Agenda

West Dunbartonshire
Health & Social Care Partnership

West Dunbartonshire Health & Social Care Partnership Board

Date: Wednesday, 19 February 2020

Time: 14:00

Venue: Council Chamber, Clydebank Town Hall, Clydebank

Contact: Gabriella Gonda, Committee Officer
Tel: 01389 737183 Email: gabriella.gonda@west-dunbarton.gov.uk

Dear Member

ITEMS TO FOLLOW

I refer to the agenda for the above meeting which was issued on 6 February and now enclose copy of Item 6, Appendices 1 and 2 to Item 8 and Item 16 which were not available for issue at that time.

Yours faithfully

BETH CULSHAW

Chief Officer of the Health &
Social Care Partnership

Note referred to:-

6 2020/21 ANNUAL BUDGET SETTING UPDATE 199 - 217

Submit report by the Chief Financial Officer providing the latest position on the 2020/21 budget setting excercise.

8 THEMATIC REVIEW OF SELF-DIRECTED SUPPORT IN SCOTLAND; WEST DUNBARTONSHIRE LOCAL PARTNERSHIP REPORT

Appendices 1 and 2 219 - 252

Submit report by the SDS Lead Officer updating on progress relating to the Improvement Plan which was agreed following Care Inspectorate Thematic Review of self-directed support in West Dunbartonshire.

15 REVIEW OF INTEGRATION SCHEME

Appendix 1 to follow

Submit report by the Interim Head of Strategy, Planning and Health Improvement providing an update on the work ongoing in West Dunbartonshire to review and update the Integration Schemes between West Dunbartonshire Council and the Health Board.

16 MEETING DATES OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BOARD 253 - 255

Submit report by the Chief Financial Officer presenting a request to add two further meeting dates to the 2020/21 schedule.

Distribution:-

Voting Members

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

Non-Voting Members

Barbara Barnes
Beth Culshaw
Jo Gibson
Jonathan Hinds
Chris Jones
John Kerr
Helen Little
Diana McCrone
Anne MacDougall
Kim McNab
Peter O'Neill
Selina Ross
Julie Slavin
Val Tierney

Senior Management Team – Health & Social Care Partnership

Date of issue: 17 February 2020

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

19 February 2020

Subject: 2020/21 Annual Budget Setting Update

1. Purpose

1.1 To provide the Health and Social Care Partnership Board with the latest position on the 2020/21 budget setting exercise.

2. Recommendations

2.1 The HSCP Board is recommended to:

- Note the 2020/21 budget update in relation to our partner bodies' indicative budget offers.

3. Background

3.1 This report provides an update on the latest information on 2020/21 revenue budget implications following the Scottish Government's indicative budget settlement offer to local authorities and health boards on 6 February 2020 and the implications for funding in integration authorities.

3.2 The main drivers from growth are: pay and price (including prescribing) inflation, activity demand and demographic impact and take account of the budget pressures identified within the regular financial performance update report, in particular the impact of increasing demand within: Children and Families community and residential placements; and Care at Home. The impact being estimated annual growth rate of 2.3% in health care services and 5.0% in social care services. The social care growth rate is inclusive of the 2019/20 budget pressures impacting on 2020/21 and will be addressed going forward.

4. 2020/21 Budget Setting Update

4.1 The Scottish Government announced details of their 2020/21 finance settlements on 6 February 2020 and they are appended to this report:

- Appendix 1 – Letter from the Minister for Public Finance and Digital Economy sets out the details of the local government finance settlement for 2020/21; and

- Appendix 2 – Letter from the Interim Director of Health Finance and Governance sets out the details of the 2020/21 indicative budget allocation for Health Boards.

4.2 The Scottish Government's budget was presented in the context of the UK Government's decision to defer its budget and the requirement on local authorities to set their council tax for the next financial year before the 11 March (Local Government Finance Act 1992). This obliged the Scottish Government make significant changes to the 2020/21 budget process which has been done with support from the Scottish Government Finance and Constitution Committee (F&CC). The compressed timetable agreed should see the Budget Bill passed on 5 March 2020 (the week before the UK Budget on the 11 March 2020) and provides for Royal Assent by 30 March 2020:

- Thursday 6 February – Budget and Budget Bill;
- Wednesday 12 February F&CC oral evidence Cabinet Secretary;
- w/b 17 February – Subject Committee oral evidence Scottish Ministers;
- w/b 24 February – Conveners' Debate;
- Thursday 27 February – Stage 1 Debate;
- Wednesday 4 March – Stage 2 at F&CC; and
- Thursday 5 March – Stage 3 Debate and approval

4.3 The late UK Budget has required the Scottish Government to present tax and spending plans for Scotland without certainty over the fiscal position in 2020/21. While the budget contains the Scottish Government's best estimate, minimum level of funding that will be available to them in 2020/21 updated economic forecasts and Block Grant Adjustments will only be available when the UK Budget is published.

4.4 The Scottish Government budget uses provisional forecasts as the basis for setting budgets, in line with the up to date forecasts of devolved tax income and social security expenditure undertaken by the Scottish Fiscal Commission. In addition assumptions have been made about the Barnett Consequentials that will be added to the Scottish Block as a result of the UK Budget and decisions have been taken about devolved tax policy without knowledge of future UK policy.

4.5 Social Care

4.6 The key funding messages from the 6 February letter (Appendix 1) are:

- £100m to be transferred from the health portfolio to local authorities in year for investment in health and social care and mental health services that are delegated to Integration Authorities under the Public Bodies (Joint Working) (Scotland) Act 2014.

- This includes a contribution towards continued delivery of the real Living Wage (£25m), uprating of Free Personal and Nursing Care Payments within the National Care Home Contract (£2.2m), implementation of the Carers Act (£11.6m) and further support for school counselling services (£4m). As with 2019/20 the school counselling funding will be transferred directly to Education.

4.7 While Finance Circular 1/2020 provides details on the total revenue support grant funding for West Dunbartonshire Council, the distribution of the £100m has yet to be clarified. The anticipated funding allocation of £96m (excluding school counselling) is detailed in Table 1 below.

Table 1 – Additional Investment in Health & Social care 2020/21

Funding	Scotland (£m)	WDC (£m)	Distribution Information
Investment in Integration	**57.2**	0.982	Confirmed within Finance Circular 1.72%
Scottish Living Wage	**25.0**	0.429	Confirmed within Finance Circular 1.72%
Free Personal and Nursing Care (within NCHC)	**2.2**	0.021	Confirmed within Finance Circular 0.95%
Carer's Act	**11.6**	0.200	Confirmed within Finance Circular 1.72%
Total	**96.0**	**1.632**	

4.8 The Minister also states:

"*The funding allocated to Integrated Authorities should be additional and not substitutional to each Council's 2019/20 recurring budgets for social care services that are delegated. Similarly, the £4 million for school counselling services must be additional. This means that when taken together, Local Authority social care budgets for allocation to Integration Authorities and funding for school counselling services* ***must be £100 million greater then 2019/20 recurring budgets***."

4.9 The Strategic Lead – Resources presented a report on "*Long Term Financial Strategy Refresh and General Services and Housing Revenue Account Estimates Update 2020/21 to 2022/23*" at the West Dunbartonshire Council meeting of 27 November 2019. This report detailed anticipated Social Care funding for 2020/21 to 2022/23 based on a range of assumptions contained within the refreshed Long Term Financial Strategy.

4.10 The indicative 2020/21 budget allocation included pay award funding at 3% and £0.217m in relation to School Counselling which has since been transferred to Education.

4.11 Since the November report a further update on the General Services budget position was been provided to Council on 29 January 2020. This report advised of further funding for pay awards for the HSCP of £1.1m for 2022/23,

but no changes to indicative funding for 2020/21 or 2021/22. The Council will consider the impact of the local government finance settlement for 2020/21 at the Council meeting on 4 March 2020, which will include a confirmed funding offer to the HSCP Board.

4.12 An Elected Members Bulletin was issued on 12 February 2020 and is included as a background paper to this report. This Bulletin advised Members that the reduction in Council funding for 2020/21 is 0.24% worse than anticipated. There is the potential (based on the Long Term Finance Strategy) for this reduction to be passed through to the HSCP which could result in a decrease in anticipated revenue budget funding for 2020/21 of £0.131m.

4.13 Discussions with the Council are ongoing and until a confirmed funding offer is made at the Council meeting on 4 March this report is based on the indicative 2020/21 funding allocation of £69.367m (figure not adjusted for potential settlement impact advised at 4.12). At this level the social care budget allocation falls significantly short of the draft 2020/21 social care budget of £70.903m, resulting in an indicative budget gap of £1.536m as detailed in Appendix 3. Table 2 below summaries the indicative budget gap for 2020/21 along with further anticipated budget gaps for 2021/22 and 2022/23.

Table 2– Social Care Budget Gaps 2020/21 to 2022/23

	2020/21 (£m)	**2021/22 (£m)**	**2022/23 (£m)**
Indicative / Draft Budget	70.903	72.880	74.967
Indicative Funding	69.367	69.683	70.258
Annual Budget Gap	**1.536**	**3.197**	**4.709**
Cumulative Budget Gap	**1.536**	**4.733**	**9.442**

4.14 The HSCP Board Meeting scheduled for 25 March will be provided with a range of options that may be required to close the confirmed 2020/21 budget gap and will include:

- Application of unapplied 2019/20 Investment in Integration funding;
- Alignment of new funding for Carers Act and Free Personal Care;
- A number of management efficiency targets aligned to the focus of work assigned to the three service improvement lead officers being:
  - Children & Families Fieldwork
  - Learning Disabilities
  - Care at Home
  - HSCP Digital Maximisation and Admin review

- A case by case review of all care packages where Ordinary Residence processes can be invoked. This would result in non WDHSCP's being liable to take on responsibility for and fund a number of high cost care packages. There is a risk that triggering this process could lead to WDHSCP being identified as having responsibility for some service users care packages not known to the HSCP at this time.

4.15 The value that these options will contribute is being considered within a range of service improvements and support required to maintain and improve service delivery. A likely value would be in the region of £0.500m to £0.700 million.

4.15 Health Care

4.16 The key funding messages from the 6 February letter (Appendix 2) are:

- Health Boards will receive a minimum baseline uplift of 3% over 2019/20 agreed recurring budgets;

- The Primary Care Fund will increase by £50m to £205m. This will support the implementation of the GP contract, develop new models of primary care and includes £10m to be invested in GP premises;

- To support the Mental Health Strategy a further increase of £28m will be invested to deliver on Action 15 commitments and the transformation of CAMHS; and

- The portfolio budget for alcohol and drugs includes an additional £12.7m and it is expected that investment by Integration Authorities will increase by 3% over and above 2019/20 recurring budgets to tackle the harm associated with the use of these substances.

