

**East Dunbartonshire HSCP Performance, Audit & Risk Committee Meeting
Wednesday 19th December 2018, 9am
Meeting Room G5, Southbank Marina, 12 Strathkelvin Place,
Kirkintilloch G66 1TJ**

AGENDA

No.	Item	Lead	Document
1.	Welcome and Introductions	S Murray	
2.	Minutes of Last Meeting – 21 st September 2018	S Murray	
3.	Internal Audit Progress Update 2018	G McConnachie	
4.	Scott-Moncrieff NHSGGC Internal Audit Plan 2018-21	G McConnachie	
5.	Audit Scotland – Health & Social Care Integration	J Campbell	
6.	Inspection Reports undertaken by the Care Inspectorate - John Street House, Meiklehill and Pine View	C Sinclair	
7.	Commissioned Spend 2017/18 – 2018/19	J Campbell	
8.	HSCP Transformation Plan 2018/19 - Update	J Campbell	
9.	Future Agenda Items -	All	
10.	A.O.C.B	S Murray	
11.	Date of next meeting – February 2019	S Murray	

**Minutes of
East Dunbartonshire HSCP Performance, Audit & Risk Committee Meeting
held at 10.00am on Friday 21st September 2018
in S1, Kirkintilloch Health & Care Centre**

Present:

Susan Murray (Chair)	(SM)	Alan Moir	(AM)
Jacqueline Forbes	(JF)	Jean Campbell	(JC)
Derrick Pearce	(DP)	Peter Lindsay	(PL)
Fiona Mitchell-Knight	(FM)	Kenneth McFall	(KMc)
Gillian McConnachie	(GM)		

In attendance: Kirsty Gilliland (Minutes) (KG)

No.	Topic	Action by
1.	Welcome and Apologies	
	Susan Murray welcomed those present. Susan Manion, Ian Ritchie, Sheila Mechan and Mags McGuire's apologies were noted.	
2.	Minutes of previous meeting – 27th June 2018	
	The minute of the meeting held on 27 th June 2018 was approved as an accurate record.	
3.	Audit Scotland – Draft 2017/18 East Dunbartonshire IJB Annual Audit Report	
	<p>Mrs Mitchell-Knight and Mr Lindsay gave an overview of the plan for 2017/18, which was previously circulated with the agenda, the Auditor's letter and letter of representation from the Chief Finance & Resources Officer. Mrs Mitchell-Knight highlighted the key issues and advised that there are no matters other than those set out in the report that need to be brought to the attention of the Committee.</p> <p>Mrs Murray was reassured those significant errors had now been corrected and that appropriate governance measures were now put in place.</p> <p>Mrs Forbes asked that we ensure the final audited accounts are used going forward rather than the unaudited accounts.</p> <p>The Committee noted the report.</p>	
4.	ED HSCP 2017/18 Final Audited Accounts	
	<p>Ms Campbell presented the final audited annual accounts 2017/18 and advised that this had been updated to remedy any consistency and presentational issues identified throughout the audit process.</p> <p>The report presents a year end deficit for the partnership of £1.1m. As reported to the IJB throughout the financial year, this required a drawdown from general reserves of £1.7m to mitigate the net impact of pressures in relation to Adult and Children's Social Work services.</p> <p>Ms Campbell advised that there is a requirement for financial accounts to be signed by the Chair, Chief Officer and Chief Finance & Resources Officer.</p>	

	<p>Mrs Forbes queried the Expenditure and Income Analysis on page 32 which details the total paid in by both organisations – in excess of £151m, however this does not equate to the contribution each partner made. Ms Campbell advised that this relates to historic resource transfer monies, pre the set up of the IJB, and relates to funding transferred from Health into the Local Authority to support community based services in response to hospital closure programmes such as Woodilee, Lennox Castle in years gone by.</p> <p>The Committee approved the recommendations and noted the report.</p>	
5.	EDC Internal Audit Progress Update 2018/19	
	<p>Mrs McConnachie gave an overview of the outputs for 2018/19 relevant to the HSCP, covering the period from April 2018 to July 2018. Any risks are highlighted to management in action plans appended to the audit reports.</p> <p>Progress is being against the 2018/19 plan with 11 outputs completed. An additional 9 outputs are in progress, which include; Freedom of Information, Direct Payments and Carefirst.</p> <p>Mrs Forbes commented that the progress was reasonable.</p> <p>The Committee noted the update.</p>	
6.	EDC Final Follow Up Audit Review 2017/18	
	<p>Mrs McConnachie provided a summary of outstanding audit issues, focusing on high risk areas which include: outstanding risks relating to Homecare, Carefirst, Direct payments and Social Work Contract monitoring.</p> <p>Mrs Forbes referred to 4.3 in the report which highlights Business Continuity as being high risk, however, there is no evidence to demonstrate that we are making progress. Ms Campbell reassured the Committee that progress was underway and outlined that controls were being put in place via various electronic systems.</p> <p>Mrs Forbes highlighted that Appendix 1 outlines that progress had been made under the Homecare review however, no target dates were identified. These need to be included.</p> <p>The Committee noted the report.</p>	
7.	NHSGGC PwC Internal Audit Activity to June 18	
	<p>Mrs McConnachie gave an overview of PwC's Internal audit annual report on NHSGG&C.</p> <p>The audit opinion given by PwC on NHS Greater Glasgow & Clyde is generally satisfactory with some improvements required. Governance, risk management and control in relation to business critical areas is generally satisfactory, however, there are some areas of weakness and non-compliance in the framework of governance, risk management and control which potentially put the achievement of objectives at risk. Three of the audit findings identified during 2017/18 rated as high risk should be reported in the Governance Statement. These include waiting times management, achieving financial balance & mental health and crisis management.</p> <p>NHS Greater Glasgow & Clyde has accepted their findings.</p> <p>Mrs Forbes highlighted that the increase and demand currently experienced across the NHS is putting strain on the budget.</p>	

	<p>Mrs Murray questioned the comment in the audit report regarding not having access to the full audit reports for NHS GG&C.</p> <p>Ms Campbell clarified that they have no obligation to disclose this to the IJB as the contractual arrangement for provision of the internal audit arrangements is between NHS GG&C and the appointed auditors, however discussion are underway with Chief Internal Auditors to improve these arrangements and ensure sufficient oversight of report to provide assurances to IJB Audit Committees.</p> <p>The Committee noted the update.</p>	
8.	<p>Homecare – Care Inspectorate Report</p>	
	<p>Mr Pearce provided an update on the outcome of the unannounced inspection of Homecare services by the Care Inspectorate in May 2018. The three quality themes the inspection looked at include; Quality of Care and Support; Quality of Staffing and Quality of Management and Leadership. The results represent a significant decline in comparison to the last announced inspection in April 2017.</p> <p>Although the inspection report is concerning, the inspectorate recognised good practice by our carers and very positive feedback from customers. This allows us a benchmark and creates an opportunity for reflection and development.</p> <p>A formal service review had already been initiated jointly between the HSCP and EDC Organisational Transformation prior to the inspection.</p> <p>An action plan has been developed, signed off internally and submitted to the Care Inspectorate who has accepted it. A number of areas are already in progress and some have been actioned. The areas covered in the action plan include; Person centered assessment, support planning and review; Customer/Carer involvement; Staff vacancies and absence; Workload and shift rotas; Staff induction, registration and supervision; Training and Quality assurance.</p> <p>This will now be implemented by the service and the impact on service and quality improvement will be monitored. The Care Inspectorate will re-visit the service in December 2018 to follow up on the required action.</p> <p>Mrs Forbes highlighted that the report was worrying, particularly around staff turnover and asked what the reason for this is. Mr Pearce explained that it is difficult to retain staff mainly due to the level of pay and it can also be a physically demanding role.</p> <p>Mrs Murray recommended noting the initiation of a service review of homecare in the development plan as it is only mentioned in the summary. She suggested including a hyperlink.</p> <p>Mr Moir was concerned about staff morale in terms of staff turnover. Staff need to know it is being taken seriously and that they are valued. Mr Pearce assured the Committee that the review process will be robust to engage with staff.</p> <p>The Committee noted the report.</p>	

9.	Adult Support & Protection Inspection	
	<p>Mr Pearce and Ms Campbell gave an overview on the outcome of the recent inspection of Adult Support and Protection services in the absence of Caroline Sinclair, Head of Mental Health, Learning Disability, Addiction & Health Improvement.</p> <p>East Dunbartonshire was one of six partnerships to be inspected and this was the first inspection of its nature. The key findings within East Dunbartonshire were good across the board. The one area for improvement was around chronologies for all adults who require them.</p> <p>Mrs Forbes commented that the report was interesting as out of the six partnerships, there was only one cited and their results were poorer than the other five.</p> <p>Mr Pearce advised that there was some learning to be gained from the other areas. He informed the committee that the comments around Leadership reflect the vacancies at the time as he and Caroline Sinclair were not in post at that time.</p> <p>The Committee noted the report.</p>	
10.	Future Agenda Items	
	<p>Mrs Murray highlighted the changing role of the HSCP Performance, Audit & Risk Committee and how we can support Susan's suggestion, from the previous committee, on providing a forum for effective oversight of financial planning whilst being functional and monitoring the progress of overall performance as we are only meeting a portion of our indicators.</p> <p>There are a number of areas of improvements identified for 2018/19 and some objectives for future meeting should include:</p> <ul style="list-style-type: none"> • HSCP Financial planning • Transformation and efficiency • External payments • Best value <p>Mrs Murray suggested that we should meet more regularly - perhaps quarterly.</p>	
11.	Date of Next Meeting	
	<p>Next meeting of the group is scheduled to take place on Monday 26th November 2018.</p>	

**EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE, AUDIT & RISK
COMMITTEE**

Date of Meeting	19 December 2018
Subject Title	Internal Audit Progress Update 2018/19
Report By	Jean Campbell, Chief Finance & Resources Officer
Contact Officer	Gillian McConnachie, Chief Internal Auditor, 0300 123 4510

Purpose of Report	<p>The purpose of this Report is to advise the Committee of the progress against the agreed 2018/19 Audit & Risk Plan (the Plan). This is the second performance monitoring report of 2018/19, covering the month to the end of August 2018. The report also includes consideration of the outputs finalised during the period.</p> <p>The information contained in this report is presented in the first instance to the council's Audit and Risk Management Committee (A&RMC), where it receives scrutiny. Once noted by the A&RMC, this report provides details on the ongoing audit work, for information, to the H&SCP Performance, Audit & Risk Committee and to allow consideration from the perspective of the H&SCP.</p>
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Recommendations	<p>The Audit Committee is asked to:</p> <p>a) Note the Update on Internal Audit Progress.</p>
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Relevance to HSCP Board Strategic Plan	None directly.
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Implications for Health & Social Care Partnership

Human Resources:	Nil
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Equalities:	Nil
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Financial:	Nil
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Legal:	Nil
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Economic Impact:	Nil
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Sustainability:	Nil	
Risk Implications:	Risks are highlighted to management in Action Plans appended to audit reports.	
Implications for East Dunbartonshire Council:	Nil	
Implications for NHS Greater Glasgow & Clyde:	Nil	
Direction Required to Council, Health Board or Both	Direction To:	
	1.1 No Direction Required	X
	1.2 East Dunbartonshire Council	
	1.3 NHS Greater Glasgow & Clyde	
	1.4 East Dunbartonshire Council and NHS Greater Glasgow and Clyde	

MAIN REPORT

- 1.1 In the month of August 2018, the Audit and Risk Team have finalised and reported on the six areas as shown in Table 1.
- 1.2 Good progress is being made against the 2018/19 plan, with 17 outputs completed. This represents 49% completion of the 35 outputs planned for the year. In delivering these outputs 39% of the resources have now been allocated in the Plan as at 42% through the year. An additional seven outputs are in progress. In short; more work has been completed in less time than anticipated and with fewer resources applied. This is a good position and allows the Internal Audit team to reinvest resources and add value in excess of that anticipated in the original plan.
- 1.3 No material issues have been identified which would impact on the ability of the team to deliver the plan or to provide an opinion at the year end at this stage.

Table 1 – Analysis of Audit and Risk Outputs in April to July 2018

Audit Area and Title		Issues Noted	High Risk	Med Risk	Low Risk
System					
12	Key Payment Controls	12	1	9	2
13	Pupil Equity Fund	3	1	2	-
Consultancy¹					

14	Controls at Mugdock	-	-	-	-
15	91 Main Street, Lennoxton – considered as private agenda item at the council’s Audit and Risk Management Committee.				
16	Property Maintenance Procurement Practices	5	2	3	-
Performance					
11	Local Government Benchmarking Framework	4	-	2	2

¹ Consultancy Notes may not classify issues in terms of High / Medium / Low risk, due to the limited scope of these assignments. The Controls at Mugdock assignment involved providing advice but without the creation of a formal action plan.

1.4 **In relation to the period since the last monitoring report, particular areas for Members to note include:**

1.5 **System Audits Concluded in the Reporting Period**

1.6 **Key Payment Controls** - Following an issue in Dundee City Council (DCC) where a serious fraud was carried out by an employee and DCC was exposed to the risk of substantial financial loss, the Chief Finance Officer of the Council requested a Key Payments Controls Audit. Auditors concluded that the key controls in the payments system are generally reasonable but that the council should implement improvement actions to further enhance assurances within the area. Auditors identified twelve areas of risk, of which one was classified as High risk, nine as Medium risk and two as low risk. These were accepted by management, with the exception of one of these which was rejected due to management advising that the previous Servitor (job costing system) invoice process is now being replaced with iProc and so the issue raised by auditors will no longer be relevant. A High risk issue was noted relating to the absence of a system audit trail and the resulting lack of a system report detailing changes in supplier data. It has been recommended that this should be introduced as a matter of priority to track changes to supplier standing data.

Appendix 1 – Summary of Audit Time and Outputs Year to 31st August 2018

Appendix & Audit Area	Audit Plan Monitoring							
	YTD Days				Outputs			
	Annual Plan Days Allocated	Actual Days at 31 Aug 18	Days Remaining / (Overspent)		Planned Annual Outputs	Actual Total YTD	Actual Work in Progress	Percentage Completion
1 - System	265	146	119		9	2	4	22%
2 - Regularity	248	72	176		15	4	-	27%
3 - Irregularity	40	3	37		1	1	-	100%
4 - Performance	20	11	9		2	1	-	50%
5 - Consultancy	162	86	76		7	9	3	129%
6 - ICT	30	6	24		1	-	-	0%
7 - Development	220	57	163		-	-	-	N/A
- Training, Management, Admin	188	48	140					
- Quality Review	10	2	8					
- Performance Monitoring	22	6	16					
Direct Audit Time	985	380	39%		35	17	7	49%

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE, AUDIT & RISK COMMITTEE

Date of Meeting	19 December 2018
Subject Title	Scott-Moncrieff NHSGGC Internal Audit Plan 2018-21
Report By	Jean Campbell, Chief Financial Officer
Contact Officer	Gillian McConnachie, Chief Internal Auditor, 0300 123 4510

Purpose of Report	This report provides members with a copy of Scott-Moncrieff's Strategic Internal Audit Plan for NHS Greater Glasgow and Clyde for 2018/19 to 2020/21.
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Recommendations	The Audit Committee is asked to: a) Note the contents of the Scott-Moncrieff Internal Audit Plan.
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Relevance to HSCP Board Strategic Plan	Management may wish to consider the implications of the risks identified in the NHS Corporate Risk Register may have on the ability of the H&SCP to achieve its Outcomes.
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Implications for Health & Social Care Partnership

Human Resources:	Nil
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Equalities:	Nil
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Financial:	Nil
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Legal:	Nil
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Economic Impact:	Nil
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Sustainability:	Nil
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Risk Implications:	NHS risks potentially pose cross-over risks to the H&SCP.
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Implications for East Dunbartonshire Council:	Nil.
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Implications for NHS Greater Glasgow & Clyde:	This plan has been approved by NHSGGC Audit and Risk Committee.
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Direction Required to Council, Health Board or Both	Direction To:	
	1.1 No Direction Required	X
	1.2 East Dunbartonshire Council	
	1.3 NHS Greater Glasgow & Clyde	
	1.4 East Dunbartonshire Council and NHS Greater Glasgow and Clyde	

MAIN REPORT

- 1.1 Scott-Moncrieff have been appointed as the internal auditors of NHS Greater Glasgow and Clyde (NHSGCC) for the period 2018 to 2021. The attached document **(Appendix 1)** details their plan of work over this period and has been approved by the NHSGGC Audit and Risk Committee.
- 1.2 To date, the only final report which has been presented to the NHSGGC Audit and Risk Committee by Scott-Moncrieff is the annual Property Transactions Monitoring report. There were no issues highlighted. It is a requirement of the Scottish Government property to ensure that property transactions are conducted in accordance with guidance in the NHS Scotland Property Transactions Handbook. The report concluded that all transactions were found to have been properly conducted.
- 1.3 Further updates on the work of Scott-Moncrieff will be provided to this committee as it is made available by NHSGCC.



NHS Greater Glasgow & Clyde

Strategic Internal Audit Plan 2018/19 – 2020/21

September 2018



Scott-Moncrieff
business advisers and accountants

NHS Greater Glasgow & Clyde

Strategic Internal Audit Plan 2018/19 – 2020/21

Introduction	1
Delivering the internal audit plan	2
Our strategic approach	3
Understanding the Board's audit needs	5
Proposed internal audit plan	7
Appendix 1 – Strategic Internal Audit Plan 2018-21	8
Appendix 2 – Corporate Risk Register	19
Appendix 3 – Internal audit universe and audit needs score	27
Appendix 4 – Internal Audit Charter	40

Introduction

Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, internal control and governance processes.

Section 3 – Definition of Internal Auditing, Public Sector Internal Audit Standards

Our strategic internal audit plan is designed to provide NHS Greater Glasgow & Clyde (NHSGGC), through the Audit and Risk Committee, with the assurance it needs to prepare an annual Governance Statement that complies with best practice in corporate governance. We also aim to support the continuous improvement of governance, risk management and internal control processes by using a systematic and disciplined evaluation approach.

The Public Sector Internal Audit Standards (PSIAS) require the Chief Internal Auditor to produce a risk-based plan, which takes into account NHSGGC's risk management framework, its strategic objectives and priorities, and the views of senior managers and the Audit and Risk Committee.

The objective of audit planning is to direct audit resources in the most efficient manner to provide sufficient assurance that key risks are being managed effectively and value for money is being achieved.

This document addresses these requirements by setting out the strategic internal audit plan for the three-year period 2018/19 to 2020/21.

Audit and Risk Committee action

We presented the 2018/19 draft internal audit plan to the Audit and Risk Committee on 5 and 19 June 2018 in the context of the three year strategic internal audit plan. At the 19 June meeting agreement was obtained on the reviews to be commenced in the first half of 2018/19. Since then, we have discussed all of the proposed areas for review in 2018/19 with the Chief Executive and executive directors. The plan was then presented to the Board at a seminar on 4 September 2018 and is now submitted to the 11 September 2018 Audit and Risk Committee meeting for final approval.

Delivering the internal audit plan

Internal Audit Charter

At Appendix 4 we have set out our Internal Audit Charter, which details how we will work together to deliver the internal audit programme.

