities in supporting their navigation through these often competing priorities. We ask the Scottish Government to provide further detail on the extent to which Scottish Government guidance is directed at shifting the balance of care and examples of this approach in operation. We also ask the Scottish Government how the shift in the balance of care is being measured and how it is to be specifically reported allowing the shift to be identified and collated. (100)

The Scottish Government fully recognises that Integration Authorities face a number of competing priorities and provide a range of guidance and assistance to navigate these competing priorities.

Integration Authorities now manage more than £8 billion of resources that were previously managed separately by the NHS and Councils. Almost half a billion pounds has already transferred from the NHS into social care. Our budget for 2017/18 transferred a further £107m from the NHS to health and social care partnerships, in addition to the £250m transferred in in 2016/17 which is now recurring, and the annual £100m integrated care fund and £30m to tackle delayed discharge.

Integration Authorities plan and design services that meet the needs of their local communities and we are supporting them to ensure the delivery of efficient integrated services that focus on the needs of service users. One of the underpinning principles of integration is to shift the balance of care for those whose wellbeing is best supported with care at home or in the community. This approach is embedded in the legislation and associated guidance and advice we provide.

We have published a range of guidance and advice that covers planning, measuring performance, finance, governance and working with partners. We also work closely with, and support, the Chief Officer Network group, Integration Managers Network, the Chief Finance Officer's network and Chairs and Vice-Chairs to discuss and address particular issues of concern from both parties.

We acknowledge that there is a need to accelerate progress and in late summer 2017 we started some work, which is still on-going, to consider issues mainly relating to governance and listen to concerns from partners over the practicalities of what is required to fully implement some key areas of the integration legislation.

Further work required to support the effective embedding of Health and Social Care Integration was set out in the Health and Social Care Delivery Plan, published in December 2016. Within this Plan we aim to reduce occupied bed days by 10 percent (around 400,000 bed days) by reducing avoidable admissions, delays and inappropriate long stay delays in hospital.

On a national level, Integration Authorities are sharing information with the Ministerial Strategic Group for Health and Community Care on their plans for improvement in a series of key and interdependent measures, including for unscheduled hospital admissions. This work includes reporting in-year progress on planned vs actual performance against these. This work, combined with the Source dataset and local improvement support team (LIST) analysts from Information Services Division (ISD), provide opportunities for benchmarking learning between Integration Authorities, which will help drive improvement.

The Scottish Government has funded ISD to provide data intelligence and support for Integration Authorities to allow them to monitor, evaluate and report progress locally. Integration Authorities have now published their Annual Performance Reports, which provide evidence of progress towards achieving the national health and wellbeing outcomes, alongside financial planning and impact. These include measures of the balance of care between institutional and community based services. We will be working closely with Integration Authorities and other key stakeholders on sharing learning from the first round of Annual Performance Reports.

We have seen significant progress on engagement and involvement of stakeholders in many Integration Authorities. However, as integration continues to bed in and evolve we acknowledge that there is still further work to be done to improve and embed a culture of openness and transparency with effective engagement and involvement practices being demonstrated by all Integration Authorities.

Best wishes.

Shona.

SHONA ROBISON

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 14 March 2018

Subject: Looking ahead to the Scottish Government Health and Sport Draft Budget 2018-19: A call for greater transparency.

1. Purpose

1.1 To bring to the Audit Committee's attention a report published by the Scottish Parliament Health and Sport Committee on 13 November 2017 and the Cabinet Secretary for Health and Sport related responses.

2. Recommendation

2.1 The Audit Committee is recommended to note this recent report published by the Scottish Parliament Health and Sport Committee, the Cabinet Secretary for Health and Sport's related responses and the commitment made to work together with Integration Authorities (IAs) and their partners to increase transparency around budgets and financial performance.

3. Background

3.1 The remit of the Scottish Parliament Health and Sport Committee is to consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Sport. The nature of this role means that it considers and scrutinises the Scottish Government's policies and expenditure in relation to a variety of matters of interest to the Partnership Board and its Audit Committee, including the overall health and social care integration agenda.

4. Main Issues

4.1 As part of its current work programme, the Committee prepared and published in November 2017 a report titled "Looking ahead to the Scottish Government Health and Sport Draft Budget 2018-19: A call for greater transparency" (Appendix 1).

4.2 The report was based on a catalogue of oral and written evidence from Integration Authorities, COSLA, CIPFA, health organisations, unions and health and social care providers.

4.3 It covered some recurring themes and issues around the establishment and performance of Integration Authorities including; budget transparency, budget setting processes, outcomes, set aside budgets, shifting the balance of care and long term budget planning.

4.4 The "Summary and Next Steps", found on page 20 of the report attached at Appendix 1, were mainly focussed on the need for greater transparency

around the £8billion of resources delegated to Integration Authorities and the need for clear leadership by Chief Officers and those leading IAs to address the challenges and barriers to change to ultimately shift the balance of care.

4.5 In December 2017 the Cabinet Secretary for Health and Sport published her formal response to this report (Appendix 2).

4.6 Ms Robison acknowledged that there was a need to review some of the original guidance around the setting of budgets, including set aside and informed the committee of plans to convene a group (Integration Finance Development Group) to undertake this work.

4.7 It was also made clear that IAs are local government bodies and as such are not required to report their performance directly to Scottish Government, however there was substantial amounts of very detailed financial information available publically ranging from annual audited accounts to regular in-year financial monitoring reports to IJB meetings.

4.8 The convenor of the Health and Sport Committee followed up with Cabinet Secretary by letter on 18 January 2018 (Appendix 3) and requested that further information be provided including:

- A consolidated report on integration authority spending (from February 2018);
- Information on mental health spending;
- Information on Alcohol and Drug Partnership budgets and spend;
- Primary care budgets and spend, including monitoring of the commitment to increase funding for primary care to 11% of the frontline NHS budget; and
- Community care budgets and spend, including monitoring of the commitment to spend more than half of “frontline spending” on community health services by the end of the Parliament.

4.9 The Cabinet Secretary formally responded on 8 February 2018 (Appendix 4) and the letter contained references to funding commitments around mental health and ADP budgets as already presented to the HSCP Board at its meeting of 14 February 2018.

5. People Implications

5.1 None associated with this report.

6. Financial Implications

6.1 Any financial implications around budget setting and funding will be covered in the regular financial performance reports to the HSCP Board.

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 None associated with this report.

10. Impact Assessments

10.1 None required.

11. Consultation

11.1 None required.

12. Strategic Assessment

12.1 The evidence, outcomes and responses provided by the appended documents will provide important information required to shape the financial arrangements of the HSCP Board in both the shorter to longer term.

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Appendices:
Appendix 1 – Looking ahead to the Scottish Government Health and Sport Draft Budget 2018-19: A call for greater transparency
Appendix 2 – Cabinet Secretary Response 12 Dec 2017
Appendix 3 – Convenor of H&S Committee follow up letter 18 Jan 2018
Appendix 4 – Cabinet Secretary follow up letter 8 Feb 2018

Background Papers: None

Wards Affected: All

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SP Paper 224
13th Report (Session 5)

The Scottish Parliament
Pàrlamaid na h-Alba

Health and Sport Committee
Comataidh Slàinte is Spòrs

Looking ahead to the Scottish Government Health and Sport Draft Budget 2018-19: A call for greater transparency

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Introduction

1. The Health and Sport Committee has adopted a full-year approach to the budget process. We have built an element of budget scrutiny into all aspects of our work. We have sought to remove the direct link between the Scottish Government's draft budget and our budget scrutiny with a view to using evidence gathered throughout the year to influence the content of future draft budgets and the relative priorities given to the health and sport elements.

2. In addition to this approach we have also conducted some specific pre-budget scrutiny work. We issued a call for written views in June 2017 and received 47 responses. On 12 September we took evidence from Integration Authorities, COSLA, CIPFA and representatives from professional health organisations and unions. On 19 September we took oral evidence from third sector and other health and social care providers as well as representatives from the health and sport sector focusing on the preventative agenda.

3. This report sets out some recurring themes and issues we have identified in relation to the Scottish Government's budget. The timing of this report, in advance of the publication of the Scottish Government's Draft Budget, is to enable the Scottish Government, if it chooses to endorse our recommendations, to implement them in its forthcoming draft budget 2018-19.

Budget Transparency

4. A recurring issue that we have highlighted repeatedly in previous Committee reports is a call for greater transparency and availability of information relating to the health and sport budget. This issue relates to the health and sport budget in general, but there are also specific issues relating to the new integration authorities (IAs). The move towards 'bundling' of health budget lines and delegation to local bodies, although motivated by a desire to increase local accountability, has acted to reduce transparency at a national level.

Integration Authorities (IAs) overall budgets

5. We have previously raised concerns regarding the lack of transparency regarding the overall budgets for each IA due to delays in IAs budgets being set.

6. Our *Health and Social Care Integration Budgets Report* published in November 2016 highlighted that Integration Authorities (IAs) had faced significant problems and delays in agreeing their budgets for 2016-17. [1]

7. The report detailed our disappointment that in the first full year of operation, the majority of IAs started the financial year without a financial budget in place. We also raised concerns some IAs had still not agreed their budgets by October 2017. [2]

8. We have been keen to monitor whether improvements have been made in the budget setting process for 2017-18.

9. In May 2017 we took oral evidence from four IAs. Three of the authorities (Angus, Shetland and Dumfries and Galloway) confirmed they had agreed their budgets for the current financial year. However, they went on to describe ongoing negotiations regarding the savings that were required and how these would be achieved.