4.17 Early 2020/21 planning assumptions included a continuation of the 2.54% budget uplift received in 2019/20. When combined with initial assumptions on budget pressures of 3.89% for pay, 5% for prescribing, 1.5% for resource transfer and continuing care adjustment this resulted in an initial budget gap of £1.401m (4.3% of controllable budget).

4.18 While NHSGCC have still to make a formal offer to the six Glasgow partnerships, a minimum baseline uplift of 3% would close the initial gap by £0.311m. In addition updated assumptions of 3% on budget pressures for both prescribing and resource transfer result in an overall reduction in budget pressures of £0.353m.

4.19 Based on the current information and updated assumptions outlined above the 2020/21 indicative budget offer for health care is £95.782, which falls short of the required position for the 2020/21 health care budget of £96.520m, resulting in an indicative budget gap of £0.738m as detailed in Appendix 4 (2.3% of controllable budget).

4.20 Historically health care budgets have been agreed for single years only which require a number of assumptions to be made in order to arrive at a future anticipated budget gap position. Table 3 below summaries the indicative budget gap for 2020/21 along with further anticipated budget gaps for 2021/22 and 2022/23 assuming planning assumptions for 2020/21 continue into future years. The 6 February letter commits the Directorate for Health Finance and Governance to continue to engage with Health Boards to finalise annual operational plans and three year planning assumptions.

Table 3 – Health Care Budget Gaps 2020/21 to 2022/23

	2020/21 (£m)	**2021/22 (£m)**	**2022/23 (£m)**
Indicative / Draft Budget	96.520	98.761	101.080
Indicative Funding	95.782	98.000	100.308
Annual Budget Gap	**0.738**	**0.761**	**0.772**
Cumulative Budget Gap	**0.738**	**1.499**	**2.271**

4.21 As with social care the HSCP Board Meeting scheduled for 25 March will be provided with a range of options that may be required to close the refined 2020/21 budget gap and are likely to include an evaluation of the anticipated 2020/21 full year impact of previous year savings and ongoing financial planning assumptions.

4.22 In contrast to local authority budget setting requirements, health boards do not have to approve their new financial year budget before 31 March. However the expectation will be that a least agreement can be reached on an indicative budget offer prior to the end of March 2020.

4.23 Medium Term Financial Plan

4.24 The figures contained within tables 3 and 4 are based on the work ongoing to develop the medium term financial plan. This plan will be submitted to the Board for approval on 25 March along with the final budgets for 2020/21 and will contain indicative budgets and assumed funding for the 5 year period to 2024/25 along with sensitivity analysis.

5. People Implications

5.1 Any staffing implications of potential savings options that may be required to close indicative budget funding gaps will be subject to the consultation processes of WDC and NHSGGC where appropriate.

6. Financial Implications

6.1 Other than the financial position noted above, there are no other financial implications known at this time.

7. Professional Implications

7.1 The Chief Financial Officer (sect. 95 responsibility) for the HSCP Board must establish a robust annual budget process that ensures financial balance.

7.2 The Chief Officer for the HSCP Board must ensure that the Strategic Plan meets the best value requirements for economy, efficiency and effectiveness.

8. Locality Implications

8.1 None.

9. Risk Analysis

9.1 There are a number of risks in relation to the current and future years including:

- Continued volatility in demand pressures across the range of community services;
- Approved management adjustments and savings options not delivering the projected value required to cover the funding gap;
- Financial sustainability and the ongoing need to ensure the reserves strategy is prudent and serves the needs of the HSCP;
- Scottish Government not providing sufficient funding for planned increases to the Scottish Living Wage;
- Delivery of targets and outcomes such as delayed discharge and waiting times;
- Managing demand and the impact of legislative changes e.g. Carers Act and Free Personal Care for under 65's;
- Implications from consumption of hosted services if current arrangements are revised;
- Potential short supply prescribing pressures and inability to deliver of efficiency programmes; and
- Possible impact on staff recruitment, drug prices and drug availability as a consequence of the United Kingdom leaving the EU.

10. Impact Assessments

10.1 Equality impact assessment of potential savings options and management adjustments will be carried out by Heads of Service and will be made available to members as part of the background papers when confirmed funding offers are received from our partners.

11. Consultation

11.1 This report has been provided to the Health Board Assistant Director of Finance and the Council's Strategic Lead for Resources.

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.

Julie Slavin – Chief Financial Officer
Date: 13 February 2020

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Background Papers: Elected Members Bulletin – 12 February 2020

Appendices:
Appendix 1 – Letter from the Minister for Public Finance and Digital Economy
Appendix 2 – Letter from the Interim Director of Health Finance and Governance
Appendix 3 – Social Care Indicative Budget Gap for 2020/21
Appendix 4 – Health Care Indicative Budget Gap for 2020/21

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Copy to: The Leaders of all Scottish local authorities

6 February 2020

Dear Alison

Today the Scottish Government set out proposed Budget, and tax plans and public sector pay policy for 2020-21, and introduced the associated Budget Bill. Further to the announcement the Scottish Government write now to confirm the details of the local government finance settlement.

Details of the indicative allocations to individual local authorities for 2020-21 are also published today in Local Government Finance Circular 1/2020 which begins the statutory consultation period on the settlement.

In coming to the decision to announce the Scottish Budget before the outcome of the UK Budget is known, the Scottish Government listened carefully to the representations COSLA made on behalf of local government of the damaging impact any further delay would have on the delivery of vital public services and also the practical challenges this would pose around the setting and collection of council tax.

The delay to the UK Budget means that we do not know what total Budget funding will be available to Scotland next year, as we do not yet have confirmation of Barnett consequentials that will flow from changes in UK Departmental expenditure or the updated economic and tax forecasts that are needed to finalise the Block Grant Adjustments that impact on over 30% of our Resource DEL budget. For the purposes of this Budget, the Scottish Government has taken an appropriately cautious approach in estimating the likely outcomes of the UK Budget on 11 March for both revenue and capital budgets, noting that the proposed timetable for the Budget Bill is for parliamentary consideration to conclude on 5 March. If the settlement from the UK government is significantly different from the assumptions the Scottish Government have made, we may need to revisit the allocations contained in this letter.

The Budget announced today prioritises our shared objectives of improving wellbeing, supporting inclusive economic growth, responding to the Global Climate Emergency and

tackling child poverty and remains firmly anchored in the jointly agreed National Performance Framework.

The Scottish Government's budget for 2020-21 is bold and ambitious, delivering on our key commitments. Prioritising these commitments has required fresh consideration of all areas of expenditure, as we continue to deal with the effects of UK Government austerity, with Scotland's discretionary resource budget from the UK Government for 2020-21 still set to be considerably lower in real terms than it was in 2010.

The total revenue funding to be provided through the settlement for 2020-21 will be £10,572.8 million, which includes distributable non-domestic rates incomes of £2,790 million.

The Capital settlement has been set at £763.1 million and this includes the continuing expansion of Early Years provision and the addition of a Heat Networks Early Adopters Challenge Fund.

The total funding which the Scottish Government will provide to local government in 2020 -21 through the settlement in funding for core services is therefore £11,336 million, and includes;

- £201 million revenue and £121.1 million capital to support the expansion in funded Early Learning and Childcare (ELC) entitlement to 1,140 hours by 2020;
- In addition to the £160 million available in 2019-20, a further £100 million to be transferred from the health portfolio to the Local Authorities in-year for investment in health and social care and mental health services that are delegated to Integration Authorities under the Public Bodies (Joint Working) (Scotland) Act 2014. This brings the total transferred from the health portfolio to support health and social care integration to £811 million in 2020-21. The additional £100 million for local government includes a contribution to continued delivery of the real Living Wage (£25 million), uprating of free personal and nursing care payments (£2.2 million), implementation of the Carers Act in line with the Financial Memorandum of the Carers Bill (£11.6 million), along with further support for school counselling services whether or not delegated under the Public Bodies (Joint Working) (Scotland) Act 2014 (£4 million);
- Baselining of the £90 million added at Stage 1 of the Budget Bill for 2019-20;
- The ongoing £88 million to maintain the pupil:teacher ratio nationally and secure places for all probationers who require one under the teacher induction scheme:
- Provision for the Teachers Pay (£156 million) and Pensions (£97 million);
- £5.3 million for Barclay implementation costs; and
- A new capital £50 million Heat Networks Early Adopters Challenge Fund to support local authorities who are ready to bring forward investment-ready heat networks.

As confirmed last week local authorities will continue to have the flexibility for 2020-21 to increase Council Tax by up to a maximum of 3% in real-terms (4.84% cash). This local discretion will preserve the financial accountability of local government, whilst also potentially generating around £135 million to support services.

The revenue allocation delivers a real-terms increase for local government for 2020-21 compared to 2019-20. Taken together with the additional spending power that comes with the flexibility to increase Council Tax (worth around £135 million next year) the total revenue funding would deliver a real-terms increase in the overall resources to support local government services of £435.9 million or 4.3%.

In 2020-21 integration will bring together, under the direction of Integration Authorities, more than £9.4 billion of expenditure previously managed separately by NHS Boards and Local

Authorities for social care, community health care and some hospital services. Integration Authorities must be empowered and supported by their Local Authority and NHS Board partners to use the totality of these resources, including any targeted investment already committed for specific purposes, to better meet the needs of their local populations.

Individual local authorities will, in return for this settlement, be expected to deliver certain specific commitments.

The funding allocated to Integration Authorities should be additional and not substitutional to each Council's 2019-20 recurring budgets for social care services that are delegated. Similarly, the £4 million for school counselling services must be additional. This means that, when taken together, Local Authority social care budgets for allocation to Integration Authorities and funding for school counselling services must be £100 million greater than 2019-20 recurring budgets.

We will also continue to take forward our ambitious programme of educational reform that will deliver an education system led by communities, schools and teachers. The Scottish Government, in partnership with local authorities, will empower schools to make key decisions over areas such as the curriculum, budgets and staffing while continuing to deepen collaboration across the education sector. In recognising that teachers are central to achieving our ambition of delivering excellence and equity in Scottish education we will continue to commit an overall funding package of £88 million in the local government finance settlement to support both maintaining the pupil teacher ratio at a national level and ensuring that places are provided for all probationers who require one under the teacher induction scheme.