Internal Audit team – indicative staff mix

Grade	Input (days)	Grade mix (%)
Partner/Director	80	15%
Manager	90	17%
Qualified	130	25%
Senior	115	22%
Junior	110	21%
Total	525	100%

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Our strategic approach

A holistic methodology

We understand that NHS Greater Glasgow and Clyde faces a highly complex and ever evolving landscape and a range of challenging issues and risks. This means that you need to balance competing priorities within demanding timescales and with limited resources. The purpose of this strategic internal audit plan is to support you in addressing these challenges by providing assurance on the internal controls that manage your key risks and by encouraging a culture of continuous improvement throughout the health board.

Our methodology is designed to reflect your environment, minimising the burden on staff to support the audit process whilst maximising the value we add both in each individual audit and from the audit programme as a whole. We plan complementary audits that enable us to provide you with a holistic view of your key risk mitigating strategies and processes. As part of this we design end-to-end process reviews that consider the knock-on impact that issues can have throughout different parts of the healthcare system.

Planning our audit work in this way means that we build our knowledge to better support you in designing and implementing effective management actions that complement changes happening at the same time in different parts of the organisation.

Best value

Our work helps you to determine whether services are providing best value. Every audit report includes an assessment of value for money by considering the design of your systems, processes and controls and whether these are working efficiently and effectively. Where we identify opportunities for improving value for money, we discuss these with management and include them in the management action plan.

Assurance, Process Improvement and Ad-Hoc Reviews

Our plan includes a mix of core assurance and process improvement work, while retaining flexibility to deliver ad-hoc reviews at the request of management or the Audit and Risk Committee. This approach allows us to target audit resource as effectively as possible, utilising the full skills of our team to help the Board address key organisational risks. We will agree the primary objective of each review with management during the planning process.

Core assurance reviews

Core assurance reviews provide the necessary coverage of key control systems on a cyclical basis, looking to confirm that the systems that mitigate your key inherent risks are operating as expected and in support of a robust internal control framework.

Process improvement reviews

Process improvement reviews allow us to look at systems in more depth, working in collaboration with management and the Audit and Risk Committee to focus on areas where it may be acknowledged that further development is required to improve either the efficiency or effectiveness of the process, or both. We work in partnership with management, in an open

way and as a critical friend, to agree improvements in those areas and systems. Systems that typically benefit most from process improvement reviews are those that cut across more than one team or department, as the interface between distinct teams is often the place where inefficiencies can occur.

Ad-hoc

Management support time allows us to react to the board's needs over the course of the year and add value in investigations, systems development and gateway reviews, project input support, risk management development and other areas where our specialist involvement may be of use.

DRAFT

Understanding the Board's audit needs

Risk and audit needs assessment

Internal audit plans are based on an assessment of audit need. "Audit need" represents the assurance required by the Audit and Risk Committee from internal audit that the control systems established to manage and mitigate the key inherent risks are adequate and operating effectively. The objective of the risk and audit needs assessment is therefore to identify these key control systems and determine the internal audit resource required to provide assurance on their effectiveness.

The risk and audit needs assessment involves consideration of both:

- Areas of high residual risk i.e. those that appear on the strategic risk register and are a current focus for the organisation
- Areas of high inherent risk i.e. key processes that are crucial to the organisation's success.

Reviewing the risk profile from both aspects ensures that our audit plan provides the Audit and Risk Committee with assurance over key processes and controls and also helps to drive process improvement and support the organisation in better managing emerging and significant strategic risks.

The risk and audit needs assessment process can be summarised as follows:



Strategic residual risks

During the risk and audit needs assessment, we consider the areas of highest residual risk in your strategic risk register and identify the control systems currently in place to manage those risks. We do this by considering the key processes in place within the Board and the relevance of each strategic risk to those processes. This helps us to understand the scope and potential impact of each risk, as well as the interdependencies across the Board.

The strategic risk register is included in Appendix 2 and cross-referenced to the internal audit plan in Appendix 1.

Inherent risks and audit universe

We also review the Board's audit universe (the potential auditable areas) and assess the inherent risk associated with each area. This enables us to identify the areas where the Audit and Risk Committee most needs assurance that systems and processes are operating effectively.

The board's audit universe and inherent risk rating is included in Appendix 3.

Environmental and change risks

Finally, we take account of ongoing projects, forthcoming changes and our wider knowledge of the NHS and public sector to ensure we provide an appropriate level of audit coverage across all key areas and risks. This includes consideration of the following key sources of information:

- The Board's Corporate Plans/ Local Delivery Plans/ Operational Plans,
- Previous internal audit reports,
- External audit reports and plans,
- The Board's website and internal policies and procedures,
- Our experience at other health boards and our understanding of the sector,
- Discussions with the Senior Management Team, the Audit Committee Executive Group and the Audit and Risk Committee.

The risk and audit needs assessment will be revised on an ongoing basis (at least annually) to take account of any changes in the Board's risk profile. Any changes to the internal audit plan will be approved by the Audit and Risk Committee.

Liaison with external audit

We seek to complement the areas being covered by NHSGGC's external auditors, Audit Scotland. We welcome comments on the internal audit plan from Audit Scotland at any time and we will formally discuss the plan with Audit Scotland on at least an annual basis. This will help us to target our work in the most effective manner, avoiding duplication of effort and maximising the use of the board's total audit resource.

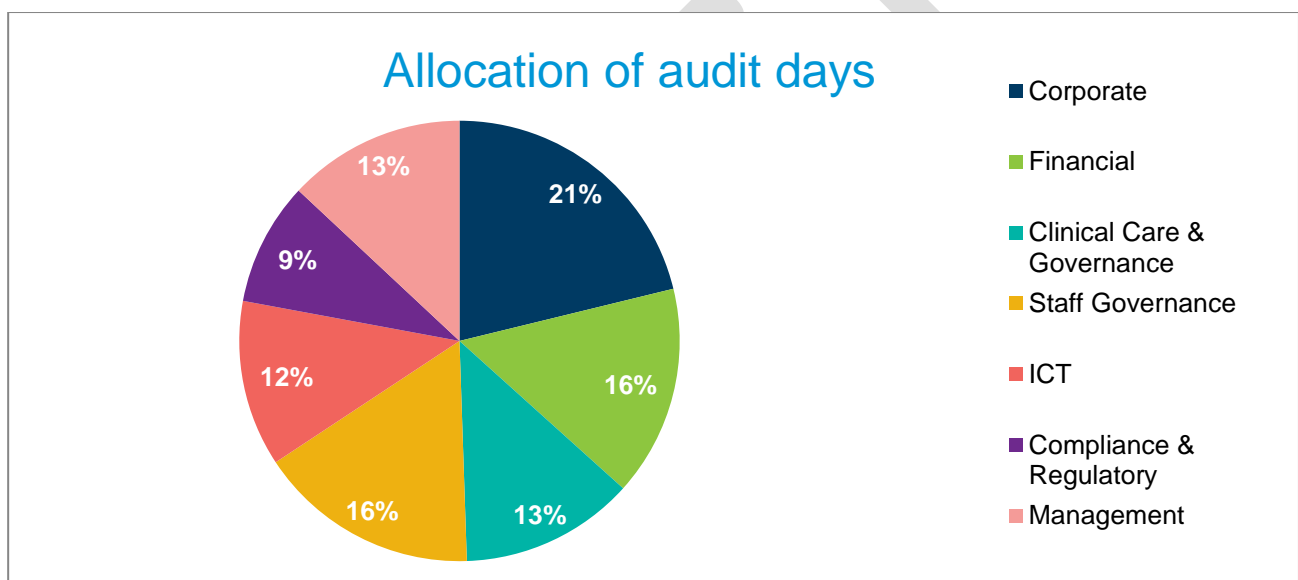
Internal audit plan

Appendix 1 presents the internal audit plan for 2018/19 to 2020/21. The three year internal audit plan is based on our latest risk and audit needs assessment dated August 2018.

As our internal audit approach is based on risk, the proposed plan is also cross-referenced to the strategic risk register, which is included in Appendix 2 for reference.

Internal audit is only one source of assurance for the Audit and Risk Committee. Assurance on the management of risk is provided from a number of other sources, including the senior management team, external audit, and the risk management framework itself.

The table below demonstrates how the internal audit days agreed for 2018-21 are allocated across each area of the audit universe:



Appendix 1 – Strategic Internal Audit Plan 2018-21

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
A. Corporate					
A.1 Strategic planning alignment	40			2054 2055 2056	To confirm that the NHSGGC Moving Forward Together Transformation Plan and the IJB strategic plans are appropriately aligned to reflect the integration of service deliverables and shift in the provision of health and social care services. This will cover the inclusion of public health objectives. The review will cover strategic integration across the 12 partnerships that NHSGGC engages with.
A.2 Moving Forward Together implementation		35	30	2054 2055 2056	To review delivery of the Moving Forward Together Transformation Plan to achieve system-wide change within NHSGGC. The review will cover the implementation, monitoring and reporting processes to assess progress and impact of individual workstreams.
A.3 Service redesign – project assurance		25	25	2054 2055 2056	Our reviews will provide programme and project assurance on specific service redesign initiatives: 2019/20: Acute Stroke Services – including additional focus on engagement and communication with members of multi-disciplinary teams and the wider public through campaigns. 2020/21: Cancer Services – including additional focus on engagement and communication with partners and third parties responsible for delivering cancer services.
A.4 Operational planning		30		2021 2061 2063	To ensure that annual operational planning processes support delivery of strategic objectives; are informed by budgetary, workforce and risk considerations; developed with input from all key parties; are