10. Angus referred to the need to identify savings of £200,000 and a £1m shortfall on the prescribing budget for NHS Tayside; Dumfries and Galloway referred to a £5m gap in identified savings and Shetland referred to a £2.5m funding gap on the NHS side, equivalent to 6% of the IA budget. [3]

11. In oral evidence to the Committee in June 2017 the Cabinet Secretary for Health and Sport was asked about the budget setting process for IAs. She told us that in the current financial year there had been a "significant improvement" on the previous year. She explained that whilst in April 2016 only 11 of the 31 IAs had agreed their budgets for 2016-17, there were only seven IAs which had not agreed their budgets for the current financial year. [4]

12. The Cabinet Secretary detailed that the IAs that had yet to agree their budgets were the six Greater Glasgow and Clyde IAs and Fife IA. She explained in the case of the partnerships in the NHS GGC area, the issue was regarding non-recurring funding to be resolved from 2016-17. In Fife the issue was around the set-aside budget. The Cabinet Secretary emphasised that in both instances she expected the issues to be resolved soon. [5]

13. Following the Cabinet Secretary's evidence session we requested a breakdown of the £8.29bn figure she had provided for the IAs overall budget for 2017-18. The Cabinet Secretary's written response on 20 July 2017 stated—

> "Each Integration Authority will publish its 2017-18 budget in its Annual Financial Statement, which we expect to be by the end of July or shortly thereafter." [6]

14. Her letter also explained—

> "In the interim, we are working with the Chief Finance Officer network to obtain individual budget and savings information from each Authority and we will provide this to the Committee when it is complete." [7]

15. To date the Committee has not received this information.

Social care fund

16. Our Health and Social Care Integration Budgets Report published in November 2016 discussed the 2016-17 draft budget announcement of £250m social care fund to be allocated to IAs via health boards specifically to address social care. Our report raised concerns the late timing of the allocation of the social care fund and initial lack of clarity on how the funding was to be used presented real challenges for IAs in agreeing their budgets.

17. CIPFA explained in relation to the funding it was "allocated to health and then transferred across to the IAs and spent on the social care side of the budget". When asked whether they considered the funding was in two places CIPFA responded—

> "My view is that, yes it was in two places, because there was expenditure on the health side and there was expenditure on the local authority side as a result of that transfer taking place." [8]

18. Audit Scotland in its *NHS in Scotland 2017* report discussed the social care fund. Its report explained that whilst the funding was included in the health budget NHS boards were required to give the funding direct to IAs. Audit Scotland stated in their report "without this element of non-health funding, the health revenue budget decreased by one per cent in real terms between 2015/16 and 2016/17." Audit Scotland added "It is important that it is clear what is included in budget figures to ensure transparency and to help scrutiny take place." [9]

Timescales for agreement

19. When considering the reasons for the delay in IAs agreeing budgets, our *Health and Social Care Integration Budget Report* identified a key challenge was health boards and local authorities had different budget cycles.

20. Our report in November 2016 recommended the Scottish Government should make a clear commitment to ensure NHS boards set their budgets in alignment with local authorities. We called for the Scottish Government to work with NHS boards and

IAs to agree a new timetable for the budget setting process. We also called for the new timetable to detail the milestones needed to be achieved by specific points in the process and any changes the Scottish Government would need to make in its approach to signing off NHS board's Local Delivery Plans. [10]

21. The Cabinet Secretary's letter issued in response to our report, in December 2016, made it clear the Scottish Government did not believe there was a need for a new advice note at that stage. The letter explained this was because integration authorities were feeling more optimistic about timescales for agreeing their 2017-18 budgets. In addition the Scottish Government considered existing statutory guidance was sufficient and with early engagement locally between parties, the process would be more straightforward in the second year. [11]

22. However, evidence received during our pre-budget scrutiny work suggested there had still been challenges in the timescales for IAs to set their budgets in the second year of operation due to issues regarding alignment of the budget setting process between local authorities and health boards.

23. The Pain Association Scotland highlighted local authority budgets were set and agreed in December 2016 and NHS budgets set and agreed in February 2017. It explained in its written submission the differences in timescales meant there were challenges in agreeing IAs budgets prior to the start of the financial year. It noted the impact this had on third sector partners—

> "Such misalignment creates real difficulties in the commissioning of services from the Third Sector and hinders engagement of the Third Sector in the overall process of integration of health and social care." [12]

24. COSLA also raised the issue of misalignment of budgets. COSLA stated in oral evidence to the Committee "It would be helpful to try to bring together the timetables within which NHS and council budgets are determined and agreed". [13]

25. The Cabinet Secretary has suggested IAs have made improvements in setting their budgets in comparison to the previous year. However, whilst a global figure of £8.29bn for the overall budget for IAs has been produced, we have no breakdown of this figure to individual integration authority level. Scrutiny of IA budgets is as a consequence very challenging as there is little by way of information on the financial position of IAs even at the most basic level.

26. Over half way through the financial year we believe this lack of transparency regarding the allocation of over £8bn of public investment is unacceptable.In the Cabinet Secretary's letter to the Committee in July 2017 she stated that she would provide confirmation of agreed budgets for each IA when it was complete. We ask the Scottish Government for an explanation for why it has not been able to provide confirmation of agreed budgets for each IA at this stage in the financial year. We suggest this information is published as soon as possible and in advance of the publication of the Scottish Government's Draft Budget 2018-19.

27. We are concerned by the oral evidence we received from IAs which suggested some IAs' budgets had been agreed without confirmation of how required savings are to be achieved. We do not understand how this can be achieved and ask the

Scottish Government why it believes some IAs have adopted this approach. We ask the Scottish Government whether IAs are complying with the guidance the Scottish Government has provided on budget setting and whether it considers it acceptable that budgets are being agreed without savings being fully confirmed.

28. In November 2016 we called for action to be taken to address the mismatch between the budget setting process for health boards and local authorities. In response we received assurances the timescales for agreement of IA budgets in the second year of operation would improve with existing statutory guidance being sufficient to address the issue. However, we have continued to hear this mismatch remains and is resulting in challenges in budget setting for IAs. We are also concerned about the impact this is having on third sector organisations' ability to plan and engage with IAs.

29. We therefore remake our recommendation made in November 2016 that there should be clear commitments to ensure NHS boards set their budgets in alignment with local authorities. We reiterate our recommendation that the Scottish Government should work with NHS boards and IAs to agree a new timetable for the budget setting process. The new timetable should detail the milestones needed to achieve the above together with signing off of NHS boards' Local Delivery Plans. The Committee believes further action must be taken immediately to ensure this mismatch in budget setting between local authorities and health boards does not remain an issue into the next financial year.

30. We raised concerns in our Health and Social Care Integration Budgets Report on transparency of the social care fund. We therefore welcome and support the call made by Audit Scotland for transparency in relation to this funding stream to provide clarity and assist scrutiny.

Identifying budget allocations to health and sport

31. We have repeatedly raised concerns, most recently in our letter to the Cabinet Secretary in June 2017, that as there is little by way of comprehensive information on the financial position of IAs overall, it is difficult to track spend in specific areas. [14]

32. This is a theme several witnesses returned to in our pre-budget oral evidence sessions.

33. The Royal Pharmaceutical Society stated the budget was "not particularly transparent." It felt that it was not clear how the funding in the budget would contribute towards the achievement of the National Performance Framework Indicators. The Royal Pharmaceutical Society explained that where funding was not allocated to a particular funding stream, it was difficult to measure if investment was being made in areas it considered could lead to a positive outcome. [15]

34. The Scottish Association for Mental Health (SAMH) described the difficulties it faced in being able to track the national commitment to invest £150m in mental health

services. SAMH called for more “clarity and transparency” at IA and national level on investment. [16]

35. Marie Curie gave the example of the Scottish Government's Health and Social Care Delivery Plan. Marie Curie welcomed the Plan’s commitment to “doubling the palliative and end of life provision in the community, which will result in fewer people dying in a hospital setting”. However, Marie Curie highlighted there was no additional or specific financial resources being committed to support the delivery of palliative care services locally. Marie Curie explained IAs had been asked to find this resource from within existing budgets but it was concerned it had not found evidence IAs were recognising this commitment. [17]

36. The Health and Social Care Alliance added that when the Health and Social Care Delivery Plan had been published, a commitment had been made to produce a financial plan to accompany it. [18]

37. As a Committee one area of spend we have been particularly interested in is the budgets for Alcohol and Drug Partnerships (ADPs). We are aware that in order to obtain information on ADPs’ budgets it has been necessary to submit Freedom of Information requests.

38. In 2017-18 Scottish Government funding for ADPs was included in health board budgets with the expectation this funding would be delegated to IAs, which have responsibility for ADPs. Alcohol Focus Scotland highlighted this approach was making it increasingly difficult to track spend on addressing alcohol harm at local level. [19]

39. Alcohol Focus Scotland called for the budget and subsequent reporting mechanisms to be changed to enable the tracking of spend on alcohol harm from national to local level. [20]

40. We recognise the delegation of the majority of the health budget to health boards and now, in turn, to integration authorities, is aimed at ensuring funds are allocated in a way that best meets local needs. However, this local delegation makes it increasingly difficult to answer even the most basic of questions about how money is allocated. We are concerned by reports of the need to submit Freedom of Information requests to obtain information on the allocation of funding to specific areas.

41. The lack of access to information on funding allocations also presents a difficulty for us, as a Committee, in conducting our scrutiny function to determine the extent to which locally the allocation of the health and sport budget reflects the Scottish Government's stated priorities for health and sport. During the course of our most recent evidence sessions on the budget, stakeholders raised examples of the challenges faced in tracking spend on mental health, sport initiatives, palliative care and alcohol and drugs partnerships. We believe greater transparency and improved information on specific budget areas is required. We consider it essential the Scottish Government compiles and publishes data on spend on the main priority areas in the health portfolio including those areas highlighted to us during our budget scrutiny. We also request an update on when

a financial plan will be produced to accompany the Health and Social Care Delivery Plan.

Outcomes

42. Integration Authorities' activities are expected to contribute towards nine 'National health and wellbeing outcomes' and we believe it is essential to measure the extent to which Integration Authorities' budgets are contributing to this.

43. We have previously raised concerns as to whether this linkage between budgets and outcomes is being made by IAs. Our concerns first arose from the responses we received to our 2016 IA survey. Only one IA made any attempt to link their budgets to outcomes. The subsequent oral evidence we received from IAs on the issue suggested a lack of awareness and understanding of the need for such reporting by IAs.