Each local authority area will continue to benefit from Pupil Equity Funding (PEF) which forms part of the overall commitment from the Scottish Government to allocate £750 million through the Attainment Scotland Fund, over the term of the Parliament to tackle the attainment gap. £120 million in Pupil Equity Funding is going directly to headteachers to provide additional support to help close the attainment gap and overcome barriers to learning linked to poverty. PEF is additional to the £62 million Attainment Scotland funding, which is outwith the local government finance settlement. Money from the Attainment Scotland Fund will continue to provide authorities and schools with additional means to provide targeted literacy, numeracy and health and wellbeing support for children and young people in greatest need.

The Heat Networks Early Adopters Challenge Fund will be a competitive fund to provide enabling and financial support to assist the build and installation of exemplar local authority-led heat network projects. The Challenge Fund will offer capital funding up to an intervention rate of 50 per cent and will be available for new and existing heat networks who are able to demonstrate progress towards greenhouse gas emissions reductions and wider socio-economic benefits. There will also be a smaller development funding call within the Challenge Fund to help develop early stage project proposals to become investment-ready in future years. The detailed terms and conditions for the Heat Networks Early Adopters Challenge Fund will be drawn up in consultation with COSLA and we anticipate that it will launch early in the financial year.

The Scottish Government remains committed to a competitive non-domestic rates regime, underlined by the proposals outlined in this Scottish Budget. The poundage in Scotland has been capped below the Consumer Price Index inflationary increase at 49.8 pence, a 1.6 per cent increase. The Scottish Government are also introducing some further support for intermediate sized properties which will ensure around 95 per cent of properties in Scotland now pay a lower poundage than they would in other parts of the United Kingdom. Full details of this and all other reliefs are set out in Local Government Finance Circular 1/2020.

In these unprecedented times with all the uncertainty imposed upon us by the UK Government the Scottish Government believe, taking into account all the circumstances, the allocations set out in this local government finance settlement is the best that could be achieved and continues to provide a fair settlement to enable local authorities to meet our shared priorities of improving wellbeing, supporting inclusive economic growth, responding to the Global Climate Emergency and tackling child poverty.

KATE FORBES

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Chief Executives, NHS Scotland

Copy to: NHS Chairs
NHS Directors of Finance
Local Authority Chief Executives
Integration Authority Chief Officers
Integration Authority Chief Finance Officers

Issued via email

6 February 2020

Dear Chief Executives

Budget 2020-21 – Indicative Allocation

Following the announcement of the Scottish Government's Budget for 2020-21 by the Minister for Public Finance and Digital Economy in Parliament today, I am writing to provide details of the funding settlement for Health Boards. A breakdown of the total is provided in **Annex A** to this letter.

The Portfolio settlement will make a significant contribution to the central purpose of the National Performance Framework - enhancing population wellbeing through our core work delivering the healthy and active outcome. In addition, there is a wider benefit from investment in the health and sport portfolio, particularly in relation to outcomes for an inclusive and sustainable economy, reducing poverty and inequality, growing and sustaining inclusive and resilient communities, and promoting a bright future through our children and early years.

The settlement will support continued delivery of the core priorities set out in the Programme for Government, which focus on; waiting times improvement, primary care, investment in mental health and delivering further progress in the integration of health and social care, as well as continuing to shift the balance of spend towards community health services. It also recognises the wider inflationary pressures faced by Boards and Integration Authorities.

Baseline Funding

All Territorial Boards will receive a baseline uplift of 3%. In addition to this, those Boards furthest from NRAC parity will receive a share of £17 million, which will continue to maintain all Boards within 0.8% of NRAC parity.

The National Waiting Times Centre, Scottish Ambulance Service, The State Hospital and NHS 24, along with the NHS National Services Division and Scottish National Blood Transfusion Services (within NHS National Services Scotland) will also receive a baseline uplift of 3%. NHS National Services Scotland, Healthcare Improvement Scotland, and NHS Education for Scotland will receive funding uplifts of 2%, which includes funding towards pay costs. The new budget for Public Health Scotland includes funding transferred from NHS Health Scotland and NHS National Services Scotland.

This position continues to assume that the £15 million of National Board savings is fully delivered in 2020-21 and that further progress is made in National Boards collaborating to deliver service improvement and further savings.

Investment in Improving Patient Outcomes

In addition to the baseline funding uplift, a total of £461 million will be invested in improving patient outcomes in 2020-21, as set out below:

Improving patient outcomes	2019-20 Investment in reform (£m)	2020-21 Investment in reform (£m)	Increase for 2020-21 (£m)
Primary Care	155	205	50
Waiting Times Improvement	106	136	30
Mental Health and CAMHS	61	89	28
Trauma Networks	18	31	13
TOTAL	**340**	**461**	**121**

When combining the £121 million increase in investment in reform with an increase of £333 million in baseline funding for frontline NHS Boards, the total additional funding for frontline NHS Boards will amount to £454 million (4.2 per cent) in 2020-21. Further detail is set out in **Annex A.**

Full details of the method of allocation and evidence of delivering against agreed outcomes will be set out by individual policy areas.

Core Areas of Investment

Primary Care
Investment in the Primary Care Fund will increase to £205 million in 2020-21. This will support the implementation of the GP contract and development of new models of primary care - where multidisciplinary teams of nurses, doctors, pharmacists, AHPs and other clinicians work together to meet the needs of their communities. This includes £10 million to be invested in GP premises.

Waiting Times Improvement Plan
Investment of £136 million will be provided to support waiting times improvement and reform. Work will continue to develop Annual Operational Plan submissions, with specific focus on inpatient and day cases, as well as wider plans to deliver sustainable solutions, including progress against the development of the elective centres. Included in this funding is £10 million for winter 2020-21, to allow Boards maximum opportunity to plan as appropriate.

Mental Health and CAMHS
Funding of £89 million will be directed to a range of partners for investment to support mental health, and children and young people's mental health. In the year ahead we will build on previous support to Territorial and National Boards through ongoing delivery of the Mental Health Outcomes Framework, the NHS Workforce Development Programme and support to improve access to high quality mental health services. We will also continue to fund the additional CAMHS staff recommended by the Children & Young People's Mental Health Taskforce from within £5.1 million administered by NHS Education Scotland. This will see a continuation in the Scottish Government's specific investment in Boards to support mental health service delivery. The Minister for Mental Health and her officials will discuss investment plans in more detail with you in the coming months.

The Mental Health Services budget also includes funding to be directed to Integration Authorities for the recruitment of 800 additional mental health workers as outlined in action 15 of the Mental Health Strategy. There will also be investment in perinatal and infant mental health overseen by the Programme Board led by Hugh Masters. Nonetheless the bulk of service provision is funded through NHS Boards' baseline funding, and we expect NHS Boards and Integration Authorities to prioritise spending in these areas in response to increasing demand and in line with Programme for Government commitments to deliver a shift in the balance of overall spending.

Trauma Networks
This funding will increase from £18 million to £31 million, taking forward the implementation of the major trauma networks.

Alcohol and drugs
The Portfolio budget includes an additional £12.7 million to tackle the harm associated with the use of illicit drugs and alcohol. The Minister for Public Health, Sport and Wellbeing and his officials will discuss investment plans in more detail with Boards and Integration Authorities in the coming months. It is expected investment by Boards and Integration Authorities will increase by 3% over and above 2019-20 agreed recurring budgets to address these issues.

Reform Funding
This budget prioritises baseline funding, along with increased investment in particular areas of reform that will improve patient outcomes. We will however work with colleagues to agree investment in specific programmes of work, such as in relation to radiology and laboratories services, as well as in-year funding to support the strategies of NHS 24 and Scottish Ambulance Service, which will have a wider benefit to the service.

Health and Social Care Integration
In 2020-21, NHS payments to Integration Authorities for delegated health functions must deliver an uplift of at least 3% over 2019-20 agreed recurring budgets.

In addition to this, and separate from the Board Funding uplift, the Health Portfolio will invest a further £100 million in Local Authorities for investment in social care and integration, and continued support for school counsellors. This will take the total funding transferred from the health portfolio to £811 million in 2020-21. The additional £100 million for local government includes a contribution to continued delivery of the Living Wage (£25 million), uprating of free personal and nursing care payments (£2.2 million), implementation of the Carers Act in line with the Financial Memorandum of the Carers Bill (£11.6 million), along with further support for school counselling services whether or not delegated under the Public Bodies (Joint Working) (Scotland) Act 2014 (£4 million).

The funding allocated to Integration Authorities should be additional and not substitutional to each Council's 2019-20 recurring budgets for social care services that are delegated. Similarly, the £4 million for school counselling services must be additional. This means that, when taken together, Local Authority social care budgets for allocation to Integration Authorities and funding for school counselling services must be £100 million greater than 2019-20 recurring budgets.

In 2020-21 integration will bring together, under the direction of Integration Authorities, more than £9.4 billion of expenditure previously managed separately by NHS Boards and Local Authorities for social care, community health care and some hospital services. Integration Authorities must be empowered and supported by their Local Authority and NHS Board partners to use the totality of these resources, including any targeted investment already committed for specific purposes, to better meet the needs of their local populations.

Capital Funding
Boards should assume an unchanged initial capital formula allocation, with additional investment planned for the elective centres and Baird and Anchor Centre in Aberdeen.

Three Year Financial Plan
We will continue to engage with Boards to finalise Annual Operational Plans and three year planning assumptions. This will set out a number of principles to be delivered in relation to finance and wider performance and I hope the information contained in this letter will assist in the finalising of plans.