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
				2089	consistently applied across the organisation; and performance is effectively monitored on a frequent basis to assess progress.
A.5 Capacity planning	25	20		2054 2055 2056	<p>2018/19: Outpatient capacity and productivity programme – To review the arrangements for assessing service demand and delivering changes to supply. This review will focus on these arrangements within a particular service to be agreed with management.</p> <p>2019/20 Bed Management and Delayed Discharges – Considering the policies and procedures to utilise beds and reduce delayed discharges within NHSGGC hospitals, including the use of daily discharge planning and a Multi-Disciplinary Team approach to discharges. We will also consider the impact WardView and PharmacyView have had and how management are monitoring and reporting the ongoing impact on bed utilisation and delayed discharges.</p>
A.6 Risk management			25		To ensure that there is a defined and consistent approach for the identification of risks; that risk registers are embedded throughout the organisation; mitigating actions are identified to manage residual risks down to an acceptable level; and registers are monitored on an ongoing basis.
A.7 Performance reporting	23			2054 2055 2056 2088	To assess the robustness of NHSGGC's overarching performance management framework, including identification of metrics to assess board-wide performance and agreement of an appropriate reporting framework for the Board, its committees and management.
A.8 Stakeholder engagement			23	2054	To ensure appropriate plans and processes are in place

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
				2055 2056 2059	to engage with key stakeholders, with particular focus on IJBs. The review will consider whether there are clear communication methods in place to support engagement; the extent to which engagement is appropriately prioritised and linked to strategic and operational objectives; the methods for recording engagement activities; and the reporting that takes place to demonstrate impact and effectiveness of the engagement undertaken.
A.9 Assurance mapping		30			To support management in developing an assurance framework in line with new requirements contained within the Scottish Government's Audit and Assurance Committee Handbook.
A.10 Emergency response planning		30			To ensure the Board has developed an effective emergency response plan in the event of a large scale disaster such as a terrorist attack or similar event. The review will include coordination of plans and resources with other emergency services.
Sub-total A	88	170	103		
B. Financial					
B.1 Financial systems health check	30	50	40	2021 2057 2061 2064	Rolling review of core financial systems covering: 2018/19: Ledger management; control account reconciliations; bank and cash; treasury management; and investments and endowments. 2019/20: Expenditure; procurement and purchasing; and accounts payable. 2020/21: Income; accounts receivable; lease contract management; and property, plant and equipment.

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
B.2 Financial planning and budget monitoring	30			2021 2056 2057 2061	To review implementation of the Financial Improvement Programme, including confirmation that progress is monitored regularly and reported to those charged with governance on a consistent basis. This review will also consider the roles of operational service managers in monitoring budgets and taking remedial action to address budget variances, including the clarity of this role, the central support provided and the consistency of application.
B.3 Payroll	20		40		To review the robustness and appropriateness of payroll procedures to ensure that accurate and authorised payroll payments are made to valid employees; changes to payroll standing data are authorised and timely; and appropriate controls are in place for review, authorisation and reconciliation of payments and deductions. May also include consideration of time recording in SSTS and travel and subsistence.
B.4 IJB financial information and reporting		25		2021 2061	To confirm that financial reporting arrangements between the IJB and Board are sufficient to provide appropriate, complete and timely information to allow oversight of Board spend.
B.5 Service costing		25		2021 2061	Review of service costing procedures to ensure appropriate and sustainable budgetary resource allocations for the delivery of acute services.
Sub-total B	80	100	80		
C. Clinical & Care Governance					

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
C.1 Hospital Standardised Mortality Ratios	40			2084 2085 2087	To assess the completeness and accuracy of hospital discharge summaries and clinical coding used to calculate HSMR and ensure that agreed coding changes have been systematically applied across different sites (including the RAH) and any other lessons learned have been embedded effectively.
C.2 Clinical pathways		25	25	2054 2055 2056	<p>Reviews covering:</p> <p>19/20 Ambulatory Care – Considering whether the criteria for determining the use of Ambulatory Emergency Care (AEC) is clear and understood by staff, whether all staff are aware of AEC and how this can be accessed, if patients accepted for AEC have met the clinical criteria for the service and that admission, readmission and assessment data is monitored to identify patterns and inform changes to the service.</p> <p>20/21 Frail Older People’s Care – Assessing the implementation and impact of ongoing work to improve care, avoid hospital admission and reduce delayed discharges for frail older people, such as community planning prior to admission and falls prevention, taking cognisance of ongoing work as part of the Moving Forward Together Programme. The review will also consider the monitoring and reporting of the number of frail older people admitted and how this information is utilised to inform service planning.</p>
C.3 Incident/SAE management			20	2060 2082 2083 2084	Covering the management and oversight of adverse events; including significant adverse events. The review will assess arrangements to ensure incidents are classified correctly; staff have received appropriate training; and staff regularly record incidents on Datix. We will also check the level of engagement with patients during the review process and identification of

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
					any lessons learned.
C.4 Review of patient results	25				To assess whether revised processes for reviewing patient results are effective and have been implemented consistently by staff.
C.5 IDL drug reconciliation		20			To review new processes for drug reconciliation as part of Immediate Discharge Letters.
C.6 Duty of Candour			30		To assess the Board's arrangements for ensuring staff comply with the Duty of Candour, including training and guidance provided to staff.
Sub-total C	65	45	75		
D. Staff Governance					
D.1 Workforce planning and management	35	35	35	2063 2086 2089	<p>Review covering different aspects of workforce planning and management each year, as identified below:</p> <p>2018/19: Sickness Absence – To ensure the NHSGGC Attendance Management Policy is up-to-date and reflective of changes to the National Promoting Attendance PIN policy. The review will also confirm whether the Board has a fair, consistent approach to promoting attendance across different locations; whether a sickness absence tolerance level has been set and is being monitored regularly; and the Board are working to maintain absence levels within this threshold.</p> <p>2019/20: Succession Planning – To confirm the Board has an effective succession planning process in place. The review will cover creation and monitoring of succession plans; processes to build resilience; and</p>

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
					<p>reporting on impact. The audit will consider the implementation of the new Performance Management Development framework launched in 2018.</p> <p>2020/21: Staff Performance Management – Evaluating the robustness of the staff performance management framework, including effectiveness of the performance appraisal, training, disciplinary and appeals processes.</p>
D.2 Use of agency and locum staff			23	2063 2086 2089 2091	To ensure appropriate arrangements are in place to identify staff need and book appropriate agency/locum staff; to confirm agency/locum staff have the necessary requirements and passed appropriate checks; and that the use of bank and agency staff is monitored and reported on.
D.3 NMAHP registration			20	2092	To assess whether NHSGGC has clear policies and procedures to ensure all NMAHPs are registered prior to appointment and re-register as required. The review will also consider procedures to manage NMAHP staff that have not complied with registration requirements and ensure staff without valid registrations are not scheduled to work.
D.4 Health and safety		20		2057 2065	To assess whether the current processes for managing and complying with HSE requirements are fit-for-purpose. To cover training roll-out across operational areas.
D.5 Other leave	20				To review the effectiveness of and staff compliance with processes surrounding all leave other than annual leave (e.g. special leave, study leave, etc); covering both the process for recording and application of policies. This audit will build on the internal review

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
					carried out in 2018/19.
D.6 Rostering	30	30		2063 2086 2089	To confirm whether consistent and effective staff resource planning rules are in place; that unsafe working patterns are identified, appropriately reported and managed; and that clinical risk is minimised through the use of suitably skilled staff. Our reviews will focus on: 2018/19 – nurse rostering 2019/20 – job planning
D.7 NMC referrals			20		To assess whether the processes for referring nurses to the NMC are effective, including the existence of clear decision-making criteria and consistent application across the Board. Our review will also confirm whether appropriate action is taken in response to any investigation launched.
D.8 Mandatory training		20			To build on the work done by management to improve completion rates for mandatory training. The review will consider the end to end process from identification of training needs to monitoring and reporting of progress and confirmation of completion to ensure that the process is efficient and that the Board maximises the opportunity to achieve full compliance.
Sub-total D	85	105	98		
E. ICT					
E.1 GDPR compliance	25			2062	To assess NHSGGC's compliance with GDPR requirements and the arrangements to identify and address remaining compliance gaps.

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
E.2 eHealth / Digital	30		30	2062	<p>To confirm that there are adequate processes in place for the development and implementation of the Board's Digital strategy.</p> <p>Our review will also consider whether there are effective processes in place to identify the costs of delivering operational and strategic elements of eHealth.</p>
E.3 Records management			30	2055 2062	<p>To ensure there is a detailed Data Management policy in place; responsibilities for data management are clearly identified; and there is an effective process to monitor and manage compliance with legal and regulatory responsibilities.</p>
E.4 Information sharing and management	25				<p>To confirm robust arrangements are in place for sharing information across the Board. The review will cover Caldicott Guardian duties; data-sharing agreements; processes for sharing data; and arrangements for checking compliance with identified protocols on an ongoing basis.</p>
E.5 IT Security		25		2062	<p>To provide assurance that network and user access is subject to adequate control, that there are sufficient measures to protect the network from external attack and that staff are aware of cyber threats, including actions that can be taken to minimise cyber risk.</p>
E.6 eESS project		25			<p>To assess the eESS project post-implementation to confirm whether project actions have been completed effectively and timeously, and whether an assessment has been made of the extent to which project objectives and expected benefits have been achieved.</p>

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
Sub-total E	80	50	60		
F. Compliance and regularity					
F.1 Governance statement readiness	5	5	5	All risks	To inform completion and sign off of Board's Governance Statement.
F.2 Waiting times audits	7	7	7		Annual validation exercise of NHSGGC audit procedures on the accuracy and integrity of waiting times data.
F.3 Property transaction monitoring	8	8	8	n/a required compliance review	Review of property transactions as required by Scottish Government Property Transaction Handbook.
F.4 Follow up	32	30	30		To provide assurance that actions are being implemented as agreed.
Sub-total F	52	50	50		
G. Management					
G.1 Contract management	35	35	35		To respond to issues as/when they arise over the year.
G.2 Audit and Risk Committee & ACEG planning and attendance	12	12	12		
G.3 Audit needs analysis - strategic and annual planning	6	3	3		

Audit area	2018/19	2019/20	2020/21	Risk Reg Ref	Audit objectives
G.4 Liaison with external audit	2	2	2		For coordination and efficiency.
G.5 Liaison meetings and progress reporting	18	18	18		
G.6 Annual internal audit report	2	2	2		
G.7 Contingency	-	-	-		Contingency days to cover additional/emergency reviews required by management in-year that cannot otherwise be accommodated by changes to the plan.
Sub-total G	75	72	72		
TOTAL	525	592	538		
OVERALLOCATION		67	13		

Appendix 2 – Corporate Risk Register

The table below shows how each risk in the risk register (dated December 2017) is covered over the course of the three year internal audit plan.