44. In November 2016 our recommendations in our *Health and Social Care Integration Budgets Report* sought to ensure IAs provided this fundamental information which is vital to understanding the impact of and relationship between budget and outcomes. [21]

45. However, evidence we have received since November 2016 suggests that IAs continue to struggle with aligning budgets to outcomes. In May 2017 in oral evidence a selection of IAs each highlighted they had faced similar challenges in adopting this approach.

46. Dumfries and Galloway IA stated that its financial systems did not have the sophistication to provide the level of detail that was required to link finances to outcomes. However, it explained it was moving to a system that linked more closely with the nine national outcomes by using more long-term qualitative indicators. [22]

47. Other IAs appeared to be in a similar position. Angus IA told us "it has proved quite difficult to drill down to match the financial resources precisely with the nine national outcomes." [23]

48. Shetland IA explained "as far as detailed mapping between the finances and the national outcomes is concerned, we still do not have a sufficient level of detail. It is work in progress." [24]

49. A further evidence session with a selection of IAs in September 2017 suggested the challenges for IAs still remained. Whilst IAs emphasised the importance of focusing on achieving outcomes, IAs such as East Renfrewshire and Glasgow City told us they were still facing difficulties in achieving linkages with expenditure. [25]

50. Although IAs emphasised the difficulties in aligning budgets to outcomes, third sector organisations, including the Pain Association Scotland, highlighted they were required to adopt and achieve this approach—

> "Health and Social Care Partnerships have reported challenges in achieving linkage between budgets and performance framework. In reality, this is something which the Association is expected to do for all its funding and clearly list the outcomes to the objectives." [26]

51. Some IAs explained the benefits of calling on the support and expertise of other bodies in the development of work on assessing IA outcomes. Aberdeen City IA discussed Healthcare Improvement Scotland's work on its improvement hub to help the IA to evaluate the impact of some of the changes being made. [27]

52. Some IAs believed there was a need for direction from the Scottish Government for IAs to be able to achieve this linkage and create consistency of approach across IAs. East Renfrewshire IA told us that the issue of aligning budgets and outcomes was "something that everyone is struggling with" and called for the Scottish Government and IA Chief Finance Officers to work together to develop a national framework so there was consistency in the approach adopted. [28]

53. The Cabinet Secretary, in her letter of 20 July 2017, told us the Scottish Government was working with the Integration Authority Chief Finance Officer Network to develop a plan to link outcomes and budgets. [29]

54. We stated in our report *Health and Social Care Integration Budgets* in November 2016 that we recognise there are challenges associated with measuring and collating information on the linkage between budgets and the performance framework. However, we remain of the view these challenges are not insurmountable. We note those in the third sector are required to achieve linkage between funding and outcomes and we believe IAs should be able to achieve this too. We also note that this is a statutory duty on the IAs.

55. IAs are managing over £8bn of public spending and we do not consider it acceptable there is a lack of assessment of the outcomes of this spending. We believe the primary responsibility rests with IAs to ensure this assessment is conducted. We are very concerned IAs are taking allocation and investment decisions without assessing, or even possessing the ability to assess the relationship between and effectiveness of spending on outcomes.

56. We also recognise, as we previously did in our *Health and Social Care Integration Budgets Report,* that there is a key role for the Scottish Government to provide IAs with clear parameters within which to measure and quantify IA budgets against specific outcomes. In particular we believe there is a role for the Scottish Government to collate and publish information across all IAs to ensure there is some consistency in approach to enable comparative information to be obtained. The complete lack of benchmarking or assessment of performance across IA must be addressed. Only in this way can efficiencies and best practices be identified.

57. The Scottish Government must have confidence its priorities are being met. There is currently very little data on the overall performance of IAs or information on how they are allocating their money. The inability of the Scottish Government

to evaluate IAs' performance against its own priorities cannot be desirable, an issue which must be resolved as a matter of priority.

58. We are pleased to learn the Scottish Government is working with the Integration Authority Chief Finance Officer Network to develop a plan to link outcomes and budgets. We ask the Scottish Government in advance of publication of the Scottish Government's Draft Budget to provide an update on this work together with a detailed timetable setting out how the concerns we have raised will be resolved.

59. There needs to be clear leadership provided by the Chief Officers of each IA in line with direction provided by the Scottish Government to drive change forward and ultimately ensure delivery. IAs are accountable for the spending of over £8bn of public money and the current difficulties they are facing in reporting against outcomes cannot be allowed to continue indefinitely.

60. An aspect of consideration of the link between budgets and outcomes is about ensuring value for money. We note that figures on spending on health per person in 2015-16 show that Scotland spent £2,258 per person in comparison to England's £2,106 and an overall spend of £2,121 per person in the UK. We ask the Scottish Government what assessment it conducts regarding the value for money that is being achieved through its higher level of spend on health per person in Scotland relative to the UK as a whole.[i]

[i] Latest year for which comparable figures are available -These are taken from HM Treasury's Public Expenditure Statistical Analyses 2017, table 9.15 (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/629966/PESA_2017_Chapter_9_Tables.xlsx

Budget Setting Process

Direct funding

61. The issue of whether IAs should receive direct funding from the Scottish Government was raised in our evidence session with IAs in May 2017. Following this session we asked the Cabinet Secretary for her view on its use. In her letter of July 2017 she stated clearly "at this stage, the Scottish Government does not intend to move to direct allocations". She explained this would be a significant change and "would signal a shift away from the principles of shared local and central ownership that are central to integration". Her letter also explained there would be a number of practical implications in relation to VAT and the suitability of existing allocation formulae. [30]

62. The issue of direct funding was again discussed at our oral evidence sessions on pre-budget scrutiny in September 2017. COSLA made clear it did not support this approach. It stated that the on-going partnership between the NHS and local government was "an essential ingredient" in the successful delivery of health and social care. [31]

63. In oral evidence, Aberdeen City IA stated it had "mixed feelings about direct allocation". It believed it would simplify lines of accountability as currently managing budgets across three organisations "is time consuming and hugely complex". However it felt that there were benefits to operating collectively, particularly as other funding streams, especially within a local authority, were also focused on addressing IA objectives of reducing health inequalities. [32]

64. Some IAs suggested there should be further consideration given to the use of direct allocations as it could be a route to addressing some of the current issues with the financing and management of funding for integration authorities.

65. East Renfrewshire IA suggested that direct allocation of funding to IAs could be a potential way to addressing the continued perception of 'health' and 'social care' funding as two distinct streams. East Renfrewshire stated that currently "the funding is not losing its identity as was the intention and by default it becomes difficult to then achieve truly integrated outcomes". [33]

66. East Renfrewshire IA noted the concern that if the IA decided on a substantial shift in resource from a council budget to an NHS budget, it could make it more challenging the following year to ensure the council gave the IA additional funding. East Renfrewshire explained that in this situation the council could be resistant to providing funding because it would think it was subsidising NHS budgets. [34]

67. East Renfrewshire also suggested it was difficult to see how the current issues could be addressed without either IAs receiving a direct allocation of resource or indicative future settlements. [35]

68. CIPFA presented a similar view. CIPFA suggested the current approach to allocating funding to IA was "convoluted" and that it was difficult for the funding to 'lose its identity' as IAs had to work "with two ledgers and two sources of funding,

and we are having to report back under those two arrangements." CIPFA told us it supported further exploration of direct funding of IAs. [36]

69. We note the views expressed by some IAs that there continues to be a perception of 'health' and 'social care' funding as two distinct streams. Two years into the operation of IAs, we are concerned funding for IAs is still failing to 'lose its identity' as the legislation on integration intended.

70. We note the reasons given by the Cabinet Secretary for not moving to direct allocations at this stage. We also note the comments made by others about the current approach to encouraging different parties to operate collectively. However, concerns around the current allocation of funding to IAs remain.

71. The current system continues previous tensions between local authorities and health boards. This situation is one of the key areas the legislation was intended to resolve and remains a barrier to the success of health and social care integration.

72. We ask the Scottish Government to indicate how it envisages the desired 'loss of identity' of IA funding sources being achieved in order to ensure true integration of funding.

Set aside budgets

73. The set aside budget (sometimes referred to as the unscheduled care budget) is the budget which is retained by NHS boards for larger hospital sites which provide integrated and non-integrated services. Set aside only applies to "large hospitals" i.e. hospitals providing care to patients from more than one partnership.

74. Audit Scotland's December 2015 report *Health and Social Care Integration* highlighted there were specific difficulties in agreeing these set-aside budgets, despite the Scottish Government issuing specific guidance. Audit Scotland explained that a fundamental concern was the risk NHS boards may regard the funding as being under their control, making it difficult for IAs to use the money to shift from acute hospital care to community-based and preventative services. [37]

75. We received evidence the concerns expressed by Audit Scotland in 2015 regarding the operation of the set aside budget still remained and may be a barrier to integration.

76. COSLA emphasised that under The Public Bodies (Joint Working) (Scotland) Act 2014, the hospital set aside budgets were under the discretion of the IAs. However, COSLA was critical of the NHS's approach to set aside budgets. It suggested there were occasions when the NHS was unwilling to transfer these budgets to IAs and that this could ultimately hinder integration. [38]

77. East Renfrewshire IA also raised concerns about the set aside budget as a potential barrier to integration "The set aside budget is still 'notional' with recognition

nationally that this requires significant progressions; this does limit the priority to shift resource from acute to community services." [39]

78. CIPFA acknowledged in oral evidence that further work was required around the set aside budget and there had not been the progress in this area that it would like to see. In written correspondence following a committee meeting, the CIPFA representative, who is employed by Glasgow City IA, when asked about savings resulting from reduced delayed discharge, commented that "unfortunately the set aside arrangements are not yet working and there has been no saving transferred to the IA." [40]

79. The Cabinet Secretary in her letter of 20 July 2017 acknowledged there was scope for improving the set aside budget arrangements. She explained a review was being conducted involving her officials, Integration Authority Chief Finance Officers, Chief Officers and Health Board Directors of Finance. The review would inform discussions at the Ministerial Strategic Group for Health and Community Care with a view to ensuring that IAs had control over hospital budgets for unscheduled care. [41]

80. IAs are facing problems with respect to set aside budgets. The evidence we have received highlights the legislative requirements on how the set aside budget should operate is not properly reflected in current practice, with one IA going so far as to state the set aside arrangements are not yet working. In the context of savings resulting from reductions in delayed discharge, the Committee understands that due to the set aside arrangements not working as intended, the IA is not currently benefiting from any savings delivered. We are very concerned by this situation and believe the current operation of set aside budgets presents a barrier to the success of integration. We believe this needs to be addressed as a matter of urgency and clear direction provided by the Scottish Government on how it can be ensured IAs have control over hospital budgets for unscheduled care.