Yours sincerely

RICHARD MCCALLUM
Interim Director of Health Finance and Governance

Annex A – Board Funding Uplifts

NHS Territorial Boards	Total 2019-20 Allocation £m	Uplift £m	Uplift %	2020-21 Total allocation £m
Ayrshire and Arran	740.2	22.2	3.0%	762.4
Borders	213.4	6.4	3.0%	219.8
Dumfries and Galloway	306.9	9.2	3.0%	316.1
Fife	679.3	22.2	3.3%	701.5
Forth Valley	541.5	17.3	3.2%	558.7
Grampian	984.0	29.5	3.0%	1,013.5
Greater Glasgow and Clyde	2,295.8	68.9	3.0%	2,364.7
Highland	645.3	20.7	3.2%	666.0
Lanarkshire	1,231.2	36.9	3.0%	1,268.1
Lothian	1,482.6	57.4	3.9%	1,540.1
Orkney	51.1	1.5	3.0%	52.6
Shetland	52.3	1.6	3.0%	53.9
Tayside	784.9	23.5	3.0%	808.5
Western Isles	77.7	2.3	3.0%	80.0
	10,086.2	**319.7**	**3.2%**	**10,405.9**
NHS National Boards				
National Waiting Times Centre	58.3	1.7	3.0%	60.0
Scottish Ambulance Service	270.3	8.1	3.0%	278.4
The State Hospital	36.5	1.1	3.0%	37.6
NHS 24	70.6	2.1	3.0%	72.7
NHS Education for Scotland*	444.8	16.7	3.8%	461.5
NHS Health Scotland / Public Health Scotland**	18.9	0.4	2.0%	47.9
NHS National Services Scotland**	345.6	9.1	2.6%	327.7
Healthcare Improvement Scotland	25.8	0.5	2.0%	26.3
	1,270.7	**39.8**	**3.1%**	**1,312.1**
Total NHS Boards	**11,357.0**	**359.5**	**3.2%**	**11,718.0**
Improving Patient Outcomes	**340.0**	**121.0**	**-**	**461.0**
Total Frontline NHS Boards* **	**10,861.9**	**453.8**	**4.2%**	**11,315.7**

* The uplift for NHS Education for Scotland includes recurring funding for training grades.
** Budget for Public Health Scotland of £47.9 million reflects budget for new public health body and includes transfer of £27.1 million from NHS National Services Scotland.
*** Frontline NHS Boards comprise the 14 NHS Territorial Boards, National Waiting Times Centre, Scottish Ambulance Service, State Hospital, and NHS 24.

WEST DUNBARTONSHIRE HSCP 2020/21 BUDGET UPDATE **Appendix 3**
SOCIAL CARE - BUDGET SCENARIO BASED ON WDC INDICATIVE ALLOCATION

Spend Categories	2019/20 Recurrent Budget West Dunbartonshire HSCP
	£000s
Employee Costs	42,854
Property	627
Transport and Plant	1,315
Supplies, Services & Admin	913
Payments to Other Bodies	46,303
Other	2,211
Total Expenditure	**94,223**
Income	(26,683)
Net Total Month 9	**67,539**
Social Care Pressures - HSCP	
Pay Award	1,245
Inflationary Uplifts including National Care Home Contract & other	669
Service transitions	250
Demographic pressure including equip, care at home and care homes places	521
Kinship Care - increasing demand numbers	553
Residential Schools - increasing demand numbers	1,411
Mental Health, Physical Disability and Learning Disabilities - increasing cost of care packages	294
Criminal Justice	122
Scottish Living Wage uplift	630
Apprenticeship Levy	138
Total Pressures	**5,833**
Offset by: Annual Income Uplifts, FYE of Approved Savings and Budget Transfer to Health	
Income 4% various e.g. Homecare, alarms, blue badges, housing support	(22)
Resource Transfer uplift including Continuing Care	(800)
2018/19 FYE - Approved Savings	(590)
2019/20 - Approved Savings	(403)
2019/20 FYE - Sales, Fees and Charges Uplift	(44)
Transfer of Frailty Budget to Health	(610)
Total Income & Savings	**(2,469)**
Total Net Pressures 2020/21	**3,364**
Budget required for 2020/21	**70,903**
Indicative WDC 2020/21 Budget Contribution as per 27 November 2019	**69,367**
Savings Gap	**1,536**
% of Controllable Budget	**2.3%**

WEST DUNBARTONSHIRE HSCP 2020/21 BUDGET UPDATE **Appendix 4**
HEALTH CARE - BUDGET SCENARIO BASED ON NHSGGC INDICATIVE ALLOCATION

Spend Categories		2019/20 Recurrent Budget West Dunbartonshire HSCP
		£000s
Prescribing		19,502
Drugs		423
Non Pay		4,082
Pay		27,203
Purchase Of Healthcare		3,766
Resource Transfer		15,763
Savings		(111)
Family Health Services *		27,327
Total Expenditure		**97,955**
Fhs Income*		(1,085)
Other Income		(3,113)
Total Income		**(4,198)**
Net Total Rollover budget at Month 9		**93,757**
Budget Eligible for HCH uplift		**67,515**
Uplifts		
Scottish Government allocation to Health Boards	3.00%	**2,025**
Additional allocation for Pays uplift (pro-rata share across GGC)		**0**
Total Uplift		**2,025**
Apprenticeship Levy		**95,782**
Pressures - HSCP		
Pay	3.89%	1,058
Resource Transfer uplift including Continuing Care	3.00%	832
Non Pay - to cover shortfall in Aids & Equipment (assume flat cash)	0.00%	0
Purchase of Healthcare (incl. Hospice) + Demand	3.00%	113
Frailty Team		610
Health Visitors Regrading		150
Total Pressures		**2,763**
Budget required for 2019/20		**96,520**
Savings Gap		**738**
% of Controllable Budget		**2.3%**

care inspectorate

Thematic review of self-directed support in Scotland

West Dunbartonshire local partnership report

June 2019

Contents

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1. About this report

Background

Self-directed support: A National Strategy for Scotland was published in October 2010. This was a 10-year strategy which set the agenda for self-directed support in Scotland. The subsequent Social Care (Self-directed Support) (Scotland) Act 2013 was implemented on 1 April 2014. The strategy and legislation were designed to encourage significant changes to how services are provided. They require public bodies to give people more say in decisions about local services and more involvement in designing and delivering them.

Fundamental principles of self-directed support are built into the legislation: participation; dignity; involvement; informed choice; and collaboration. Further principles of innovation, responsibility and risk enablement were added. Social care should be provided in a way that gives people choice and control over their own lives and which respects and promotes human rights.

The thematic review

This report forms part of a thematic review led by the Care Inspectorate, which was undertaken jointly with Healthcare Improvement Scotland. The inspection teams included associate assessors with lead roles in self-directed support in partnerships and other organisations across Scotland.

The review looked at the implementation of self-directed support in six partnerships across Scotland: East Lothian; East Ayrshire; West Dunbartonshire; Shetland; Moray and South Lanarkshire. The specific findings from and recommendations for the individual partnerships visited are reported separately in these local partnership reports.

As part of the thematic review we have also published an overview report. This sets out the key messages and recommendations from the review. We hope that all partnerships across Scotland and organisations interested in self-directed support will be able to learn from these findings.

The focus of our thematic review

The main purpose of the review was to improve our understanding of the implementation of self-directed support to support improvement in the delivery of this important agenda in Scotland. We sought to find out if the principles and values of self-directed support were being met and delivering positive personal outcomes.

Under this overarching inspection question, we explored the extent to which the partnerships had ensured that:

- people were supported to identify and achieve personal outcomes
- people experienced choice and control
- people felt positive about their engagement with professionals and services
- staff were enabled and empowered to implement self-directed support
- the principles and values of self-directed support were embedded in practice
- there was information, choice and flexibility for people when accessing services.

This local partnership report sets out our findings, evaluations and recommendations against the following themes:

- Key performance outcomes
- Getting support at the right time
- Impact on staff
- Delivery of key processes
- Policy development and plans to support improvement in services
- Management and support of staff
- Leadership and direction that promotes partnership.

Approach to the partnership inspection

To find out how well self-directed support is being implemented in West Dunbartonshire, we gathered the views of staff across social work, health and provider organisations. We carried out an online survey between 27 June and 13 July 2018, aimed at gathering the views of staff in relation to self-directed support. In addition, we worked with partnerships and invited them to coordinate a supported person questionnaire to ensure we got their perspective on how self-directed support had shaped their experiences of receiving services. The survey was completed by 128 staff and the supported person questionnaires were completed by 18 people.

We read the files of 60 supported people who received a social work assessment and subsequent care and support services and 20 files of people who had been signposted to other services at the point of enquiry. During the inspection we met with a further ten supported people and nine unpaid carers to listen to their views about their experiences of services. We also spoke to various staff from a range of agencies who worked directly with supported people and unpaid carers and are very grateful to everyone who talked to us as part of the thematic review of self-directed support.

Staff survey and case file reading analysis

Where we have used figures, we have standardised the terms of quantity so that ‘few’ means up to 15%; ‘less than half’ means 15% up to 50%; ‘the majority’’ means 50% up to 75%; ‘most’ means 75% up to 90%; and ‘almost all’ means 90% or more.

Evaluations

Evaluations are awarded on the basis of a balance of strengths and areas for improvement identified under each quality indicator. The evaluation is not a simple count of strengths and areas for improvement. While each theme within an indicator is important, some may be of more importance to achieving good outcomes for supported people and unpaid carers that they are given more weight than others. Similarly, weaknesses may be found that impact only on a small number of individuals but be so significant, or present such risks, that we give them greater weight. All evaluations are based on a thorough consideration of the evidence.

Definitions

"Self-directed support options" refer to the four self-directed support options under the legislation:

- **Option 1:** The individual or carer chooses and arranges the support and manages the budget as a direct payment.
- **Option 2:** The individual chooses the support and the authority or other organisation arranges the chosen support and manages the budget.
- **Option 3:** The authority chooses and arranges the support.
- **Option 4:** A mixture of options 1, 2 and 3.

'Supported people' or 'people' describes people who use services or supports as well as people acting as unpaid carers for someone else.

'Good conversations' are the conversations that take place between supported people and staff. These conversations allow an understanding to develop of what is important to, and for, supported people on their terms. This allows the identification of desired personal outcomes for the supported person.

'Personal outcomes' are defined as what matters to supported people in terms of the impact or end result of activities. These can be used both to determine and evaluate activity.

'Staff' includes paid staff working across health, social work and social care services; this includes staff from all sectors statutory and third and independent sectors involved directly or indirectly in the provision of advice, care and support.

'Providers' refers to organisations that employ and manage staff in the provision of advice, care and support. These organisations can be from the statutory, third or independent sector.

'The partnership' refers to the integration authority which has statutory responsibilities for developing strategic plans and ensuring that the delivery of the functions delegated to the local authority complies with the integration delivery principles.

‘Independent support’ including independent advocacy is impartial, can take many forms and may be provided by different organisations. It does not involve providing direct care or related tasks; rather, it helps people make informed decisions about self-directed support**.**

2. Key performance outcomes

Supported people experience positive personal outcomes through the implementation of self-directed support

Summary

The available performance data relating to self-directed support for West Dunbartonshire was less positive than the national picture and supported the inspection findings that self-directed support was underdeveloped in this partnership area. There were examples of positive self-directed support approaches achieving good outcomes for people with a learning disability or with acquired brain injury. While these approaches were not as evident across other larger service areas, such as in services for older people, there were still beneficial outcomes for supported people in these services. However, practice in these areas was not yet underpinned by the principles of self-directed support. Current assessment tools did not prompt staff to have or record good conversations and were not focussed on personal outcomes. Carers we met had mixed experiences of their outcomes being met. While the partnership did not have systems in place for measuring and collecting aggregated data on personal outcomes, they were in the early stages of developing an approach to do this.