Risk ref	Brief Description	Inherent Risk Score		Residual Risk Score		Notes	2018/19 Plan	2019/20 Plan	2020/21 Plan	Reviews
		L x I	Score	L x I	Score					
Operational										
2054	Failure to achieve Elective waiting time targets: Inpatient / outpatient and day case targets / Treatment Time Guarantees Diagnostic targets Cancer targets Condition specific targets	4x4	High	4x4	High		✓	✓	✓	A.1 Strategic Planning Alignment A.2 Moving Forward Together Implementation A.3 Service redesign – project assurance A.5 Capacity Planning A.7 Performance Reporting A.8 Stakeholder Engagement C.2 Clinical Pathways
2056	Increased delays in discharging patients from hospital resulting in increased bed days and deterioration in condition of patients awaiting discharge.	4x4	High	3x3	Medium		✓	✓	✓	A.1 Strategic Planning Alignment A.2 Moving Forward Together Implementation A.3 Service redesign – project assurance A.5 Capacity Planning A.7 Performance Reporting A.8 Stakeholder Engagement B.2 Financial planning and budget monitoring C.2 Clinical Pathways
Clinical										
2055	Failure to achieve unscheduled care targets. Managing emergency patient flows. Managing the impact on downstream bed management.	4x4	High	4x3	High		✓	✓	✓	A.1 Strategic Planning Alignment A.2 Moving Forward Together Implementation A.3 Service redesign – project assurance A.5 Capacity Planning A.7 Performance Reporting A.8 Stakeholder Engagement

Risk ref	Brief Description	Inherent Risk Score	Residual Risk Score	Notes	2018/19 Plan	2019/20 Plan	2020/21 Plan	Reviews	
								C.2 Clinical Pathways E.3 Records Management	
2085	Compliance with all applicable clinical standards, protocols and strategies to further improve value for money in prescribing is not achieved and balanced, so that patient medicines are not prescribed, dispensed or administered safely at all times, resulting in adverse events, patient harm and wasted resources.	4x4	High	3x4	High	✓		C.1 Hospital Standardised Mortality Ratios	
2084	Compliance with all applicable clinical standards and protocols is not achieved within Mental Health Services resulting in death or harm to staff, patients, visitors, and the public arising from:- - suicide or deliberate self harm; - violent patients; - absconding patients; - hospital acquired infection outbreak; - Child protection and Vulnerable Adults - medication errors; - nutrition needs - confidentiality of data.	4x4	High	3x4	High	✓	✓	C.1 Hospital Standardised Mortality Ratios C.3. Incident / SAE management	
Financial									
2057	Expected reduction in capital funding and pressure on revenue resources impacts on backlog maintenance and Health and Safety obligations leading to the possibility of non compliance with applicable Health and Safety	3x4	High	3x3	Medium	✓	✓	✓	B.1 Financial systems health check B.2 Financial planning and budget monitoring D.4 Health and safety

Risk ref	Brief Description	Inherent Risk Score	Residual Risk Score	Notes	2018/19 Plan	2019/20 Plan	2020/21 Plan	Reviews	
	legislation and SGHD policies and guidance.								
2021	<p>1. The Board faced an unprecedented financial challenge in 2017/18, with an overall savings challenge within the main Board of £97.8m. Savings were identified, all with a significant degree of risk, meaning the original financial plan predicted a y/e deficit of £18.5m.</p> <p>2. Due to additional pressures and later than expected crystallisation of savings schemes, that projection was revised at Month 4 to be £26m.</p>	4x4	High	3x4	High	✓	✓	✓	<p>A.4 Operational planning</p> <p>B.1 Financial systems health check</p> <p>B.2 Financial planning and budget monitoring</p> <p>B.4 IJB financial information and reporting</p> <p>B.5 Service costing</p>
2061	<p>The reduction in funding and the underachievement of savings throughout 2015-16 and 2016-17 has required the use of non-recurring funds and reserves to balance. However, this has created an underlying recurring deficit of £68m going into 2018/19. This will create a significant financial challenge in-year, unlikely to be met through CRES. Due to the timing of information from SGHD the uplift for 2018/19 is unknown.</p>	4x4	High	4x4	High	✓	✓	✓	<p>A.4 Operational planning</p> <p>B.1 Financial systems health check</p> <p>B.2 Financial planning and budget monitoring</p> <p>B.4 IJB financial information and reporting</p> <p>B.5 Service costing</p>

Risk ref	Brief Description	Inherent Risk Score	Residual Risk Score	Notes	2018/19 Plan	2019/20 Plan	2020/21 Plan	Reviews	
Resilience									
2059	Failure to fully meet the requirements of the Civil Contingencies (Scotland) Act 2005 due to a major incident or emergency in the Greater Glasgow and Clyde area.	3x3	Medium	2x3	Medium			✓	A.8 Stakeholder Engagement
Screening									
2060	Breakdown of failsafe mechanisms for all Public Health Screening Programmes - Abdominal Aortic Aneurysm, Bowel, Breast, Cervical, Diabetic Retinopathy, Pregnancy & Newborn, Preschool Vision screening programmes	3x4	High	2x4	Medium			✓	C.3 Incident / SAE management
IT									
2062	Cyber threats are a dynamic and growing threat to the NHS. Until recently, much of the focus of such threats was the theft of financial data, not personal or patient information. However, there is now a growing risk that we will be targeted in order to disrupt a key component of critical National infrastructure.	3x4	High	2x3	Medium	✓	✓	✓	E.1 GDPR E.2 eHealth/Digital E.3 Records Management E.5 Cyber Security
Staffing									
2063	The Board faces a range of risks in relation to the current and future medical workforce. Over the next 5 years there will be major challenges for the service with a number of senior medical staff projected to retire. By 30 th November	4x3	High	4x3	High	✓	✓	✓	A.4 Operational planning D.1 Workforce planning and management D.2 Use of agency and locum staff D.6 Rostering

Risk ref	Brief Description	Inherent Risk Score	Residual Risk Score	Notes	2018/19 Plan	2019/20 Plan	2020/21 Plan	Reviews	
	<p>2017 19.7% of consultants will have reached the age of 55+ and could have potentially retired or be considering it.</p> <p>This number may be accelerated further by recent changes to the pension scheme, making it more beneficial to retire before normal retirement age.</p> <p>Extrapolating forward to November 2021, 33.3% of the current consultant establishment will potentially have retired, or be eligible to leave.</p> <p>When added to the current difficulties in recruiting to senior medical posts and the general turnover at consultant level, this may result in reduced senior medical cover to deliver patient care or increased locum and agency spend to cover service gaps.</p> <p>Work in relation to reducing Band 3 rotas remains a challenge and a 'live' risk to the Board.</p>								
2086	<p>The training schemes introduced as part of SMT could lead to a significant increase in vacancies. Risks associated with the amount of vacancies of junior doctors may affect rosters and ability to deliver service. This could lead to a reduction in the available doctors for direct patient care.</p>	4x4	High	3x3	Medium	✓	✓	✓	<p>D.1 Workforce planning and management</p> <p>D.2 Use of agency and locum staff</p> <p>D.6 Rostering</p>
2089	<p>Failure to provide safe, equitable and effective nurse staffing levels</p>	4x4	High	4x4	High	✓	✓	✓	<p>A.4 Operational planning</p> <p>D.1 Workforce planning and</p>

Risk ref	Brief Description	Inherent Risk Score	Residual Risk Score	Notes	2018/19 Plan	2019/20 Plan	2020/21 Plan	Reviews	
	throughout inpatient areas of NHSGGC.							management D.2 Use of agency and locum staff D.6 Rostering	
2091	Failure to undertake a range of preemployment screening processes and checks of new employees, which could lead to risks around child and adult protection, criminality and undisclosed infection risks eg. Hepatitis B.	4x4	High	3x4	High		✓	D.2 Use of agency and locum staff	
2092	Failure of Registered nurses to prepare for and meet Nursing and Midwifery Council (NMC) revalidation requirements resulting in removal From NMC register and unable to fulfil NHS GGC contractual obligations as a Registered practitioner	4x3	High	2x3	Medium		✓	D.3 NMAHP registration	
Fire safety									
2064	The probability of Queen Elizabeth University Hospital being at high risk due to the incorporation of Aluminium Composite Materials (ACMs) similar but not the same to those used in Grenfell Tower, leading to an increased likelihood of a fire occurring. Update November 2017 - as part of the inspection work on cladding, a further issue has been uncovered regarding a section of ladding on the RHC. HFS have conducted an inspection and deemed the building safe.	2x3	Medium	1x3	Low	✓	✓	✓	B.1 Financial systems health check
2065	Risk of non-compliance with established Board policies and procedures by members of staff during a fire emergency, as a result of lower than	3x3	Medium	2x2	Medium		✓		D.4 Health and Safety