81. We therefore welcome the Scottish Government's review of set aside budget arrangements. We ask the Scottish Government in response to this report to detail the findings of the review and what actions have been taken by the Ministerial Strategic Group for Health and Community Care as a result to ensure set aside budgets will operate effectively.

NHS and social care staff pay

82. The Scottish Government has announced that it intends to end the 1% public sector pay cap in 2018-19.

83. UNISON welcomed the announcement and told us—

> "We want there to be a significant increase in pay this year. If we are to tackle some of the long-standing issues in attracting people into the sector, we need to do more." [42]

84. The RCN also supported the Scottish Government's commitment to ending the 1% pay cap, but noted that—

> "unless staff are appropriately remunerated, as well as being given the time and support to develop, issues around recruitment and retention within nursing teams will persist." [43]

85. We welcome the Scottish Government's announcement about ending the 1% public sector pay cap. We ask the Scottish Government, in its response to this report, to detail whether the budget allocated to NHS boards will take into account the increased costs of a higher pay settlement or whether the expectation is that costs will be met from existing budgets.

Sleepovers

86. We have continued to pursue with the Scottish Government its progress on delivering the Scottish Living Wage to staff employed to provide sleepover care.

87. Following our most recent request for an update, the Cabinet Secretary's letter of July 2017 detailed that in partnership with COSLA it had developed a template to enable IAs to provide for their area the actual cost data for extending the Living Wage commitment to sleepover hours.

88. On 19 October 2017 the Scottish Government announced that in 2018/19 Care workers will now be paid the real Living Wage for sleepover hours. [44]

89. The Coalition of Care and Support Providers in Scotland raised concerns regarding the Scottish Government's statement. It stated—

> "The gap between current pay for sleepovers and the Living Wage is far in excess of anything we've tried to address up to this point, but the statement is completely silent on what it will cost, where the money will come from or how it will reach employers" [45]

90. We ask the Scottish Government if the data has now been received from each IA to determine the actual cost of extending the Living Wage to sleepover provision in each authority and how this will be funded. We ask the Scottish Government to respond to the concerns raised by the Coalition of Care and Support Providers in Scotland regarding the resources required to deliver on its commitment to provide the Living Wage for sleepover hours in 2018/19.

Long-term budget planning

91. We highlighted in our *Health and Social Care Integration Budgets report* that uncertainty regarding longer-term funding for IAs presented challenges to them developing long term strategic plans.

92. This concern was raised again in the evidence we received on pre-budget scrutiny. COSLA told us “a short-term input focused budget process is an inhibitor to genuine reform.” [46] RCN raised similar concerns and supported the call for a three-year planning cycle because “at the moment, the constant annual cycle requiring budgets to break even does not allow a step change to come to fruition over a number of years.” [47]

93. SAMH highlighted the difficulties for the third sector in having short-term budgets. SAMH explained that it made it difficult to recruit and retain staff and that it was hard for people who were using services to feel safe and secure about their long-term provision. [48] Marie Curie expressed a similar view and detailed the advantages of long-term contracts “We have more time to innovate, develop, redesign and invest in services as we go along” [49]

94. Audit Scotland has repeatedly argued more generally for longer-term budgeting in government, not just with regard to the health and sport portfolio, and reiterated these points to us in its written submission. The Healthcare Financial Management Association in its written submission highlighted the Nuffield Trust's comment in its Learning from Scotland report “Scotland has yet to produce a multi-year national analysis that sets out how much funding will be available, how much needs to be saved and what services will be undeliverable as a result of this at a regional level.” [50]

95. The Scottish Government has committed previously to looking at a longer time frame for the budget process. In the Cabinet Secretary's letter of 20 July 2017 she referred to the findings and recommendations of the Budget Process Review Group which included moving to a longer time frame in the budget process. The Review Group recommended that the Scottish Government prepares and publishes a medium-term financial strategy, setting out its expectations and broad financial plans/projections for at least five years ahead. However in relation to annual budget-setting, the Review Group's report also noted "the timing of the UK budget affects when the Scottish Government will be in a position to produce its own firm budget proposals [...]" . [51]

96. The Cabinet Secretary's letter detailed there was an expectation that the Finance and Constitution Committee and Scottish Government would make joint recommendations to the Parliament for a new budget process. [52]

97. The benefits of developing long-term budget planning for the health and sport portfolio and for all portfolios in the Scottish Government budget are clear. We believe it would assist long term planning which in turn would support effective decision taking and delivery of the Scottish Governments Performance Framework. We are not alone in our call for this change to be made, with the Budget Process Review Group and Audit Scotland also arguing its merits. We believe the Scottish Government should take steps to implement this approach and would expect future draft budgets to move to a longer time frame. We note the comments made by the Budget Process Review Group that the timing of the UK budget affects when the Scottish Government is in a position to produce its

own firm budget proposals and recognise this is a factor impacting on definitive long-term budget planning.

Shifting the balance of care

Achieving change

98. IAs have been tasked with delivering transformational change to the provision of health and social care. In our 2016 report *Health and Social Care Integration Budgets* we recognised that shifting resources and care to the community sector would require time to be achieved. We noted in our report the expectation that in the next financial year there should be evidence of changes made in the allocation of resources. [53]

99. However, we received evidence that challenges in achieving this transformational shift in the balance of care remain.

100. Some organisations called for transitional funding to be provided to enable the shift in the balance of care to be delivered.

101. Organisations including the BMA told us that to move services into the community setting required capacity to first exist in community health services. The BMA suggested this required some initial 'double running' of services so that patients were unaffected. [54]

102. RCN Scotland also questioned whether a shift in resource was "possible in the current climate" given what it described as the pressure on acute services. RCN Scotland also called for a double funding arrangement so that the "step change" required could be delivered. [55]

103. Social Work Scotland noted that whilst the Scottish Government's former change funding had initially been used to fund prevention initiatives, as budget pressures had increased it had been subsumed into normal funding to support mainstream care services. [56]

104. We received some suggestions from organisations including COSLA that additional resources would be required to deliver the desired pace of change in shifting the balance of care. [57]

105. Aberdeen City IA told us that whilst it had ambitions to change services, it had to be realistic about the pace of the change. It explained that it had forecast some significant pressures on its budget, which it had put reserves aside for, but this would impact on its ability to deliver transformational change in its services. [58]

106. CIPFA detailed that "a number of IAs had modelled the level of additional resources required to meet cost and demand pressures, with estimates between 3% (for 2018/19) and 14% (over two years) of existing budgets". [59]

107. A range of organisations have questioned whether sufficient funding has been provided to deliver the desired pace of change in shifting the balance of care. Funding concerns centre on the current pressures on acute services and the need for dual running of some services in the acute and community sector until the shift in the balance of care is achieved. CIPFA has highlighted that a number of IAs have modelled the level of additional resources required to meet cost and demand pressures. We ask the Scottish Government for its comments on the analysis conducted by IAs regarding their requirement for additional resources. We also ask whether the Scottish Government agrees that double-running of services is required and how the costs of this should be addressed. We believe clearer direction must come from the Scottish Government regarding how integration authorities can navigate these financial challenges to enable the pace of change to be accelerated and delivered to ensure integration is a success.

Measuring change

108. We have been keen to assess whether changes are being made in the allocation of resources with a view to achieving the Scottish Government's stated aim by the end of this Parliament to have at least 50% of spending taking place in the Community Health Service.

109. In our report *Health and Social Care Integration Budgets,* we called upon the Scottish Government to provide a breakdown of the respective shares of the budgets it would expect to see IAs allocate to community and institutional care in the next financial year.

110. In October 2016 our letter to the Scottish Government regarding our short piece of work on delayed discharge stated that delivering reductions in the number of delayed discharges would be a key marker of the success of the new integrated system.

111. The Cabinet Secretary's response in November 2016 explained that some partnerships had used parts of their delayed discharge allocations for preventative measures. In addition an early analysis of the £100m per year Integrated Care Fund suggested that 20% was being used for prevention and anticipatory care. The Cabinet Secretary highlighted that the first IA Performance Reports were due to be published in July 2017. [60]

112. Now that the first IA Performance Reports have been published we ask the Scottish Government for an assessment of how it believes IAs are performing in delivering the shift in the balance of care. We ask the Scottish Government what the respective shares of the budgets it had expected each IA to allocate to community and institutional care in their first and second years of operation. We also ask the Scottish Government how each IA has performed against these expectations. We also ask for the Scottish Government in responding to this report to detail its projections for IAs' performance in the next financial year. Local authorities and health boards have an equal role to play in ensuring a shift in the

balance of care and we ask how their performance in this regard is being assessed.

113. Reductions in delayed discharges are a key indicator of whether shifting the balance of care is being delivered. Some IAs are performing better than others in tackling the issue of delayed discharges. We ask the Scottish Government for its views on why this variation continues and ask specifically if those areas which are performing better are investing more of their delayed discharge allocation in preventative measures. We ask the Scottish Government what barriers the IAs are reporting in shifting their resource to this approach.