Evaluation – Adequate

In West Dunbartonshire, we saw that staff worked hard and were committed to the delivery of person-centred and person-focused services. Whilst overall staff had a sound understanding of how to support people to achieve positive outcomes, a truly asset-based approach was only consistently evident in learning disability services and acquired brain injury services. Most of the evidence of supported people experiencing positive personal outcomes through accessing self-directed support options was in these services. In these service areas, self-directed support was relatively well embedded and supported people had more choice and control. We saw some good examples of creative and personalised approaches to meeting personal outcomes.

The majority of people were being supported in line with their needs, wishes and agreed personal plans. The supported person's strengths and assets were considered in just over half of the records we read. This was having a positive impact. However, the outcomes being achieved were through a deficit-led approach to assessment rather than as a result of asset-based, personal outcomes approaches. There was still work to do to ensure that all assessments were outcomes-focused and that practice and processes were underpinned by the principles of self-directed support. There was evidence of poor personal outcomes in 32% of the files we read. Therefore, there was still work to be done by the partnership to identify where poor outcomes were occurring and why.

Unpaid carers we met had mixed experiences of their outcomes being met. The majority of them spoke about having good conversations with staff from the carers

centre and the health and social care partnership (HSCP). However, some described the partnership's responses as primarily reactive rather than proactive or preventative and not outcomes-focused.

The partnership had recently implemented a two-tier carers' assessment tool which had been developed following consultation with carers and carers' organisations. The majority of carers who needed support following assessment had had their needs met primarily by universal services without accessing services through self-directed support. In half of the records we read there was evidence that the assessment had led to improved outcomes. As the implementation of the Carers (Scotland) Act 2016 embeds, it will be important that the partnership is able to demonstrate how carers' outcomes are being improved.

The partnership told us they used a number of tools to measure progress against individual personal outcomes and to monitor the impact and outcomes of support plans. These tools were used in addiction services, children's services and services for people with a learning disability. However, we saw little evidence of the use of outcomes tools or frameworks in practice in the case files we read. Only 2% of the files from these services had evidence of an outcomes tool/framework being used.

The performance data in respect of West Dunbartonshire was less positive than the national picture. The partnership was behind in their progress with self-directed support in relation to other authorities across a range of measures. Nationally the self-directed support implementation rate in 2016/17 was 39%, an increase from 26% in 2015/16. In West Dunbartonshire the rate had remained static from the 2015/16 figure of 3% and continues to remain considerably lower than the national average. The partnership was ranked 28 of all 32 local authorities on the percentage of adults that used direct payments or personalised managed budgets to meet their support needs. It was ranked 32 of all 32 local authorities on the percentage of social care clients who made an informed choice regarding their self-directed support[1]. The partnership was developing a new self-directed support tool which would be able to consistently record how supported people made informed choices about their support and this would enable the partnership to target improvements in performance in a more informed way.

The partnership had not used data to shape and inform the practice and direction of self-directed support and to help improve people's outcomes. We saw that they had been able to use data, including outcome related data, to good effect when looking at, for example, data to support anticipatory care planning and additional preventative support. This approach had not however been extended to self-directed support.

[1] Source: Local Government Benchmarking Framework: Areas of council performance – Adult Social Care Services 2014/15 to 2015/16

At the time of inspection, intelligence on personal outcomes for people could only be checked manually. Information about individual outcomes could be gathered from reviews, supervision and the contracts team, however, this information was not routinely collated and used for improvement.

The partnership was in the early stages of developing an approach to collecting outcome related data. They were developing a new outcomes-focused assessment tool for their recording system Carefirst. This would allow them to interrogate their information system and produce reports on how effectively outcomes are being met.

Recommendation for improvement
The partnership should seek to ensure that supported people across all service groups and all unpaid carers consistently experience positive personal outcomes and take action to ensure that it is able to record, measure and report on these.

Recommendation for improvement
The partnership should take steps to analyse and understand its local and national performance information and use this to inform and drive improvement in self-directed support.

3. Getting support at the right time

Supported people are empowered and have choice and control over their social care and support

Summary

Supported people benefited from the engagement and good conversations they had with staff. The carers centre, Alzheimer Scotland and in particular the direct payment staff had made a positive contribution to informing and advising supported people about self-directed support. There was a comprehensive, well used, award winning telephone advice line for older people in West Dunbartonshire called link up. This service was a good example of co-production and community capacity building. However, information on resources specific to localities was not as widely available within communities as it could have been. We saw evidence of people having choice and control in learning disability services and also for children in transition. The partnership had a single point of access through which they effectively signposted people to community resources. Access to independent advocacy was limited but where it was received this was well regarded and provided for as long as required. There were no systems in place to capture or measure the impact of preventative or early intervention services.

Evaluation – Adequate

The range and quality of information about self-directed support available to the public in West Dunbartonshire was variable. The council website provided easily accessible information about self-directed support. The council also had a Facebook page on self-directed support. There was nothing specifically about self-directed support on the West Dunbartonshire health and social care partnership website. We were told that work was underway to improve the quality of the information on this website.

The carers of West Dunbartonshire organisation had a website offering a range of services such as information, advice, support, training and practical assistance to carers and supported people eligible for self-directed support. The support given was free, confidential and independent. The good life group provided training and advice to supported people and unpaid carers on self-directed support. Alzheimer Scotland also provided good, quality information and advice on supports and self-directed support.

There was a comprehensive, well used, award winning telephone advice line for older people in West Dunbartonshire called link up. This service was run by the partnership along with West Dunbartonshire community and volunteering service. It was widely promoted throughout West Dunbartonshire. This service provided a range of information for older people and signposted people to a range of services and supports in the community. It had been recognised with a care accolade award from the Scottish Social Services Council in 2014, the 2014 self-management project

of the year for the Health and Care Alliance Scotland Awards and in 2015; it received the gold award in the local matters category at the COSLA excellence awards. Link up was a good example of co-production and community capacity building.

There was a need to develop and extend access to information in more formats and within more community settings. As part of their improvement support for self-directed support the partnership had established the self-directed support review group. This group was to look at the provision of public information as part of their review activity. There were no details or any timescales available for this activity at the time of inspection.

There was no evidence that the sources, impact, understanding and value of information given to supported people had been evaluated. Evaluation would give the partnership an awareness of the timeliness and the quality of information being given and any gaps that had to be addressed.

Reflecting the trend we saw throughout the inspection, there were better examples of informed decision making about the four options within specific care groups. Some supported people and unpaid carers spoke positively about the information they were given about the four options and how this influenced their choice of option. There were positive examples of individuals being able to change their chosen option. We saw good practice examples where two physical disability service users were supported to use self-directed support creatively to complete university courses. This included adapting the self-directed support as their needs changed. However, practice was not consistent and many people did not have the same levels of choice and control. Younger supported people in transition and people with learning disabilities had more opportunities for innovative support and had more choice and control than other groups.

The results of a consultation exercise in 2018 with users of local third sector organisations showed a concern about slow progress in the embedding of self-directed support in the West Dunbartonshire area. In June 2018 following this consultation, Clyde shopmobility and West Dunbartonshire community and volunteering service successfully applied to the Inspiring Scotland Support in the Right Direction 2021 fund and secured 36 months funding. The IDEAS project (increasing discussion and encouraging access to self-directed support) was created through this funding to address some of the gaps in progress of self-directed support.

This project had identified a suite of measures to help embed self-directed support and its principles across the partnership. Among these measures were an improvement in information pathways, an increase in the number and availability of published resources about self-directed support and a raising of community awareness of these locally. The IDEAS project was also looking at the creation of a team of peer advocates to support people investigating and potentially accessing self-directed support. Independent brokerage would also be developed through this project. This work was at a very early stage but would go some way to ensuring that self-directed support information was more widespread and comprehensive.

Independent advocacy was only provided in a small proportion of cases. The partnership acknowledged that there were limitations to the extent that people could access independent advocacy. It was predominantly available for statutory interventions for people with mental health problems, a learning disability or acquired brain injury. This impacted upon people, other than those who required statutory support, getting access to advocacy to support good conversations, choice and control at the point of considering self-directed support options. Where advocacy support was provided however, this appeared to be well regarded and effective. The partnership said the use of advocacy services was under review as part of a wider review of commissioning and procurement.

The partnership had a single point of access for adults and older people. Through this they made an initial assessment of the care and support required. People were then signposted to alternative support such as the carers centre or into the formal assessment process from the first point of contact. During file reading we looked at 20 cases that did not progress to a formal assessment and where supported people were signposted to alternative support services. We saw that people were signposted appropriately in the majority of these records.

Self-directed support was not routinely discussed at the first point of contact. From our analysis of records and from speaking with supported people, this was only discussed if a full assessment was then being carried out. The partnership did not capture information about referrals or services provided for those who were signposted to alternative support and did not have any system for evaluating the effectiveness of prevention and early intervention services. It was difficult for the partnership to evidence how these referrals might reduce the need for services funded through personal budgets.

Consideration of investment in the development of community and early intervention services was at an early stage. The partnership recognised that they needed to be more open to the third and independent sector being involved in service development and new models of care.

Staff we spoke with demonstrated some awareness of local informal services. There was no formal directory on informal supports available so individual worker knowledge or local knowledge was relied on. We were told that locality-based directories were being developed to bring together information about early intervention and prevention services.

Recommendation for improvement
The partnership should develop appropriate pathways for individuals to access advocacy and/or independent brokerage if and when they need it to support decision-making around self-directed support options, choice and control.

Recommendation for improvement
Where people are signposted to early intervention and preventative services the partnership should take steps to measure the effectiveness of these supports in reducing the need for more formal services and supports.

4. Impact on staff

Staff feel confident, competent and motivated to practice in an outcome-focussed and person-led way

Summary

While staff spoke confidently and demonstrated a basic broad knowledge about the principles and values of self-directed support and how they could apply these within their work, not all staff were confident in using asset-based approaches in practice. Staff from learning disability services and those working in the acquired brain injury service demonstrated a sense of confidence and competence in relation to self-directed support principles and had the frameworks in place within their services to be able to carry out the principles in practice. Most other staff we spoke with outside of these service groups, said that they were unable to build on their knowledge and become confident in practice because they did not have the supporting framework in place to allow them to do so. There was a lack of communication between service areas to share asset-based approaches in practice. Systems and forums for staff to support and inform an asset-based approach were not used effectively. There were missed opportunities to discuss self-directed support and support improved practice with staff.