Risk ref	Brief Description	Inherent Risk Score	Residual Risk Score	Notes	2018/19 Plan	2019/20 Plan	2020/21 Plan	Reviews
	expected numbers of staff undertaking mandatory fire training. This may cause delays in evacuating buildings in the event of a fire.							
Protection of vulnerable groups								
2082	Inconsistent assessment and application of Child Protection procedures may result in: 1. poor identification of children at risk or children who have been harmed; 2. legislative requirements not being complied with; and 3. adverse publicity and reputational damage to the Board.	4x5	Very high	3x5	High			✓ C.3 Incident / SAE management
2083	Inconsistent assessment and application of Adult Support and Protection procedures may result in:- 1. poor identification of those at risk or those who have been harmed; 2. legislative requirements not being complied with; and 3. adverse publicity and reputational damage to the Board.	3x3	Medium	2x3	Medium			✓ C.3 Incident / SAE management
Infection control								
2087	Failure to comply with recognised policies and procedures in relation to infection control. Emerging pathogens represent a risk because often the epidemiology and routes of transmission are not fully understood. The consequences are cross transmission and outbreaks.	4x4	High	3x4	High	✓		C.1 Hospital Standardised Mortality Ratios

Risk ref	Brief Description	Inherent Risk Score		Residual Risk Score		Notes	2018/19 Plan	2019/20 Plan	2020/21 Plan	Reviews
2088	Failure to achieve reduction of MRSA/ MSSA bacteraemia to 24 cases per 100,000 occupied bed days by 2018. Pending any updated changes to target at national level.	4x4	High	3x4	High		✓	✓		A.7 Performance Reporting

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Appendix 3 – Internal audit universe and audit needs score

Strategic risk score

We assess the relevance of strategic risks to key processes using the following criteria:

Multiplier	Category	Description
0%	Not relevant	Risk has no relevance to the process
25%	Low relevance	Minimal relevance to or overlap within the process
50%	Medium relevance	Risk may have interdependencies with or relevance to this process that require consideration
75%	High relevance	Risk is likely to be a focus or key consideration for this process
100%	Very High relevance	Risk mainly relates to this process area

We apply the multiplier listed to the residual strategic risk score to arrive at an overall audit needs score

Inherent risk scoring

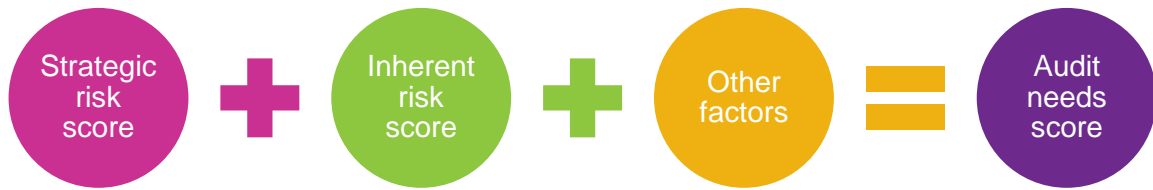
We assess the inherent risk score and assign an audit needs score based on the following criteria:

Score	Category	Description
5	Very low	A control failure in this process would have little or no impact
10	Low	A control failure in this process would have a low impact, meaning performance would not fall to below acceptable levels
15	Medium	A control failure in this process would have a moderate impact and would lead to objectives, goals or targets not being met
20	High	A control failure in this process would have a significant impact and would require urgent remedial action
25	Very High	A control failure in this process would have a severe impact on the organisation and affect critical objectives, goals or targets

Other factors

We use the same methodology as applied within the scoring of process inherent risks to consider whether there are other factors not already captured that should be considered e.g. ongoing projects, previous high-risk audit findings or forthcoming legislative, regulatory or other changes.

Audit needs score



The audit needs score is used to determine the frequency of reviews and the level of audit resource to be allocated. This is determined in consultation with management and by considering the level of complexity of the process in question, the level of assurance the Audit and Risk Committee receives from other sources and whether any of the other audits in the annual plan provide assurance over an element of that process.

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Audit Universe

Auditable area	Strategic risk	Risk rating	Strategic risk multiplier	Strategic risk score	Inherent risk score	Audit needs score	2015 /16	2016 /17	2017 /18	2018 /19	2019 /20	2020 /21	Frequency
A. Corporate													
Strategic Planning	2021	16	50%	8	25	77							Key risk area, particularly in light of health and social care integration - cyclical audit every 3 years
	2054	16	75%	12									
	2055	16	75%	12									
	2056	16	75%	12									
	2061	16	50%	8									
Operational Planning	2021	16	75%	12	25	85							Key risk area - cyclical audit every 3 years
	2054	16	75%	12									
	2055	16	75%	12									
	2056	16	75%	12									
	2061	16	75%	12									
KPI Setting & Monitoring	2054	16	75%	12	15	85.25							Not identified as key area for review
	2055	16	75%	12									
	2056	16	50%	8									
	2063	12	50%	6									
	2084	16	25%	4									
	2085	9	25%	2.25									
	2088	16	75%	12									
	2089	16	50%	8									
	2092	12	50%	6									
Capital Works	2057	12	50%	6	15	26		✓					Not identified as key area for review
	2064	6	75%	4.5									
Estate Management	2057	12	75%	9	15	29	✓	✓					Not identified as key area for review
	2064	6	75%	4.5									

Estate Planning	n/a	0	0%	0	15	15	✓	✓						Not identified as key area for review
Facilities Security	n/a	0	0%	0	5	5								Not identified as key area for review
Fleet Management	n/a	0	0%	0	10	10								Not identified as key area for review
Investment Management	n/a	0	0%	0	10	10								Not identified as key area for review
Community Engagement	n/a	0	0%	0	15	15					✓	✓		Covered as part of reviews focusing on different aspects of service redesign
Service Level Agreements	n/a	0	0%	0	10	10								Not identified as key area for audit
Energy & Utilities Management	n/a	0	0%	0	10	10								Not identified as key area for review
Insurance Claims	n/a	0	0%	0	10	10								Not identified as key area for review
Space Management	n/a	n/a	0%	0	10	10								Not identified as key area for review
Waste Management	n/a	0	0%	0	5	5								Not identified as key area for review
Service Redesign	2054	16	75%	12	20	61	✓	✓			✓	✓		Key risk area covered by targeted reviews on specific areas of UCC Programme
	2055	16	75%	12										
	2056	16	75%	12										
	2063	12	25%	3										
	2085	9	25%	2										
Risk Management	n/a	0	0%	0	25	25	✓	✓	✓		✓		Moderate risk area covering risk strategy and management - cyclical audit every 5 years	
Risk Strategy & Appetite	n/a	0	0%	0	15	15					✓		Moderate risk area covering risk strategy and management - cyclical audit every 5 years	
Performance Management	2054	16	75%	12	20	86		✓			✓			Key risk area covered by targeted reviews on performance reporting
	2055	16	50%	8										
	2056	16	50%	8										
	2063	12	50%	6										
	2084	16	25%	4										
	2085	9	25%	2.25										
	2088	16	75%	12										
2089	16	50%	8											
Performance Reporting	2054	16	50%	8	15	47		✓		✓	✓			Key risk area covered by targeted reviews on performance reporting
	2055	16	50%	8										
	2056	16	50%	8										

	2088	16	50%	8										
Stakeholder Engagement	2021	16	25%	4	20	58.75						✓	✓	Covered as part of reviews focusing on different aspects of HSCP and service redesign; and dedicated stakeholder engagement audit
	2054	16	50%	8										
	2055	16	50%	8										
	2056	16	50%	8										
	2059	9	75%	6.75										
	2061	16	25%	4										
Partnership Working	2021	16	25%	4	20	55						✓	✓	Key risk area, particularly in light of health and social care integration - cyclical audit every 3 years. Covered as part of IJB-specific and stakeholder engagement reviews.
	2054	16	50%	8										
	2055	16	50%	8										
	2056	16	50%	8										
	2059	6	50%	3										
	2061	16	25%	4										
B. Financial														
Budget Setting	2021	16	100%	16	25	67						✓		Key risk area covering financial planning and management – cyclical audit every 3 years.
	2056	16	25%	4										
	2057	12	50%	6										
	2061	16	100%	16										
Budget Monitoring	2021	16	100%	16	25	57						✓		Key risk area covering financial planning and management – cyclical audit every 3 years.
	2061	16	100%	16										
Accounts Payable	n/a	0	0%	0	15	15	✓		✓			✓		Covered within rolling financial systems healthcheck programme - assurance provided by External Audit
Accounts Receivables	n/a	0	0%	0	15	15							✓	Covered within rolling financial systems healthcheck programme - assurance provided by External Audit
Endowments	n/a	0	0%	0	15	15		✓		✓				Key risk area covering financial planning and management – cyclical audit every 3 years.
Efficiency Targets including savings	2021	16	100%	16	25	57						✓		Key risk area covering financial planning and management – cyclical audit every 3 years.
	2061	16	100%	16										
Financial Planning	2021	16	75%	12	25	53						✓		Key risk area covering financial planning and management – cyclical audit every 3 years.
	2061	16	100%	16										