114. We also would like to take up the Scottish Government's offer to provide a detailed analysis of the £100m per year Integrated Care Fund to assess how much was spend on preventative and anticipatory care.

Preventative spend

115. As we have noted in our November 2016 report *Health and Social Care Integration Budgets,* ultimately shifting the balance of care is about moving resources towards preventative spending. [61]

116. As part of our strategic plan which sets out our 'aim to improve the health of the people of Scotland' we have committed to scrutinising policy issues in relation to their preventative focus.

117. Several responses to our call for views welcomed the increased focus and investment in preventative measures. However, the responses also suggested there was a need to further increase investment. The Scottish Directors of Public Health stated—

> "Achieving the appropriate rebalancing of the Draft Budget between prevention and health and social delivery remains a challenge. Progress is being made, but perhaps clearer guidance on what proportion of financial efficiencies should be invested in work to address health inequalities may be a useful tool. Such efficiencies are possible." [62]

118. Alcohol Focus Scotland also suggested there were opportunities to generate more income to be spent on preventative measures. It noted its disappointment that the Public Health Supplement had not been renewed on its expiry in 2015. Alcohol Focus suggested that the reintroduction of the supplement could generate additional income which in turn could be invested in tackling and preventing health-harming behaviours. [63]

119. Sport was a specific area suggested as meriting increased investment due to the benefits it brought as a preventative spending measure. COSLA summarised the role of sport as a preventative measure in its written submission

> "Sport brings undoubted health and wellbeing benefits and encourages healthy active lives, supporting mental as well as physical health and promoting communities." [64]

120. In oral evidence, COSLA provided the specific example of cases in West Lothian of individuals with depression being prescribed a six-week course at a local fitness centre run by West Lothian Leisure rather than them being prescribed medication. [65]

121. The Scottish Sports Association called for there to be increased recognition that an individual's level of physical activity and sport can impact on their life expectancy. The Scottish Sports Association believed an increase in the budget allocated to sport and physical activity would assist in delivering the Scottish Government's identified priorities of reducing inequality and focusing on prevention and early intervention. It cited research findings that an estimated £77m per year could be saved in the treatment of heart disease, diabetes, cerebrovascular disease, gastrointestinal cancer and breast cancer through physical activity and sport. [66]

122. Some witnesses raised concerns that the benefits sport delivers could be affected if the recommendations in the Barclay review group were implemented. The Barclay review group has recommended leisure trusts and sports facilities should no longer be excluded from paying business rates. The Scottish Sports Association stated this could amount to a potential £45m cost to local sport and leisure trusts. [67] Unison Scotland believed if the Barclay review group's recommendations were implemented and local authorities did not meet any shortfall there would be a "big cut" in sport and leisure facilities. [68]

123. We received evidence that there were challenges faced in both adopting a preventative approach and evaluating the benefits of its use. The Royal College of Physicians of Edinburgh told us that whilst it had called for increased investment in preventative activities, one issue was that it took longer to see the results of investment in prevention compared with investment in what it termed 'repair' spending, i.e. to deal with short term health problems. [69]

124. The Scottish Directors of Public Health also suggested that 'the bar was set much higher' for adopting preventative interventions than clinical interventions, and added "preventative measures sometimes involve people's personal decision making or the decision making of a population, which are areas into which people sometimes do not want to go-certainly the media makes it difficult to do so" [70]

125. There are clearly benefits to adopting a preventative approach in relation to health and sport spending. To further encourage a shift towards this type of spending these benefits need to be clearly identified, recognised and actively promoted. We believe more needs to be done to quantify the financial and practical benefits of long-term investment in preventative healthcare for the people of Scotland. This would ensure there is proper acknowledgement that areas of spending such as physical activity and sport have a positive impact on addressing issues of health inequalities and improving an individual's life expectancy.

126. As we stated in our *Health and Social Care Integration Budgets* report we are keen to understand what level of funding is being allocated to preventative policies, and how this is being evaluated and its cost effectiveness assessed. We call upon the Scottish Government to provide details of how this information can be included within future draft budget documents.

Summary and next steps

127. It is our task to monitor the spending of in excess of £8billion by the IAs, to evaluate how this is being undertaken and we are disappointed at the apparent lack of progress in the true integration of budgets. We have heard each blaming the others for the lack of progress. At a basic level it is unacceptable 2 years[ii] on that it is impossible to evaluate spending, or begin to evaluate outcomes.

128. IAs are the vehicle which have been tasked to deliver the shift in the balance of care. In this report we have identified some of the challenges which are being faced by IAs including areas such as the setting of budgets, measuring the outcomes of their investment and shifting resource to ensure transformational change in health and social care. These are issues which the Committee has returned to several times in the last two years.

129. In order to be a success it is vital that IAs tackle these challenges. We have the clear sense these matters are being allowed to drift and are repeatedly told change in the NHS takes time. After two years we expected to have seen more progress towards meeting the aims Parliament endorsed when passing the legislation.

130. There needs to be clear leadership provided by the Chief Officers of each IA in line with direction provided by the Scottish Government to drive this change forward and ultimately ensure its delivery. IAs are accountable for the spending of over £8bn of public money and the current difficulties they are facing cannot be allowed to continue indefinitely.

131. We remain concerned those leading IAs require to rise to and address the challenges preventing change from occurring. In our view that is their fundamental challenge and one upon which we expect to see significant progress being made forthwith.

132. Finally we are disappointed at the absence of data to identify and evaluate outcomes, including spending and savings. To our mind this would be unacceptable in any small organisation never mind ones responsible for this level of public money. This requires to be rectified immediately and a mechanism for facilitating scrutiny and benchmarking established.

[ii] We include in this period the 12 months provided for set up.

Annex A - Minutes of Meeting

15th Meeting, 2017 (Session 5) Tuesday 30 May 2017

1. Draft Budget 2017-18: The Committee took evidence from—

- Keith Redpath, Chief Officer, West Dunbartonshire Health and Social Care Partnership;
- Vicky Irons, Chief Officer, Angus Health and Social Care Partnership;
- Katy Lewis, Chief Finance Officer, Dumfries and Galloway Health and Social Care Partnership;
- Karl Williamson, Chief Finance Officer, Shetland Health and Social Care Partnership (via video conference).

4. Draft Budget 2017-18 (in private): The Committee considered the evidence heard earlier in the meeting.

16th Meeting, 2017 (Session 5) Tuesday 13 June 2017

12. Integration Authorities Engagement with Stakeholders and Draft Budget 2017-18: The Committee took evidence from—

- Shona Robison, Cabinet Secretary for Health and Sport;
- Geoff Huggins, Director for Health and Social Care Integration;
- Christine McLaughlin, Director of Health Finance, all Scottish Government.

14. Integration Authorities Engagement with Stakeholders and Budget 2017-18 (in private): The Committee considered the evidence heard earlier in the meeting.

16. Draft Budget 2018-19 (in private): The Committee considered and agreed its approach.

19th Meeting, 2017 (Session 5) Tuesday 12 September 2017

3. Draft Budget 2018-19: The Committee took evidence from—

- Sharon Wearing, Chief Finance and Resources Officer, CIPFA IJB Chief Finance Officer Section;
- Judith Proctor, Chief Officer, Aberdeen City Health and Social Care Partnership;
- Julie Murray, Chief Officer, East Renfrewshire Health and Social Care Partnership;
- Councillor Peter Johnston, Health and Wellbeing Spokesperson, COSLA;

and then from—

- Rachel Cackett, Policy Adviser, Royal College of Nursing Scotland;

- Elaine Tait, Chief Executive Officer, Royal College of Physicians of Edinburgh;
- Jill Vickerman, National Director, BMA Scotland;
- Dave Watson, Head of Policy and Public Affairs, UNISON Scotland;
- Dr Miles Mack, Chair, RCGP Scotland.

4. Draft Budget 2018-19 (in private): The Committee considered the evidence heard earlier in the meeting.

20th Meeting, 2017 (Session 5) Tuesday 19 September 2017

3. Draft Budget 2018-19: The Committee took evidence from—

- Andrew Strong, Assistant Director (Policy and Communications), Health and Social Care Alliance Scotland (the ALLIANCE);
- Aileen Bryson, Interim Director for Scotland, Royal Pharmaceutical Society;
- Richard Meade, Head of Policy and Public Affairs, Marie Curie;
- Carolyn Lochhead, Public Affairs Manager, SAMH;

and then from—

- Dr Andrew Fraser, Director of Public Health Science, Scottish Directors of Public Health;
- Kim Atkinson, Chief Executive Officer, Scottish Sports Association;
- Sheila Duffy, Chief Executive, ASH Scotland;
- Alison Douglas, Chief Executive, Alcohol Focus Scotland.

5. Draft Budget 2018-19 (in private): The Committee considered the evidence heard earlier in the meeting.

24th Meeting, 2017 (Session 5) Tuesday 31 October 2017

5. Draft Budget 2018-19 (in private): The Committee considered a draft report and agreed to consider a re-draft of the report at its next meeting.