Evaluation – Weak

During the course of the inspection, we met with staff at all levels of the partnership, including 11 frontline staff and a similar number of frontline managers. We also received 130 responses to our staff survey. Of these respondents, 48% were employed by the local authority in social work or social care and 43% by the NHS.

Staff felt they had a broad understanding of self-directed support and outcomes-focused practice. They spoke with confidence about the principles of self-directed support, how the four options might work for people and the role of good conversations in facilitating this. In our staff survey, most of the respondents agreed or strongly agreed that staff had positive conversations with people about what mattered to them and the support they needed. However, while they had a sound understanding of self-directed support, less than half of the staff in the survey agreed that they felt confident in delivering self-directed support in practice. A lack of creative options for supported people was given as the primary reason for this. The impact of time constraints was also frequently highlighted. Only slightly more than half of respondents in our staff survey felt they had adequate time and capacity to work in a person-centred way.

Staff acknowledged that self-directed support ethos and practice was more effectively embedded in learning disability and mental health services than older people's services. They felt the creation of a self-directed support team within the learning disability service at the time of the legislation had helped establish and embed the ethos more successfully there than in other areas. Staff felt that there was inconsistency in how self-directed support was applied across the partnership

and that there was little communication and sharing between teams in relation to self-directed support and how to apply the principles in practice.

Most respondents to our staff survey agreed that they were encouraged and enabled to exercise professional autonomy. However, staff we met felt they would benefit from greater autonomy in decision making processes in relation to self-directed support. The decision-making processes following assessments were widely viewed as challenging. Some staff had not developed the confidence and competence to present to the resource groups. Some staff felt the process for securing approval of service requests was not in keeping with the principles and values of self-directed support and that the focus was more on finance than realising positive outcomes for supported people.

Staff in the partnership who received supervision generally felt supported through their supervision arrangements. In learning disability services however, staff emphasised the role of supervision in encouraging and reinforcing the use of asset-based approaches with supported people. We did not hear about supervision being used like this in other areas of service.

Recommendation for improvement

The partnership should take action to measure the impact of learning and development and practice processes on staff competence, confidence and motivation.

5. Delivery of key processes

Key processes and systems create conditions that enable supported people to have choice and control

Summary

File reading showed a predominance of practice and recording which was not in keeping with a self-directed support approach. The partnership recognised this and was moving in a direction that advocated the use of asset-based and outcomes-focussed approaches. It was laying the foundations for changes in assessment and recording that would support this. New assessment documentation was at the point of being piloted and the business system was being developed to support self-directed support practice. Positive risk taking and protection were appropriately considered during assessment processes in the majority of records looked at. While there were no significant delays in people getting an assessment, there were sometimes delays in people accessing services due to the resource allocation process. There was some evidence that the partnership engaged people in planning and feeding back on services. There was no evidence that they actively monitored, evaluated or sought feedback on the co-production of assessments. The impact of employing asset-based approaches was not routinely captured making it difficult to accurately assess the benefit of using such approaches.

Evaluation: Weak

The assessment formats and templates that were being used across services in the partnership were not effective in supporting a personalised outcomes approach. The single shared assessment format was deficit-led and not reflective of good conversations that may have taken place. Just over half of the personal plans we looked at were not comprehensive and were not SMART (Specific, Measurable, Achievable, Realistic and Time-bound). There were no contingency arrangements in just over half of the records we read.

The partnership had recognised these gaps and had drafted a new assessment format to support an outcomes-focused approach. This format was in line with self-directed support values and principles. Assessment and other supporting tools such as care planning and review documentation also being developed at the time of inspection supported an asset-based approach. This documentation was to become operational at the end of 2018 and rolled out across all service areas.

The partnership did not monitor and evaluate how well or how meaningfully people engaged in planning their own support. The Carefirst recording system was highlighted by frontline staff as being unable to capture how people's strengths and assets could be used as alternatives to formal services and supports. The impact of employing asset-based approaches, where these were used in practice, was therefore not routinely captured making it difficult to accurately quantify the benefit of using such approaches.

In most of the files we read, appropriate consideration was given to looking at supported people taking positive risks as part of the assessment. Most of the staff in our staff survey felt that positive risk taking took place**.** Work was underway to adapt the risk assessment tool used in adult support and protection and modify it into a general risk assessment tool for both adult protection and non-protection risks. The tool had a clear focus on risk enablement and positive risk taking which the partnership felt was transferable to a self-directed support approach.

The decision-making and resource allocation processes following assessments were widely viewed as challenging. Some staff felt the resource allocation process was more to do with finance than realising positive outcomes for supported people. Other staff were not confident or had not developed the necessary skills to be as confident as they could be when presenting assessments to the various resource groups that had responsibility for allocating resources. This meant that assessments and service requests considered by the resource group were occasionally declined by the group or put on hold pending further information. This led to delays in assessed needs being met. Our review of case records showed no evidence of unreasonable delay in supported people getting an assessment. However, we heard from some supported people about delays at times in getting services following assessment.

When we spoke to supported people and to frontline staff it was evident that supported people had a limited understanding of what happened during the resource group process. Supported people were not involved in meetings to agree service requests and relied on feedback from their allocated care manager. We did not see where supported people had influenced their care packages. This lack of involvement of supported people did not support a transparent approach to systems and processes and impacted on people's experience of control.

While the carers centre was seen as positive, carers told us their experience was that it was so busy the centre could only manage new referrals and was unable to review existing carer support plans. There was a risk that without review, carers needs would not continue to be met.

Recommendation for improvement
The partnership should embed a self-directed support ethos and approach across all key processes and systems. It should progress the planned changes to tools and processes and to the business system to ensure these support asset-based and outcomes-focused practice.

Recommendation for improvement
The partnership should ensure that they can demonstrate that good decisions are made in relation to positive risk taking. This should be monitored and evaluated to inform ongoing risk management and risk enablement.

Recommendation for improvement
The partnership should ensure that supported people are better informed about and more involved in key processes regarding their support.

6. Policy development and plans to support improvement in services

The partnership commissions services that ensure supported people have a range of choice and control over their social care and support.

Summary

Outcome-focussed commissioning had not been a focus for the partnership. Approaches to support flexibility, choice and control for people using services were at an early stage of development. Commissioning in the partnership was weighted towards traditional services with little evidence of innovation. With most services still provided directly by the council and significant levels of services under block contracts[2] there was little flexibility, choice and control for supported people. We saw some use of spot purchasing resulting in more personalised support for people in learning disability services but not elsewhere. There was an increasing awareness of the issues and the gaps in the partnership's current provision and a recognition that their commissioning direction needed to change. Steps had been taken to increase the range of providers available and for provision to be more in line with self-directed support. Work had started on changing the shape of the market in care at home and respite services. The partnership was in the process of appointing a commissioning manager to bring more focus to their change in direction.

Evaluation: Weak

The services provided in West Dunbartonshire were traditional and not consistent with the principles and values of self-directed support. The chief officer was leading a review and refresh of their approach but this was at an early stage.

The partnership's service delivery was predominantly through block contracts. Partnership staff at all levels recognised that the existing model of block contracts hindered choice and control. There had been some use of spot purchase[3] and this was supportive of innovation and tailored support for some people. A few examples of this were given in relation to supported people with learning disabilities.

In the partnership, there was still a reliance on council-provided service delivery. Eighty per cent of services were provided directly in this way. Corporate and political decisions in the council had directed the shape of service delivery to a great extent. There had been a commitment to retain as many services as possible within the council as this was seen as a way of supporting local employment. This had restricted innovation and the development of alternative care models. The level of in-house provision for care at home clearly limited choice. In practice, the majority of people had to accept council services. The senior management team felt strongly that a culture change was needed in the provision of services and that this could be done without impacting on the council's commitment to support local employment.

[2] Block contracts are payments made to a provider to deliver a specific, usually broadly defined service

[3] Spot contracts are when a service is purchased by a partnership as and when they are needed for a supported person. They are purchased on an individual basis for a single person.

The partnership had begun to work on shaping the market. There had been a minor shift of some care at home provision to external providers and the partnership was looking at new models of care using reablement. It was also seeking to increase respite provision and the range of respite opportunities. The partnership was keen to encourage small and medium-sized providers and had highlighted this in their market facilitation plan. They recognised that this would give more choice to individuals, increase choice and grow the market. However, there was no clear strategic plan in place for the partnership to continue enabling and growing the market.

The partnership had established a market facilitation consortium which included partners from across the statutory, independent and third sectors. The consortium aimed to make the best use of the resources across local communities. The consortium principles were described as *'*a comprehensive partnership approach across all sectors providing health and social care services; a commitment to provide enhanced delivery of service to individuals and communities and a need to create diversity within the marketplace based on population needs[4]*'.* This initiative was a positive one and borne out of a commitment to partnership working at locality levels. It was, however, not clear how this was to be translated into locality developments. The approach was developed in 2015 and there was little evidence that this approach had resulted in any real diversity within the marketplace. There was no evidence that it had been updated and linked into their strategic needs assessment, strategic plan, commissioning plans or locality planning forums.

While expenditure on self-directed support Options 1 and 2 in the partnership had increased[5], the partnership had a higher percentage of people opting for Option 3 compared with other partnerships. The partnership felt that high satisfaction with the partnership's social care services meant that people were less motivated to take up self-directed support direct payments or individual service funds options. The high number of people choosing Option 3 did not necessarily mean that this was not the right option for them. Within the partnership however, supported people did not necessarily have real choices open to them across all four options. The partnership did not routinely engage supported people or staff in getting feedback after options had been chosen so it was impossible to evidence that people were happy with their option choices.

Commissioning needed to be more creative and responsive. While there was still a requirement for traditional services for some supported people, it was clear that new models of care needed to be explored. Some staff recognised that due to the majority of services being in-house, people were steered towards taking services under Option 3. Staff felt they had ideas to offer about options that would support more innovative service, save money and improve outcomes.