Financial Reporting	n/a	0	0%	0	20	20		✓			✓		Dedicated audit relating to IJB financial information and reporting
Capital Planning	2021	16	50%	8	20	36							Not identified as key area for review
	2057	12	75%	9									
	2061	16	50%	8									
Cashflow Management	2021	16	50%	8	15	23				✓			Covered within rolling financial systems healthcheck programme - assurance provided by External Audit
	2061	16	50%	8									
Treasury Policies and Procedures	n/a	0	0%	0	10	10	✓	✓		✓			Covered within rolling financial systems healthcheck programme - assurance provided by External Audit
Debt Recovery	n/a	0	0%	0	10	10						✓	Covered within rolling financial systems healthcheck programme - assurance provided by External Audit
Income	2021	16	50%	8	10	18						✓	Covered within rolling financial systems healthcheck programme - assurance provided by External Audit
	2061	16	50%	8									
Intangible Assets	n/a	0	0%	0	10	10							Not identified as key area for audit
Investments	n/a	0	0%	0	10	10				✓			Covered within rolling financial systems healthcheck programme - assurance provided by External Audit
Lease Contract Management	n/a	0	0%	0	10	10						✓	Covered within rolling financial systems healthcheck programme - assurance provided by External Audit
Ledger Management	n/a	0	0%	0	10	10		✓		✓			Covered within rolling financial systems healthcheck programme - assurance provided by External Audit
Bank & Control Account Reconciliations	n/a	0	0%	0	10	10				✓			Covered within rolling financial systems healthcheck programme - assurance provided by External Audit
Patient Funds	n/a	0	0%	0	15	15							Not identified as key area for audit
Payroll	n/a	0	0%	0	15	15	✓	✓	✓	✓		✓	Key risk area covering payroll processes - cyclical review every 3 years

Pension Management	n/a	0	0%	0	15	15				✓		✓	Key risk area covering payroll processes - cyclical review every 3 years	
Starters & Leavers	n/a	0	0%	0	15	15				✓		✓	Key risk area covering payroll processes - cyclical review every 3 years	
Time recording	n/a	0	0%	0	10	10				✓		✓	Key risk area covering payroll processes - cyclical review every 3 years	
Travel & Subsistence	n/a	0	0%	0	10	10				✓		✓	Key risk area covering payroll processes - cyclical review every 3 years	
Procurement & Tendering	n/a	0	0%	0	15	15	✓					✓	Covered within rolling financial systems healthcheck programme - assurance provided by External Audit	
Property, Plant and Equipment	2057	12	75%	9	10	22						✓	Covered within rolling financial systems healthcheck programme - assurance provided by External Audit	
	2064	6	50%	3										
Infection Control	2087	16	100%	16	25	57							Moderate risk area - cyclical review every 5 years. Not identified as key area for audit within 3 year plan.	
Prescribing	2085	9	75%	7	15	22							Moderate risk area - cyclical review every 5 years. Not identified as key area for audit within 3 year plan.	
C. Clinical & Care Governance														
Clinical Governance	2060	12	50%	6	25	86	✓	✓	✓	✓			Key risk area - cyclical review every 3 years	
	2063	12	50%	6										
	2084	16	75%	12										
	2085	9	100%	9										
	2087	16	50%	8										
	2088	16	50%	8										
	2089	16	75%	12										
Clinical Pathways	2054	16	75%	12	20	90						✓	✓	Key risk area in light of service redesign of clinical pathways - Annual review focusing on specific areas
	2055	16	75%	12										
	2056	16	75%	12										
	2060	12	50%	6										

	2082	20	50%	10									
	2083	20	50%	10									
	2084	16	50%	8									
Incident Management	2060	12	75%	9	15	74.75	✓	✓					Key risk area - cyclical review every 3 years
	2082	20	50%	10									
	2083	20	50%	10									
	2084	16	50%	8									
	2085	9	75%	6.75									
	2087	16	50%	8									
	2088	16	50%	8									
Culture	n/a	0	0%	0	15	15							Not identified as key area for audit
Equality & Diversity	n/a	0	0%	0	15	15							Not identified as key area for audit
Fraud Prevention & Detection	n/a	0	0%	0	20	20							Not identified as key area for audit
Freedom of Information	n/a	0	0%	0	10	10							Not identified as key area for audit
Governance Structures	n/a	0	0%	0	15	15	✓						Not identified as key area for audit
Board & Committee Evaluation	n/a	0	0%	0	15	15	✓						Not identified as key area for audit
Member Policies & Training	n/a	0	0%	0	15	15	✓						Not identified as key area for audit
UK Bribery Act	n/a	0	0%	0	15	15							Not identified as key area for audit
Whistle Blowing	n/a	0	0%	0	15	15							Not identified as key area for audit
D. Staff Governance													
Absence Management	2063	12	50%	6	20	42							Not identified as key area for audit
	2086	16	50%	8									
	2089	16	50%	8									
Appeals & Disciplinary Procedures	n/a	0	0%	0	10	10							Not identified as key area for audit
Evaluation & Appraisals	n/a	0	0%	0	15	15							Not identified as key area for audit
HR Policies & Procedures	n/a	0	0%	0	10	10							Not identified as key area for audit
HR Strategy	2063	12	50%	6	25	46							Not identified as key area for

	2086	16	25%	4										audit		
	2089	16	50%	8												
	2092	12	25%	3												
NMAHP Registration	2063	12	100%	12	10	22							✓	Moderate risk area - cyclical audit every 5 years		
People Management	2063	12	75%	9	15	42								Not identified as key area for audit		
	2086	16	50%	8												
	2089	16	25%	4												
	2092	12	50%	6												
Recruitment	2063	12	75%	9	15	40								Not identified as key area for audit		
	2086	16	50%	8												
	2091	16	50%	8												
Safeguarding	2082	20	100%	20	20	48								Not identified as key area for audit		
	2083	20	100%	20												
	2084	16	50%	8												
	2091	16	50%	8												
Staff Rostering	2063	12	75%	9	20	53							✓	✓	Moderate risk area covering workforce compliment and rostering - cyclical audit every 5 years	
	2086	16	75%	12												
	2089	16	75%	12												
Training & Development	2062	12	25%	3	20	66									Not identified as key area for audit	
	2065	9	100%	9												
	2082	20	50%	10												
	2083	20	50%	10							✓					
	2085	9	25%	2												
	2086	16	25%	4												
	2087	16	50%	8												
Use of Agency Staff	2021	16	25%	4	15	37									Moderate risk area covering workforce compliment - cyclical audit every 5 years	
	2061	16	25%	4												
	2063	12	50%	6							✓			✓		
	2086	16	25%	4												

	2089	16	25%	4										
Use of Locums	2021	16	25%	4	15	37						✓	Moderate risk area covering workforce compliment - cyclical audit every 5 years	
	2061	16	25%	4										
	2063	12	50%	6										
	2086	16	25%	4										
	2089	16	25%	4										
Health & Safety	2057	12	75%	9	15	39			✓		✓		Moderate risk area - cyclical review every 5 years	
	2064	6	100%	6										
	2065	9	100%	9										
Workforce Planning	2021	16	50%	8	25	74						✓	Key risk area - cyclical review every 3 years	
	2061	16	50%	8										
	2063	12	75%	9										
	2086	16	75%	12										
	2089	16	75%	12										
Internal Communications	2054	16	25%	4	20	46						✓	✓	Covered as part of annual reviews focusing on delivering of services and service redesign
	2055	12	50%	6										
	2056	16	50%	8										
	2059	9	25%	2										
	2062	12	50%	6										
Midwifery Supervision	n/a	0	0%	0	15	15							Not identified as key area for review	
E. ICT														
Business Continuity Management	2059	9	75%	7	25	38	✓						Not identified as key area for review	
	2062	12	50%	6										
Cyber Security	2062	12	100%	12	20	32		✓	✓		✓		Moderate risk area - cyclical audit every 5 years. Assurance provided via recent IA and EA reviews.	
Data Management	n/a	0	0%	0	20	20	✓	✓				✓	Moderate risk area - cyclical audit every 5 years	

Digital Strategy	2062	12	50%	6	15	21	✓							Not identified as key area for review
eHealth	2055	16	25%	4	15	25				✓			✓	Key risk area supporting implementation of UCC actions - cyclical review every 3 years
	2062	12	50%	6										
ICT Disaster Recovery	2059	9	50%	4.5	20	25				✓				Not identified as key area for review
	2062	12	75%	9										
ICT Governance	n/a	0	0%	0	15	15								Not identified as key area for review
ICT Project Management	n/a	0	0%	0	15	15			✓					Not identified as key area for review
ICT Service Management	n/a	0	0%	0	20	20								Not identified as key area for review
ICT Strategy	2062	12	25%	3	15	18								Not identified as key area for review
Installation Security	2062	12	50%	6	20	26								Not identified as key area for review
IT General Controls	2062	12	50%	6	15	21								Moderate risk area - cyclical audit every 5 years. Not identified as key area for audit within 3 year plan.
Network Security	2062	12	50%	6	20	26								Not identified as key area for review
Records Management	2055	12	50%	6	20	26							✓	Moderate risk area - cyclical audit every 5 years
Telecare	n/a	0	0%	0	15	15								Not identified as key area for review
Social media	n/a	0	0%	0	5	5								Not identified as key area for review
Website Content Management	n/a	0	0%	0	10	10								Not identified as key area for review
Compliance and Regularity														
Property Transaction Monitoring	2057	12	25%	3	10	13	✓	✓	✓	✓	✓	✓	✓	Annual review of property transactions as required by Scottish Government Property Transaction Handbook.