25th Meeting, 2017 (Session 5) Tuesday 7 November 2017

4. Draft Budget 2018-19 (in private): The Committee considered and agreed a revised draft report.

Annex B - Evidence

Written Evidence

- ASH Scotland
- Audit Scotland
- Mark Miller
- Scottish Directors of Public Health
- NHS Tayside Directorate of Public Health
- Community Pharmacy Scotland
- Marie Curie
- Royal College of Physicians Edinburgh
- Pain Association Scotland
- UNISON Scotland
- Healthcare Financial Management Association
- BMA Scotland
- NHS Borders
- British Dental Association
- National Community Hearing Association
- High Life Highland
- Paths for All
- NHS Lanarkshire Directorate of Public Health
- Royal Pharmaceutical Society
- Bliss Scotland and TAMBA
- Fields in Trust
- North Ayrshire Health and Social Care Partnership
- Medtronic
- NHS Fife
- the ALLIANCE

- Arthritis Research UK
- The British Association for Counselling and Psychotherapy
- East Renfrewshire Health and Social Care Partnership
- sporta
- Scottish Association for Mental Health (SAMH)
- Live Active Leisure
- Glasgow Life
- Royal College of Paediatrics and Child Health Scotland
- Royal College of Nursing Scotland
- Scottish Professional Football League Trust
- Alcohol Focus Scotland
- Soil Association Scotland
- VOCAL
- Scottish Children's Services Coalition
- CIPFA IJB Chief Finance Officer Section and CIPFA
- NHS Lothian Public Health and Health Policy
- Social Work Scotland
- RCGP Scotland
- Professor Graham Watt
- Alzheimer Scotland
- Scottish Sports Association
- COSLA

Additional Written Evidence

- Alcohol Focus Scotland
- ASH Scotland
- Scottish Association for Mental Health (SAMH)
- Scottish Directors of Public Health
- East Renfrewshire Health and Social Care Partnership
- CIPFA IJB Chief Finance Officer Section and CIPFA

Correspondence with the Cabinet Secretary for Health and Sport

- Letter from Cabinet Secretary to the Convener - 18 November 2016
- Letter from Cabinet Secretary to the Convener - 15 December 2016
- Letter from the Convener to the Cabinet Secretary - 20 June 2017
- Letter from Cabinet Secretary to the Convener - 20 July 2017

Official Reports of Meeting

Tuesday 30 May 2017 - Evidence from stakeholders

Tuesday 13 June 2017 - Evidence from the Cabinet Secretary

Tuesday 12 September 2017 - Evidence from stakeholders

Tuesday 19 September 2017 - Evidence from stakeholders

1 Health and Sport Committee. 2nd Report, 2016 (Session 5). *Health and Social Care Integration Budgets* (SP Paper 44).

2 Health and Sport Committee. 2nd Report, 2016 (Session 5). *Health and Social Care Integration Budgets* (SP Paper 44).

3 Health and Sport Committee. *Official Report 30 May 2017.*

4 Health and Sport Committee. *Official Report 13 June 2017*, Col 35.

5 Health and Sport Committee *Official Report 13 June 2017,* Col 34-35.

6 Letter from Cabinet Secretary for Health and Sport, 20 July 2017.

7 Letter from Cabinet Secretary for Health and Sport, 20 July 2017.

8 Health and Sport Committee. *Official Report, 12 September 2017*, Col 10.

9 Audit Scotland. (2017) *NHS in Scotland 2017*

10 Health and Sport Committee. 2nd Report, 2016 (Session 5). *Health and Social Care Integration Budgets* (SP Paper 44).

11 Letter from Cabinet Secretary Health and Sport 15 December 2016.

12 The Pain Association. Written submission.

13 Health and Sport Committee, *Official Report, 12 September,* Col 17.

14 Letter from Health and Sport Committee to Cabinet Secretary for Health and Sport. 20 June 2017.

15 The Royal Pharmaceutical Society. Written submission. Health and Sport Committee. *Official Report, 19 September 2017,* Col 27.

16 Health and Sport Committee. *Official Report, 19 September 2017*, Col 27.

17 Health and Sport Committee. *Official Report, 19 September 2017*, Col 26-27. Marie Curie. Written submission.

18 Health and Sport Committee. *Official Report, 19 September 2017*, Col 27-28.

19 Alcohol Focus Scotland. Written submission.

20 Alcohol Focus Scotland. Written submission.

21 Health and Sport Committee. 2nd Report, 2016 (Session 5). *Health and Social Care Integration Budgets* (SP Paper 44).

22 Health and Sport Committee. *Official Report, 30 May 2017*, Col 18.

23 Health and Sport Committee. *Official Report, 30 May 2017*, Col 19.

24 Health and Sport Committee. *Official Report, 30 May 2017*, Col 19.

25 Health and Sport Committee. *Official Report, 12 September 2017,* Col 22.

26 Pain Association Scotland. Written submission.

27 Health and Sport Committee. Official Report, 12 September 2017, Col 26.

28 Health and Sport Committee. *Official Report, 12 September 2017,* Col 22.

29 Letter from Cabinet Secretary for Health and Sport, 20 July 2017.

30 Letter from Cabinet Secretary for Health and Sport, 20 July 2017.

31 Health and Sport Committee. *Official Report, 12 September 2017*, Col 8.

32 Health and Sport Committee. Official Report, 12 September 2017, Col 19.

33 East Renfrewshire Integration Authority. Written submission.

34 Health and Sport Committee. Official Report, 12 September 2017, Col 7.

35 East Renfrewshire Integration Authority. Written submission.

36 Health and Sport Committee. *Official Report, 12 September 2017,* Col 7-8, 10.

37 Audit Scotland. (2015) *Health and Social Care Integration*, paragraph 74.

38 Health and Sport Committee. *Official Report, 12 September 2017*, Col 8.

39 East Renfrewshire Integration Authorities. Written submission.

40 CIPFA. Further written evidence.

41 Letter from Cabinet Secretary Health and Sport 20 July

42 Health and Sport Committee. *Official Report, 12 September 2017*. Col 46.

43 RCN. Written submission.

44 Scottish Government. 19 October 2017 Pay Boost for Carers. https://news.gov.scot/news/pay-boost-for-carers

45 CCPS Scotland. 19 October 2017 CCPS Responds to announcement on living wage for overnight support. http://www.ccpscotland.org/wp-content/uploads/2017/10/Press-Release-19th-October.pdf

46 Health and Sport Committee. *Official Report, 12 September 2017*, Col 5.

47 Health and Sport Committee. *Official Report, 12 September 2017*, Col 45.

48 Health and Sport Committee. *Official Report, 19 September 2017*, Col 28.

49 Health and Sport Committee. Official Report, 19 September 2017, Col 29.

50 The Healthcare Financial Management Association. Written submission.

51 Letter from Cabinet Secretary for Health and Sport, 20 July 2017.

52 Letter from Cabinet Secretary for Health and Sport, 20 July 2017.

53 Health and Sport Committee. 2nd Report, 2016 (Session 5). *Health and Social Care Integration Budgets* (SP Paper 44).

54 BMA. Written submission.

55 Health and Sport Committee. Official Report, 12 September 2017, Col 45.

56 Social Work Scotland. Written submission.

57 Health and Sport Committee. Official Report, 12 September 2017, Col 17.

58 Health and Sport Committee. Official Report, 12 September 2017, Col 19.

59 CIPFA. Written submission.

60 Letter from Cabinet Secretary November 2016.

61 Health and Sport Committee. 2nd Report, 2016 (Session 5). *Health and Social Care Integration Budgets* (SP Paper 44).

62 The Scottish Directors of Public Health. Written submission.

63 Alcohol Focus Scotland. Written submission. Health and Sport Committee. *Official Report, 19 September 2017*, Col 57.

64 COSLA. Written submission.

65 Health and Sport Committee. *Official Report, 12 September 2017,* Col 10, 11.

66 Scottish Sport Association. Written submission. Health and Sport Committee. *Official Report, 19 Sept Col* 43, 46.

67 Health and Sport Committee. *Official Report, 19 September 2017*, Col 41.

68 Health and Sport Committee. Official Report, 12 September 2017, Col 43-44.

69 Health and Sport Committee. Official Report, 12 September 2017, Col 32.

70 Health and Sport Committee. Official Report, 19 September 2017, Col 53.

Cabinet Secretary for Health and Sport
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Mr Neil Findlay MSP
Convener
Health and Sport Committee

By Email.

12 December 2017

Dear Neil,

Thank you for your letter of 10 November 2017 and the accompanying report. The comments and recommendations set out in the report have been fully considered as part of the planning work that has been undertaken for the Health and Sport Portfolio in advance of the publication of the 2018 19 Draft Budget on 14 December 2017.

Integration Finance Development Group

A number of the recommendations made in the report relate to Integration Authorities – including the setting of budgets and reporting of savings, as well as how more specific issues are being managed, such as set aside budgets. While guidance in relation to these areas was issued when Integration Authorities were established, after nearly two years of Integration Authorities functioning, I recognise that some areas would benefit from review and clarification. As a result, the Director of Health Finance at the Scottish Government will convene a group (Integration Finance Development Group) to undertake work in this area, looking at where partnerships are experiencing common challenges. The group will include representatives from Chief Officers, Chief Finance Officers, Local Government Directors of Finance, NHS Directors of Finance, COSLA, Audit Scotland and CIPFA and will begin meeting from January. I will ensure that outputs from this group are shared with the Committee.

2017 18 Budgets and Reporting of Financial Performance

You asked specifically about the budgets set in 2017 18 and level of savings required. Integration Authorities are local government bodies and are not required to report their performance to Scottish Government. Regulations include provisions to ensure that proper reporting of financial information is made publically available. In addition to publication of their annual audited accounts, every year, each Integration Authority publishes its budget in an Annual Financial Statement and during the year financial performance reports are published regularly along with other papers from Integration Joint Board meetings; and an Annual Financial Report is included in the Annual Performance Report which is published within three months of the end of the financial year. The legislation requires sufficient information on the budget and financial performance of each Integration Authority to be in the public domain. However, despite all of this available information, I agree that it is currently difficult to obtain a collective view, or oversight, of Integration Authorities' financial position as to do so would currently require accessing thirty one separate reports.

My officials are therefore working with the Integration Authority Chief Finance Officer (CFO) CIPFA section who are developing a template for a statement of budgets and savings for all Integration Authorities and a template for regular in-year financial reporting for all Integration Authorities, which will then be shared with Scottish Government, the Committee and others. The statement of budgets is complete and subject to approval by the CFO section at their next meeting on 19 December 2017. The financial performance report template is being developed and will be in place for the new financial year.

Regulations require that each Integration Authority includes in its Annual Performance Report information on expenditure on various care groups and services. As part of the work referred to above, to produce consolidated financial reports, my officials will work with the CFO CIPFA section to include collective information on expenditure on services and care groups of interest to the committee and others.