[4] West Dunbartonshire Market Facilitation Consortium Paper September 2015
[5] From 1.39% of the overall adult social care spend in 2013/14 to 2.16% 2017/18

Service managers were very clear about the need to move to an outcome-focussed approach to commissioning. Procurement was predominantly corporately based. While the service managers worked closely with procurement services, there was a task ahead to educate their corporate partners as to what they wanted to achieve as they embedded the self-directed support approach, and how corporate partners could support them in doing this.

The commissioning of services was led by service managers. While all the managers had a good knowledge and understanding of self-directed support this was not reflected in their commissioning practices and the services commissioned. The partnership recognised the issues and risks around the current approach to contracts and commissioning. They were developing a commissioning manager post for the partnership. The partnership stated that this would clarify the responsibilities and roles of strategic commissioning and contract management within the health and social care partnership alongside the council's procurement team. The commissioning manager's role was to consider how primary and secondary health services could support the implementation of self-directed support. The partnership wanted this approach to lead to the embedding of self-directed support across all social care and health planning and ensure that the corporate approaches taken reflected the self-directed support ethos. They hoped this approach would support a streamlined and consistent contract monitoring approach across the partnership.

The Carers (Scotland) Act 2016 places additional demands on the partnership's budgets at a time of continuing financial austerity. The potential implications of the Act, including the financial impact of waiving of charges for carers, had not as yet been fully quantified. Finance staff had some concern about the financial impact of meeting carers' needs via self-directed support. The senior management team members were more confident. At the time of inspection, carers' needs were mostly being met through universal services. There was little use of self-directed support and budgets therefore it was having little financial impact. There was no evidence that the partnership was monitoring services to carers to ensure that needs were being appropriately met or forecasting need for newly commissioned services and ensuring any financial impact from that would be met. A detailed financial plan was to be developed over the next year to ensure a robust financial framework for the delivery of the priorities of the Act. The position of having no eligibility criteria for carers would be reviewed at that point.

The development of the partnership's approach to planning and commissioning services to support flexibility, choice and control was at a very early stage. There was no overarching commissioning plan which explicitly showed the self-directed support improvement actions.

Recommendation for improvement
The partnership should engage with supported people, carers and frontline staff to inform the development of new models of care focussed on delivering positive outcomes.

Recommendation for improvement
The partnership should take steps to increase local choice of provider and flexibility in the delivery of services to ensure people have genuine choice and control over how their support is delivered.

7. Management and support of staff

The partnership empowers and supports staff to develop and exercise appropriate skills and knowledge

Summary

Training, supervision and management support was not being used effectively to promote self-directed support. There had been an investment in training at the time of self-directed support implementation in 2014. This had not been maintained. There was no existing training for current or new staff including those moving into management roles, nor was any training extended to external providers. The partnership had begun to refresh their self-directed support guidance and had begun to develop continuous professional development material. The specifics and timescales for implementing these were unclear.

Evaluation: Weak

There had been a strong focus on self-directed support awareness raising and training in the early years of self-directed support. The partnership had delivered training to staff across social work, health and the third sector in 2014. This included creating champions or peer mentors. The direct payment team was also established at that time to support implementation within the learning disability team. This team was recognised by staff and managers as being knowledgeable and confident in working with supported people and staff around self-directed support.

The self-directed support team and guidance co-produced with the Royal National Institute of Blind People (RNIB) "*My life My choice; A Guide to Planning My Support*" were identified as helpful sources of information about self-directed support and for awareness raising amongst both staff and the wider community.

There was no ongoing training for new or existing staff at frontline and first line management level. There was a need for awareness raising and training about self-directed support to be refreshed and undertaken on an ongoing basis.

The senior management team acknowledged that they need to be confident that all stakeholders, including external providers, are working with a self-directed support ethos but they had no plans to offer any training to the third sector.

The partnership had recently released a practitioner from frontline work to develop new guidance and continuous professional development (CPD) material on self-directed support but there was no clearly articulated work plan to deliver the material.

Supervision for social work staff took place routinely on a six-weekly basis, with case file audits on a quarterly basis. Staff had the opportunity to attend practitioner forums although many staff told us that operational pressures often stopped them from attending. These were potential opportunities for staff to reflect on self-directed support within these forums but there was no evidence to suggest that this was happening.

In older adults' case records we saw that most interventions were positive and person-centred. However, much of this was done from a deficit-led approach to assessment and was process driven. This did not fit with the principles of self-directed support. Training, supervision and management support could have been used more successfully across all service groups to support staff to shift their practice to a more self-directed support, strengths-based approach.

The partnership indicated an intention to develop established practitioner forums and identify champions to get frontline staff more meaningfully engaged in the agenda. They were looking at ways that they could evaluate the effectiveness of these new initiatives.

Recommendation for improvement
The partnership should take a strategic approach to the development and delivery of self-directed support training for staff at all levels across the partnership.

Recommendation for improvement
The partnership should consider the training and development needs of all partners.

8. Leadership and direction that promotes partnership

Senior leaders create conditions that enable supported people to experience choice and control over their social care and support.

Summary

Some staff expressed doubt about the degree to which leaders in the organisation were committed to self-directed support. The senior management team had seen a number of senior staff retire or move onto other promoted posts. This led to a change of leadership. At the time of inspection, there were still temporary positions within this team. This had led to difficulties in driving the changes required to deliver self-directed support and maintaining a consistent approach to its implementation. The partnership's focus on health and social care integration over recent years had diverted their attention away from self-directed support. New members of the senior management team were committed to ensuring that self-directed support would be a significant and central activity for the whole health and social care partnership over the next year. They felt that once all senior managers were in post, they would have the opportunity to start a cultural shift in how they approached the delivery of all of their services. They recognised the need to develop a common understanding and direction around self-directed support across all partners including external providers. They had taken some steps to put the required foundations in place to reinvigorate this agenda. They needed to develop more robust plans to take this forward.

Evaluation: Weak

In the partnership's annual public performance report 2017, there was a large section on self-directed support which reinforced their commitment to meeting the requirements of the self-directed support legislation. The partnership had not yet met the commitments set out in this report.

The newly appointed senior management team articulated a commitment to reinvigorate full implementation of self-directed support. They had taken important initial steps, including the establishment of the self-directed support review group. All service managers were part of this group which demonstrated their commitment and their ownership of the agenda. This group was in the process of producing practitioner guidance during our inspection. The senior management team had overseen early progress on developments in training, tools and processes. Within a relatively short period of time they had also overseen a number of specific actions demonstrating their commitment to change.

Senior managers recognised the limitations in care at home and care home provision in supporting the delivery of self-directed support by the third and independent sector and were keen to develop their partnership with providers. They were developing plans to progress this. They recognised the importance of improving their approach to commissioning and planned a review of procurement and commissioning procedures. They were developing a commissioning manager post to address this.

It was evident that statutory partners across health and social care were starting to look at how they could work together to create a cultural change which would support innovative practice in line with the values and principles of self-directed support. Their stated intention was to use self-directed support as the approach that they would take in delivering all services. To ensure this cultural shift, the senior management team recognised that all leaders across the statutory partnership and all other stakeholders had to be more meaningfully engaged. Health leaders in particular had to be more visible and active in this agenda. A paper on self-directed support had gone to the integration joint board in November 2017. This board needed to be more actively involved in leading and supporting the changes that self-directed support required.

The senior management team recognised that the third and independent sector had to be more fully involved. While this was stated in the market facilitation plan, there were no plans as yet to show how this would be achieved.

While leaders had taken initial steps to progress self-directed support, we saw no overarching plan which brought together all the various improvement actions into one place. We saw no evidence of the use of evaluation and performance information to inform how they moved forward in developing and embedding self-directed support. While the senior management team could articulate their vision about where they needed and wanted to be, there was a lack of robust planning to support this. There were no clear timescales, pathways or plans in place to achieve their vision.

Finance staff had a very good understanding of self-directed support. There were constructive relationships between the senior management team and finance managers. They offered a supportive role to operational services. While driven by best value and the recognition that embedding self-directed support had to be done within the confines of decreasing resources, finance staff were committed to the ethos of self-directed support. They were advocates of transparency and equality of spend across care groups in relation to self-directed support and understood the principles of choice and control. This was important in preparing for the partnership to expand access to self-directed support across all care groups.

To embed self-directed support the partnership recognised that it has to more closely align to other factors such as its charging policy, its eligibility criteria and the implementation of the Carers Act. It had not yet assessed the impact of full implementation of self-directed support on its finances. This was a key risk yet they had not formally logged any identified any risks around this in the partnership risk register.

Staff completing our survey and those we met expressed significant levels of doubt about the degree to which leaders in the organisation were committed to self-directed support and how they facilitated and supported creativity and innovation. Senior managers and leaders were keen to stress their confidence that this perception would change in time, as a result of the changes that had more recently taken place at senior management level. It was too early however to say how effectively this would be progressed.

Recommendation for improvement
The partnership should accelerate its progress in embedding self-directed support and set clear timelines for full implementation of self-directed support across all care groups.

Recommendation for improvement
The partnership should develop a robust strategic plan for self-directed support aligned to its other partnership plans. The strategy should be underpinned by detailed action plans setting out how the partnership intends to fully implement self-directed support for all care groups across the partnership.

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Tha am foillseachadh seo ri fhaighinn ann an cruthannan is cànain eile ma nithear iarrtas.

অনুরোধসাপেক্ষে এই প্রকাশনাটি অন্য ফরম্যাট এবং অন্যান্য ভাষায় পাওয়া যায়।

یہ اشاعت درخواست کرنے پر دیگر شکلوں اور دیگر زبانوں میں فراہم کی جاسکتی ہے۔

ਬੇਨਤੀ 'ਤੇ ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਹੋਰ ਰੂਪਾਂ ਅਤੇ ਹੋਰਨਾਂ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਉਪਲਬਧ ਹੈ।

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Key message (KM2) The partnership should seek to ensure that supported people across all service groups and all unpaid carers consistently experience positive personal outcomes and take action to ensure that it is able to record, measure and report on these. The partnership should take steps to analyse and understand its local and national performance information and use this to inform and drive improvement in Self-directed Support.	
Key message (KM3) The partnership should develop appropriate pathways for individuals to access advocacy and/or independent brokerage if and when they need it to support decision-making around Self-directed Support options, choice and control. Where people are signposted to early intervention and preventative services the partnership should take steps to measure the effectiveness of these supports in reducing the need for more formal services and supports.	
Key message (KM4): The partnership should take action to measure the impact of learning and development and practice processes on staff competence, confidence and motivation.	
Key message (KM5): The partnership should embed a Self-directed Support ethos and approach across all key processes and systems. It should progress the planned changes to tools and processes and to the business system to ensure these support asset-based and outcomes focussed practice. The partnership should ensure that they can demonstrate that good decisions are made in relation to positive risk taking. This should be monitored and evaluated to inform ongoing risk management and risk enablement. The partnership should ensure that supported people are better informed about and more involved in key processes regarding their support.	
Key message (KM6) The partnership should engage with supported people, carers and frontline staff to inform the development of new models of care focussed on delivering positive outcomes. The partnership should take steps to increase local choice of provider and flexibility in the delivery of services to ensure people have genuine choice and control over how their support is delivered.	
Key message (KM7): The partnership should take a strategic approach to the development and delivery of Self-directed Support training for staff at all levels across the partnership. The partnership should consider the training and development needs of all partners.	

Improvement objectives	Actions for delivery	Responsible	Timescales /Review	Evidence of improvement	RAG status
Key outcome. Supported people are empowered to experience positive personal outcomes, through the effective implementation of SDS.	Delivery of the agreed Improvement Plan will be governed by a communication and reporting structure including the Chief Officer and Chief Social Worker. See **Appendix 1** HSCP Programme Board (PB) will oversee delivery of the Improvement plan by supporting Operational Managers to release staff to participate in collaborative working with relevant HSCP colleagues, partner agency staff and community representatives. (KM: 2,3,4,5,6,7)	Programme board (PB): Chair, Jonathan Hinds and members of the PB. Chief Officer, PB and SDS Lead.	April 2020 April 2020	Service users will report improved choice and control: this will be evident in performance data and Service-user feedback. Staff and partners will be working collaboratively to deliver the Improvement plan.	Green Green

Improvement objectives	Actions for delivery	Responsible	Timescales /Review progress	Evidence of improvement	
Key outcome To nurture a confident, competent workforce who can work in a person-centred way, within the principles of SDS legislation.	The Staff Training and Support SLWG will make recommendations to the Working group on how the HSCP can deliver: A training-for-trainers programme, building a network of practitioners who are confident in relation to: SDS legislation and the principles of the ACT. Asset-based assessments. Outcome focussed support planning. Engaging with community resources. The HSCP will support the Trainers to deliver in-house training to colleagues, as well as sharing good practice across the HSCP to embed SDS principles in everyday practice. An electronic training module will be developed to support new staff during their induction. (KM:4,7)	Staff training and support short-life working group. SDS lead, Staff Training SLWG and SDS workers. SDS lead and HSCP Comms and I.T. staff.	December 2019 December 2019 December 2019	Staff appraisal and PDP will reflect improved knowledge of SDS. HSCP training log will reflect full engagement with training. HSCP will training data will evidence full compliance with e-learning module among new staff.	Amber Amber Green

Improvement objectives	Actions for delivery	Responsible	Timescales /Review progress	Evidence of improvement	
Key outcome By developing a data-rich service, improved delivery will be evidenced and reportable.	Data/Documentation and Performance SLWG will compile and pilot a person-centred assessment which focuses on the assets of supported people and identifies their outcomes.	SDS lead and SLWG.	November 2019.	HSCP documentation will facilitate appropriate reporting capability to measure improvement around the extent to which supported people are exercising choice and control.	Amber
				Staff will report increased confidence in person-centred working.	Red
HSCP assessment, support planning and review processes will be standardised as far as practicable and will align to resource allocation and procurement processes.	SLWG will develop a set of practitioner guidance, detailing all HSCP assessment, support-planning and review processes, in line with good practice. SLWG will liaise with colleagues reviewing the IRF and procurement processes. (KM: 4,5,6)	SDS lead and SLWG SDS lead and SLWG		The HSCP SDS network will regularly review all documentation in line with good practice examples and Scottish Government guidance.	Red

Improvement objectives	Actions for delivery	Responsible	Timescales /Review progress	Evidence of improvement	
Key outcome HSCP leaders will create conditions which enable supported people to experience more choice and control. HSCP systems and processes will facilitate greater choice and control for supported people.	HSCP leaders will participate in and support staff to train in all aspects of SDS informed practice. HSCP leaders will work with staff and partners to develop a culture of increased choice and control and personalised care and support by supporting engagement events and protecting staff time for training and sharing good practice. HSCP staff and partners will collaborate in reviewing HSCP systems and processes in line with SDS principles and legislative requirements. (KM:2,5,7)	Chief Officer and HSCP Senior Management Team Chief Officer and HSCP Senior Management Team	Review progress at each SMT meeting and report to each IJB meeting Review April 2020	HSCP staff and partners will report a shared language culture and understanding around personalisation and SDS.	Red Red

Improvement objectives	Actions for delivery	Responsible	Timescales /Review progress	Evidence of improvement	
Key outcome The development of an effective communication and engagement programme of resources and activities.	Communication SLWG (which includes service users, advocacy and carers) will work with HSCP staff to refresh and improve the HSCP website in relation to: What is SDS? How to access information and advice. How to access support. The range of services and resources in West Dunbartonshire. The implications for Carers. Use existing Local Engagement Networks to engage West Dunbartonshire residents. Agree and arrange creative engagement events with Health Improvement colleagues and community groups such as Golden Memories and the Good Life Group. A service user forum will be formed. (KM:2,3,5,6)	SDS lead and SLWG will make recommendations to Programme Board. Community Engagement Officer and SLWG. Chief Officer, PB and SLWG. SDS lead, Community Engagement Officer and SDS Ideas.	December 2019 December 2019 December 2019 December 2019	SDS and personalisation will be routinely discussed in service review and development work with partners and providers.	Amber Amber Green

Improvement objectives	Actions for delivery	Responsible	Timescales/Review progress	Evidence of improvement	RAG status
Key outcome					
HSCP commissioning and procurement processes will facilitate choice and control.	Finance SLWG will work with Council Procurement colleagues to develop a financial framework which supports person-centred resource allocation.	SDS lead, SMT and WDC finance.	April 2020	HSCP budgetary alignment will reflect greater choice and control for supported people.	Amber
	SDS lead will facilitate sharing of good practice with colleagues in other HSCPs who have already begun this change process.	SDS lead.	November 2019	Service user feedback will evidence more personalisation and use of a range of providers.	Green
	HSCP will review : Charging and contributions Free personal care Respite SDS for Carers (KM:2,3,5)	SDS lead, SMT and WDC finance.	April 2020	HSCP SMT will have suite of policies and guidance in place.	Amber

WEST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP BOARD

19 February 2020

Subject: Meeting Dates of the Health and Social Care Partnership Board

1. Purpose

1.1 To present the Health and Social Care Partnership Board with a request to add two further meeting dates to the 2020/21 schedule.

2. Recommendations

2.1 The Partnership Board is asked to:

- Approve the request for an additional meeting date of the HSCP Board on 25 March 2020 to comply with previous decision to increase frequency to six per year; and
- Approve the request for an additional special meeting of the HSCP Board on 23 September 2020, immediately after a meeting of the Audit and Performance Committee to recommend the "sign off" of the 2019/20 audited annual accounts.

3. Background

3.1 Standing Orders state that the Integrated Joint Board shall meet as such place and such frequency as may be agreed by the Integrated Joint Board, known as the Health and Social Care Partnership Board.

3.2 The HSCP Board meeting of 20 February 2019 approved to extend the number of meetings to six per calendar year from the previously agreed four. The report also highlighted that there may be a further request for realignment of dates to allow for the approval of the audited annual accounts.

3.3 The HSCP Board meeting of 13 November 2019 approved a revision to the Terms of Reference of the Audit Committee which recommended that for the 2019/20 Annual Accounts exercise the "Audit and Performance Committee" would continue to approve the draft annual accounts including the governance statement with the final approval of the audited annual accounts and report the responsibility of the HSCP Board.

4. Main Issues

4.1 The HSCP Board is required to approve annually the revenue allocations from its partner organisations of West Dunbartonshire Council and NHS Greater Glasgow and Clyde Health Board and set an annual budget before the 31 March to allow delivery of strategic planning priorities for the new financial year commencing on 1 April.

4.2 This requirement was reinforced by the Ministerial Steering Group's (MSG) Review of the Progress of Integration Report published in February 2019. The report while recognising the differing budget timetables of local authorities and health boards recommended that delegated budgets to IJBs should be agreed timeously.

4.3 The December 2019 UK General Election caused a delay to the Scottish Government's annual budget announcement until 6 February 2020 which has had an impact on the timing of the budget offers from our partner organisations. West Dunbartonshire Council plan to set their 2020/21 budget on 4 March 2020, as is their statutory duty, which will include the revenue budget allocation to the HSCP Board. NHS Greater Glasgow and Clyde Health Board have yet to notify IJB's of the date of their formal offer but in line with the MSG recommendation this should be by 31 March.

4.4 The uncertainty around the final revenue allocations does not allow the HSCP Board to set a budget at this February meeting. Therefore it is recommended that an additional meeting of the board is scheduled to be held in Clydebank Town Hall on 25 March at 11.30am to consider the 2020/21 Annual Budget Setting Report and potential savings options to close any budget gap.

4.5 As set out in section 3.3 above, following a review of the Terms of Reference (ToR) of the Audit Committee, it is now the responsibility of the HSCP Board to approve the audited annual accounts and report before the 30 September. This follows a review of the draft annual accounts by the Audit and Performance Committee, charged with "*overseeing the internal control environment and financial governance arrangements of the Partnership Board"* (extract from ToR).

4.6 To join up the two responsibilities it is recommended that immediately following the Audit and Performance Committee scheduled to be held in Church Street, Dumbarton on 23 September at 2pm, a special board meeting is convened to allow approval and sign off of the 2019/20 annual accounts.

5. People Implications

5.1 No specific implications associated with this report.

6. Financial and Procurement Implications

6.1 The addition of HSCP Board meetings may have a small financial impact with regard to printing of papers.

7. Risk Analysis

7.1 The Chief Financial Officer (Sect.95 responsibility) for the HSCP Board must establish a robust annual budget process that ensures financial balance.

7.2 The Chief Officer for the HSCP Board must ensure that the Strategic Plan meets the Best Value requirements for economy, efficiency and effectiveness.

8. Equality Impact Assessment (EIA)

8.1 There is no requirement for an Equality Impact Assessment.

9. Consultation

9.1 There is no requirement for consultation; however the additional meeting dates will be published on the HSCP website.

10. Strategic Assessment

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

Julie Slavin – Chief Financial Officer
10 February 2020

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Appendices:	None
Background Papers:	Terms of Reference – Audit and Performance Committee
Wards Affected:	All.