Outcome Budgeting

I wish to thank the Committee for their positive feedback on the important work that has commenced in relation to outcome budgeting. CIPFA has been commissioned to identify options for a methodology to facilitate outcomes budgeting reporting. Integration Authority Chief Officers and Chief Finance Officers are fully committed to driving this forward in partnership with CIPFA and the agreement of a methodology is a key step in the process that will ultimately provide further assurance of value for money. This is expected to be a challenge to existing financial reporting processes for Health Boards, Local Authorities and Integration Authorities and my officials will keep the Committee informed of progress.

Living Wage/Sleepover Provision

As part of the 2017-18 budget £10 million was allocated to support the extension of the Living Wage in Care commitment to sleepover hours. This was on the basis that further work would be carried out in-year to understand if further resource would be required to deliver this on a full year basis. In partnership with COSLA we developed a template which was circulated to Health and Social Care Partnerships to enable us to understand the financial and policy impact of extending the Living Wage commitment to sleepover hours. This has allowed partnerships to provide us with actual cost data for their area enabling us to inform a decision nationally on whether any additional financial resource is required. Through this work we have identified that the full year cost of delivery would be £20 million, including resource for the inflationary increase to the new Living Wage rate. Therefore, requiring an additional £10 million in 2018 19 to fully extend the commitment. Scottish Government and COSLA Officials have agreed this amount as an accurate reflection of the anticipated costs to deliver on the extension of this commitment.

Committee Appearance

I am aware that I am due to give evidence to the Committee on 9 January 2018 in relation to the Draft Budget, and will use that opportunity to discuss some of the issues raised in more detail. As I hope you will understand, there are some areas – such as in relation to NHS and social care staff pay – where it would be inappropriate for me to offer detailed comment in advance of the Draft Budget announcement.

I would like to thank the Committee for their report and look forward to providing further evidence in the New Year.

Best wishes,

Shona,

SHONA ROBISON

The Scottish Parliament
Pàrlamaid na h-Alba

Cabinet Secretary for Health and Sport

Issued via email

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18 January 2018

Dear Shona

Thank you for your letter of 12 December 2017 to my predecessor detailing the Scottish Government's response to the Health and Sport Committee's report *Looking ahead to the Scottish Government Health and Sport Draft Budget 2018-19: A call for greater transparency* and the oral evidence you provided to the Committee at its meeting on 9 January 2018 on the Scottish Government's Draft Budget 2018-19.

We welcome your recognition of the concerns raised in our report regarding the need for greater transparency in the budget data currently provided. The evidence session was a useful and productive one for exploring your commitment to provide further information on future spending plans and the collation and publication of further budget data. This letter seeks further clarification from you regarding some of these commitments. This letter also sets out how we would wish this further data to be presented to best assist the Committee to perform its scrutiny function.

During the evidence session, a number of references were made to data that was being collected and that could be made available to the Committee to support better scrutiny. These included:

- A consolidated report on integration authority spending (from February 2018)
- Information on mental health spending
- Information on Alcohol and Drug Partnership budgets and spend
- Primary care budgets and spend, including monitoring of the commitment to increase funding for primary care to 11% of the frontline NHS budget
- Community care budgets and spend, including monitoring of the commitment to spend more than half of "frontline spending" on community health services by the end of the Parliament

The exact format, coverage, timing and frequency of reporting was not clear from the evidence session. In particular, it was unclear whether the reporting would relate specifically to integration authorities or whether it would – where appropriate – cover the wider health budget. The Committee would welcome clarity on these issues and welcomes the offer made during the evidence session for the Committee to provide comment and feedback on the proposed reporting framework. With regard to the headline commitments, clarification of definitions used would also be helpful.

Mental health remains a key area of interest for the Committee. We note the comments that the Scottish Government will be monitoring closely whether there is a real terms increase in mental health spend at a health board/integration authority level. We ask for the quarterly consolidated report to detail if this requirement is being met. We also request that this quarterly report contain an assessment of performance against the mental health waiting time target. (Col 22, 25-26). As discussed at the evidence session it would also be helpful to have a breakdown of the annual planned increase over the five year period in the mental health workforce to ensure the commitment to have 800 additional workers in mental health is delivered within this timeframe. (Col 26).

We believe there is merit in assessing the total spend on mental health, not only that allocated under the mental health budget. Conducting this type of analysis would provide a more comprehensive assessment of where money is being spent in mental health provision and assist in evaluating how this contributes to the desired outcomes for mental health. We therefore wish to accept the offer that has been made for the Scottish Government to commission this analysis of mental health spending. (Col 28)

The Committee discussed with you at the evidence session the lack of transparency on ADP funding and the difficulty this causes in scrutinising budgets in this priority area. We welcome the commitment you made at the meeting to publish further information on ADP budgets. We would like to request that the published information covers the total budgets of the ADPs, including income from all sources. It is our understanding that this information is already collected by the Scottish Government. (Col 28-29)

The development of a financial framework was referenced during the course of the evidence session. It was explained that in the medium term the Scottish Government

envisaged this would set out expenditure on and reform of health and social care and shifting the balance of care. We highlighted in our report the Budget Process Review Group recommendation that such plans should set out expectations and board financial plans/projections for at least five years ahead. Are you able to confirm the time frame the financial framework for health and social care will cover and when it will be published? (Col 13)

We welcome the comments made that a capital investment strategy is being developed along with a national infrastructure board aimed at prioritising investment at a national level. Are you able to provide further detail regarding when it is expected the board will be operational and when a capital investment strategy will be published? (Col 11)

There was also some discussion around NDP and PFI health projects. Christine McLaughlin noted that it would be helpful to look at the way in which NPD projects operate compared with earlier PFI deals and also commented that work earlier this year had involved review of the earlier PFIs. She also noted that this review work had generated “almost another £1 million just from looking at the annual contract values”. The Committee would welcome any further information that can be provided on this issue, which is of considerable interest to Committee members.

There were two further requests for further information made by Committee members during the evidence session. You offered to provide clarification on whether sportscotland’s funding allocation incorporated capital spend. You also discussed the resourcing and approach being taken to reduce reliance on nurse agency spending and it would be much appreciated if further detail could be provided on this issue in response to this letter.

As stated we welcome and support the steps being taken by the Scottish Government to increase and enhance the information provided on the health and sport budget. We believe this will greatly assist our future scrutiny of the Scottish Government’s budget.

Yours sincerely

Lewis Macdonald MSP
Convener of the Health and Sport Committee

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Mr Lewis Macdonald MSP
Convener
Health and Sport Committee

8th February 2018

Dear Lewis,

Thank you for letter dated 18 January 2018. I have set out below some further detail and clarification in response to the questions and points raised in your letter.

I appreciate the importance of supplying the Committee with further financial information, and agree that it was useful to discuss this in greater detail at the meeting of the Committee on 9 January 2018.

Much of the financial information that has been requested relates to responsibilities delegated to Integration Authorities, and as I said at Committee, a consolidated report is now being developed which will mean that the position across all Integration Authorities will be regularly reported on a consistent and consolidated basis. This report is currently being developed by Integration Authorities and is due to be available from the end of March. Once this is complete it will be sent to the Committee.

Given the Committee's particular interest in mental health and spending by Alcohol and Drugs Partnerships, it should be noted that information in relation to spend in these areas will be included as part of this report sent to the Committee. The responsibilities in these areas, for adults and where relevant for children, now sit with Integration Authorities.

As the key Programme for Government commitments regarding shifting the balance of care are set out in the context of frontline NHS spending, a working group has been established to monitor progress and delivery of these commitments. This will allow more detailed reporting and quarterly forecasting to commence as part of Health Boards' regular financial reporting from the first quarter of 2018-19. Practical local approaches to these commitments are set out in Integration Authorities' individual strategic commissioning plans, financial statements and annual performance reports. The Ministerial Strategic Group for Health and Community Care receives regular updates on Integration Authorities' progress in this regard.

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Mental health spending and commitment to increase workers

Between now and 2021-22, 800 additional mental health workers will be employed to improve access to dedicated mental health professionals across key settings including A&E, GP practices, police station custody suites and prisons. The Scottish Government's Draft Budget for 2018-19 includes an additional £12 million to be made available to support the first phase of this commitment. The phased approach will allow local and national service providers to coordinate service developments to provide effective models of care and efficient use of resources.

The level of additional funding to support this commitment will increase to £35 million by 2021-22. This approach will enable the workforce to be built up in a sustainable way which reflects the evolving needs of people across Scotland.

The commissioning and service delivery landscape for mental health continues to evolve as partners work at national, regional and local level to agree and deliver innovative and effective solutions. Therefore, our approach to delivering the commitment is through facilitating the national and local discussions needed, but not to direct the detailed planning.

We will monitor delivery of the commitment by working with our partners to identify and record the recruitment of the 'additional' workforce. This will allow scrutiny of the phased budgets allocations, the location of the additional workforce and the number of this additional workforce. The Minister for Mental Health will provide an update on progress to the Committee in April 2018.

Alcohol and Drugs Partnerships

The funding in 2017-18 of £53.8 million for drug and alcohol treatment services is provided to Alcohol and Drug Partnerships (ADPs) via Integration Authorities in their delegated budgets from NHS Boards. These resources are supplemented by additional contributions from others, including local authorities, primary care, criminal justice and others. As I have set out above, the Committee will receive, by the end of the financial year, further detail on spend in this area by Integration Authorities.

The additional £20 million that was announced as part of the Programme for Government is to support work to foster improvement and innovation in the way that services are developed and delivered as part of the new substance use strategy. The strategy is being developed and I will write to the Committee when we are making Boards aware of their individual allocations and any associated Ministerial expectations.

Financial framework

The financial framework, to be published in the spring, will underpin the strategic direction of travel set out in the Health and Social Care Delivery Plan. This framework will cover the next five years, with a key focus on shifting the balance of care towards community health services. My officials will engage with the Committee in its development.

Capital investment strategy

We will be establishing a National Infrastructure Board to be operational in 2018-19, providing strategic leadership and expertise in driving forward a National Strategy for infrastructure change. It will also provide national oversight on the continued safe and effective operation of the retained estate.

NPD and PFI projects

Health Facilities Scotland (HFS) manages a Specialist Support Team (SST) which provides expert advice to NHS Boards on Public Private Partnership contracts (PFI, PPP, NPD and hub). The SST has focussed on work such as the development of standard KPIs, lifecycle management and the development of guidance materials. Collaboration and peer support is also a key area of focus for the practitioners group in order to maximise the opportunities for the application of best practice and standardised ways of working.

The SST completed the work plan for Financial Year 2016-17 and identified £1.6 million in non-recurring financial benefits and £1.9 million of recurring financial benefits. These financial benefits have been delivered via the Boards' participation in the annual work plan and through their own contract management initiatives. Examples of benefits include over £0.3 million for NHS Lothian arising from changes to car park income arrangements and £0.15 million for NHS Forth Valley arising from contract management savings.

Sportscotland funding allocation

I can confirm that the Sportscotland budget is entirely a revenue allocation.

Agency spending

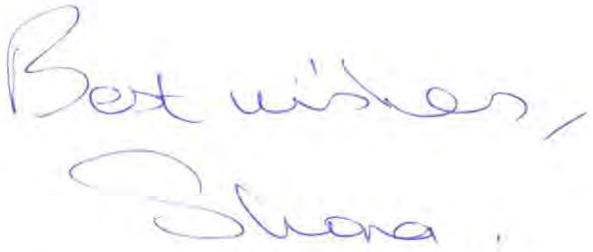
As I mentioned at the Committee session, there has been a reduction in agency spend. This was noted in the Audit Scotland *NHS in Scotland 2017* Report, which confirmed that spending decreased by 3% in real terms between 2015-16 and 2016-17.

The Scottish Government remains committed to reducing the reliance on agency staff, and has taken action to address this, with further development of the Staff Bank Network including establishing Regional Staff Banks. This means NHS Boards now have access to over 35,000 nurses and 2,900 doctors who are registered on the Staff Bank, providing better value for money than agency staff. Strengthened governance arrangements also mean that agency staff are only used as a very last resort. The majority of agency staff are sourced through our national framework contract, which limits those agencies on the contract to paying staff NHS rates of pay.

In terms of ongoing work in this area, a dedicated team based in NHS National Services Scotland is working directly with NHS Boards to help reduce spend and reliance on agency staff. Directed by a governance group that is chaired by the Chief Executive of NHS Education for Scotland, the group has identified, commissioned and implemented various workstreams which are focused on reducing spend and reliance on agency staff.

Conclusion

I trust the above is useful to the Committee and, as I confirmed when I gave evidence, further information will be provided on a regular basis to support you in your work.



SHONA ROBISON

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP

Audit Committee: 14 March 2018

Subject: Provision of Taxi Services for non-scheduled and scheduled taxi journeys for the Community Health and Care Partnership

1. Purpose

1.1 The report seeks Audit Committee approval to proceed with a re-tendering process to secure Taxi Services for non-scheduled and scheduled taxi journeys to predominately support the Health and Social Care Partnership services, as part of a co-ordinated arrangement between the Council and the Health Board.

2. Recommendations

2.1 The Audit Committee is asked to approve the following recommendations approve:

2.1.1 That a tender exercise in line with European legislation and Council Standing Orders involving a Dynamic Purchasing System (DPS) be advertised in the Official Journal of the European Union (OJEU) and Public Contracts Scotland to obtain non-scheduled and scheduled taxi journeys for Council and Health Board premises located in the West Dunbartonshire area, for an initial fixed 5 year period with a further potential 5 years agreed on an year by year decision;

2.1.2 That authority be delegated to the Chief Officer of the Health and Social Care Partnership, to accept the most economically advantageous tender/s received and appoint a successful tenderer or tenderers; and

2.1.3 At the end of the fixed agreement period, the Chief Officer of the Health and Social Care Partnership should review the position and consider whether to extend the contract for a maximum of a further additional 5 year period on an year by year decision.

3. Background

3.1 At the Community Health and Care Partnership Committee on 18 February 2015 approval was given for a re-tendering process to secure Taxi Services for non-scheduled and scheduled taxi journeys to support the Health and Social Care Partnership services, as part of a co-ordinated arrangement between the Council and the Health Board.

3.2 On completion of the re-tendering process a Framework Agreement was put in place with three companies; Clydebank & District T.O.A., Dumbarton & Alexandria T.O.A. and Wrights Taxis to provide this service for an initial 2 year contract period with a potential extension to be agreed annually. The current Framework Agreement expires on 31st July 2018. In order to secure contracts for 2018/19 and beyond, it is now necessary to begin the re-tendering process.

3.3 Continued cross sector collaboration with Greater Glasgow & Clyde Health Board for this Taxi service, via a formal tender route for both parties, can be viewed as a positive demonstration of partnership working for the Health and Social Care Partnership. Prior to the current agreement being put in place Greater Glasgow & Clyde Health Board had no formal contract in place covering the Dumbarton and Vale of Leven area.

3.4 West Dunbartonshire Council's Legal, Democratic & Regulatory Services, Corporate Services' Procurement Team and Head of Procurement for Greater Glasgow & Clyde Health Board have been consulted regarding this potential collaboration work and have no objections.

4. Main Issues

4.1 The current framework agreement is made up of 4 Lots:

Lot 1 - Provision of a taxi service, with or without escort, in and from the Clydebank area.
Lot 2 - Provision of a taxi service, with or without escort, in and from the Dumbarton area.
Lot 3 - Provision of a taxi service, with or without escort, in and from the Alexandria area.
Lot 4 - Provision of a taxi service for transfer of records or samples from Health Board premises located in West Dunbartonshire area.

4.2 It is proposed that the re-tendering process will again be made up of the same 4 Lots. The HSCP Quality Assurance team, supported by West Dunbartonshire Council's Legal, Democratic Regulatory Service, Corporate Services' Procurement Team and Greater Glasgow Clyde Health Board's Procurement Team will control and monitor the re-tendering process throughout. Tenderers will be able to bid for a single, two or all of the Lots.

4.3 As a result of the anticipated contract spend exceeding the EU Public Procurement threshold of £181,302 for the life of the contract, the Council must comply with appropriate public procurement procedures.

4.4 Given the number of anticipated bidders for the tender and that the contract value will exceed the EU Procurement Threshold it is advised that the re-procurement procedure will use the Dynamic Purchasing System (DPS) and the Public Contract Scotland portal to both advertise and award the tender.

4.5 The DPS procurement procedure allows for longer contract duration and the opportunity by any new provider who comes into the local market of joining the agreement and possibly offering lower rates. Interested parties will submit information in response to set tender questions. Their tender responses will be evaluated and through delegated authority as per 2.1.2 the successful bid/s will be accepted and issued with an Invitation to join the agreement.

4.6 The contract duration would be for a fixed 5 year agreement period. West Dunbartonshire Council will review the position and reserve the right, at the discretion of the Chief Officer of the Health and Social Care Partnership, to decide

whether to cancel or extend the contract for a further fixed period on an annual basis for up to a maximum of 5 years.

4.7 A wide section of services within West Dunbartonshire HSCP currently make use of the existing framework agreement. The main users of the service are: Community Care Teams, Adult Services, Older People Services, Children's Services, Children with Disabilities and Care at Home.

4.8 Contractors, currently on the framework, transport service users, with or without escort, from pick-up point to destination when booked by designated West Dunbartonshire Council Officers. Typical journeys are to and from schools, college, health centres, hospital, respite locations, Council services and offices within the West Dunbartonshire Council boundaries. There are also some planned journeys taking service users to services located out with West Dunbartonshire.

4.9 Greater Glasgow & Clyde Health Board journeys are mainly the transfer of personnel, records or samples; blood etc. from the Vale Hospital and from Health Centres, Dumbarton Joint Hospital and other Health Board premises located in the Dumbarton and Vale of Leven area.

5. People Implications

5.1 There are no personnel issues in this tender. The Framework Agreement will be managed by existing staff.

6. Financial Implications

6.1 The 2015 spend for non-scheduled and scheduled taxi usage was £151,355.49. For 2016 it was less at £123,778.58.

6.2 As the contract value of the combined services over the term of the contract exceeds the threshold identified at 4.3, we are required to follow guidance relating to the European Procurement Thresholds.

7. Professional Implications

7.1 There are no professional implications associated with this report.

8. Locality Implications

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

9. Risk Analysis

9.1 Failure to proceed with the retendering exercise will result in current contracts terminating on 31st July 2018. This will result in a return to the previous situation where any Taxi firm/driver can provide the service. There would be no agreed fixed rates per journey, visibility on mileage rates, escort rates, and offer the opportunity to provide volume discounts to the Council. It could compromise the safety of staff and the general public should a company provide a taxi driven by an individual who does not have Disclosure Scotland Certificate.

10. Impact Assessments

10.1 There is no change from the previous February 2015 report seeking agreement to retender when no issues were identified in screening for potential equality impacts.

11. Consultation

11.1 The re-tender will be undertaken with the guidance and assistance of staff West Dunbartonshire Council's Legal, Democratic & Regulatory Service, Corporate Services' Procurement Team and Greater Glasgow & Clyde Health Board's Procurement Team.

12. Strategic Assessment

12.1 The Council's Strategic Plan 20127/22 has the strategic has "Support Individuals, families and carers living independently and with dignity" as one of the strategic priorities.

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Date: 19 January 2018

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Appendices: None

Background Papers: Tender Committee Report: Provision of Taxi Services for non-scheduled and scheduled taxi services for the Social Work and Health Department (June 2010)

Tender Committee Report: Provision of Taxi Services for non-scheduled and scheduled taxi services for the Social Work and Health Department (June 2011)

Community Health and Care Partnership Committee Report: Tender for provision of non-scheduled and scheduled taxi services (February 2015)

Wards Affected: All