Compliance Monitoring	2057	9	50%	4.5	20	60							Not identified as key area for audit
	2059	6	50%	3									
	2065	9	50%	4.5									
	2082	20	50%	10									
	2083	20	50%	10									
	2091	16	50%	8									
Public Health Committee													
Campaigns	2060	16	50%	8	15	23		✓					Not identified as key area for review
Strategic Planning	n/a	0	0%	0	10	10							Not identified as key area for review
External communications	n/a	0	0%	0	10	10							Not identified as key area for review
Public screening	2060	16	50%	8	15	23			✓				Not identified as key area for review
Complaints Management													
Complaints Management	n/a	0	0%	0	15	15		✓					Not identified as key area for audit
Customer Satisfaction	n/a	0	0%	0									
External Communications	2055	12	25%	3	15	20				✓	✓		Covered as part of reviews focusing on different aspects of service redesign
	2059	9	25%	2									
Change Management	2054	16	75%	12	15	59							Not identified as key area for audit
	2055	16	75%	12									
	2056	16	75%	12									
	2086	16	50%	8									
Project Management	2054	16	50%	8	15	39			✓				Not identified as key area for audit
	2055	16	50%	8									
	2056	16	50%	8									
Project Reporting	2054	16	25%	4	15	19			✓				Not identified as key area for audit
	2055	16	50%	8									
	2056	16	50%	8									
	2088	16	50%	8									
Patient Transport	n/a	0	0%	0	5	5							Not identified as key area for review
Portering	n/a	0	0%	0	5	5							Not identified as key area for review
Theatre Utilisation	n/a	n/a	0%	0	10	10							Not identified as key area for review
Catering	n/a	0	0%	0	10	10			✓				Not identified as key area for audit
Legal Claims Handling	n/a	0	0%	0	10	10							Not identified as key area for

															<i>audit</i>
Contract Management	<i>n/a</i>	<i>0</i>	<i>0%</i>	<i>0</i>	<i>15</i>	<i>15</i>									<i>Not identified as key area for audit</i>

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Appendix 4 – Internal Audit Charter

Internal auditing is an independent and objective assurance and consulting activity that is guided by a philosophy of adding value to improve the operations of NHS Greater Glasgow and Clyde (“the Board”).

It helps the Board accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.

Aim

The aim of this Charter is to set out the management by all parties of the internal audit process. The Charter sets out the context of the internal audit function, including the place of the Audit and Risk Committee, the Audit and Risk Committee Executive Group, the key personnel, timescales and processes to be followed for each internal audit review.

Role

The internal audit activity is established by the Audit and Risk Committee on behalf of the Board. The internal audit activity's responsibilities are defined by the Audit and Risk Committee as part of its oversight role.

Professionalism

The internal audit activity will adhere to Public Sector Internal Audit Standards (PSIAS), which are based on mandatory elements of the Chartered Institute of Internal Auditors' International Professional Practices Framework (IPPF) including the Core Principles, Definition of Internal Auditing, the Code of Ethics and the International Standards for Internal Auditing.

The IPPF's Implementation Guidance, Supplemental Guidance and Position Papers will also be adhered to as applicable to guide operations. In addition, the internal audit activity will adhere to the Board's relevant policies and procedures and the internal audit activity's standard operating procedures manual.

Internal audit activity will also reflect relevant Scottish Government directions, as appropriate to the Board.

Authority

The internal audit activity, with strict accountability for confidentiality and safeguarding records and information, is authorised full, free, and unrestricted access to any and all of the Board's records, physical properties, and personnel pertinent to carrying out any engagement. All employees are requested to assist the internal audit activity in fulfilling its roles and responsibilities. The internal audit activity will also have free and unrestricted access to the Audit and Risk Committee.

Accountability

The Chief Audit Executive will be accountable to the Audit and Risk Committee and Audit and Risk Committee Executive Group and will report administratively to the Director of Finance.

The Audit and Risk Committee will approve all decisions regarding the performance evaluation, appointment, or removal of the Chief Audit Executive.

The Chief Audit Executive will communicate and interact directly with the Audit and Risk Committee, including between Audit and Risk Committee meetings as appropriate.

Independence and objectivity

The internal audit activity will remain free from interference by any element in the Board, including matters of audit selection, scope, procedures, frequency, timing, or report content. This is essential in maintaining the internal auditors' independence and objectivity.

Internal auditors will have no direct operational responsibility or authority over any of the activities audited. Accordingly, they will not implement internal controls, develop procedures, install systems, prepare records, or engage in any other activity that may impair internal auditor's judgment.

Internal auditors must exhibit the highest level of professional objectivity in gathering, evaluating, and communicating information about the activity or process being examined. Internal auditors must make a balanced assessment of all the relevant circumstances and not be unduly influenced by their own interests or by others in forming judgements.

The Chief Audit Executive will confirm to the Audit and Risk Committee, at least annually, the organisational independence of the internal audit activity.

Scope and responsibility

The scope of internal auditing encompasses, but is not limited to, the examination and evaluation of the adequacy and effectiveness of the organisation's governance, risk management, and internal control processes in relation to the organisation's defined goals and objectives. Internal control objectives considered by internal audit include:

- Consistency of operations or programmes with established objectives and goals
- Effectiveness and efficiency of operations and use of resources
- Compliance with significant policies, plans, procedures, laws, and regulations
- Reliability and integrity of management and financial information processes, including the means to identify, measure, classify, and report such information.
- Safeguarding of assets.

Internal Audit is responsible for evaluating all processes ('audit universe') of the Board, including governance processes and risk management processes. In doing so, internal audit maintains a proper degree of coordination with external audit.

Internal audit may perform consulting and advisory services related to governance, risk management and control. It may also evaluate specific operations at the request of the Audit and Risk Committee or management, as appropriate.

Based on its activity, internal audit is responsible for reporting significant risk exposures and control issues identified to the Audit and Risk Committee and to senior management, including fraud risks, governance issues, and other matters needed or requested by the Board.

Annual internal audit plan

The audit year runs from 1 April to 31 March.

At least annually, the Chief Audit Executive will submit to the Audit and Risk Committee and the Audit and Risk Committee Executive Group an internal audit plan for review and approval. The internal audit plan will detail, for each subject review area:

- The Board's risk profile;
- The outline scope and audit objectives for the review;
- The number of days budgeted,;
- The timing, including which Audit and Risk Committee the final will report will go to; and
- The review sponsor.

The internal audit plan will be developed based on a prioritisation of the audit universe using a risk-based methodology, including input of senior management. Prior to submission to the Audit and Risk Committee for approval, the plan will be discussed with senior management and the Audit and Risk Committee Executive Group. Any significant deviation from the approved internal audit plan will be communicated through the periodic activity reporting process.

Assignment Planning and Conduct

An assignment plan will be drafted prior to the start of every assignment setting out the scope, objectives, timescales and key contacts for the assignment.

Specifically, the assignment plan will detail the timescales for carrying out the work, issuing the draft report, receiving management responses and issuing the final report. The assignment plan will also include the name of the staff member who will be responsible for the audit (review sponsor) and the name of any key staff members to be contacted during the review (key audit contact).

The assignment plan will be agreed with the review sponsor and the key audit contact(s) before the review starts.

The internal auditor will discuss key issues arising from the audit as soon as reasonably practicable with the key contact and/or review sponsor, as appropriate.

Reporting and Monitoring

A written report will be prepared and issued by the Chief Audit Executive or designee following the conclusion of each internal audit engagement and will be distributed to the review sponsor and key contacts identified in the assignment plan for management responses and comments.

Draft reports will be issued by email within 10 working days of fieldwork concluding. The covering email will specify the deadline for management responses, which will normally be within a further 10 days. The management comments and response to any report will be overseen by the review sponsor.

The internal auditors will issue the final report to the review sponsor and the Director of Finance. The final report will be issued within 5 working days of the management responses being received. Finalised internal

audit reports will be presented to the Audit and Risk Committee executive group and if appropriate, the Audit and Risk Committee. Finalised internal audit outputs must be in the hands of the committee secretary at least 10 working days before the date of each meeting

The working days set out above are maximum timescales and tighter timescales may be set out in the assignment plan.

The internal audit activity will follow-up on engagement findings and recommendations. All significant findings will remain in an open issues file until cleared.

Audit and Risk Committee Executive Group

The Audit and Risk Committee Executive Group meets four times a year, normally in June, September, December and March. Dates for meetings will be provided to internal audit as soon as they are agreed. The Chief Audit Executive and/ or Internal Audit Manager will attend all meetings of the Audit and Risk Committee Executive Group.

Internal audit will schedule its work so as to spread internal audit reports reasonably evenly over the meetings. The annual internal audit plan will detail the internal audit reports to be presented to each meeting.

The internal auditor will generally present specific reports to the committee as follows:

Output	Meeting
Audit needs assessment	December
Annual internal audit plan	December / March
Follow-up report	All meetings
Annual report	June
Progress report	All meetings

Audit and Risk Committee

The Audit and Risk Committee meets five times a year, normally twice in June and in September, December and March. Dates for meetings will be provided to internal audit as soon as they are agreed. The Chief Audit Executive and/ or Internal Audit Manager will attend all meetings of the Audit and Risk Committee.

Internal audit will schedule its work so as to spread internal audit reports reasonably evenly over the meetings. The annual internal audit plan will detail the internal audit reports to be presented to each meeting.

The internal auditor will generally present specific reports to the committee as follows:

Output	Meeting
Audit needs assessment	December
Annual internal audit plan	December / March

Annual report	June
Audit summary report	All meetings

The Audit and Risk Committee will meet privately with the internal auditors at least once a year.

Periodic Assessment

The Chief Audit Executive is responsible for providing a periodic self-assessment on the internal audit activity as regards its consistency with the Audit Charter (purpose, authority, responsibility) and performance relative to its Plan.

In addition, the Chief Audit Executive will communicate to senior management, the Audit and Risk Committee Executive Group and the Audit and Risk Committee on the internal audit activity's quality assurance and improvement programme, including results of ongoing internal assessments and external assessments conducted at least every five years in accordance with Public Sector Internal Audit Standards.

Review of Charter

This Charter will be reviewed by both parties each year and amended if appropriate.

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**EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE, AUDIT & RISK
COMMITTEE**

Date of Meeting	19 th December 2018
Subject Title	Audit Scotland: Health and Social Care Integration – Update on Progress Report
Report By	Jean Campbell, Chief Finance & Resources Officer
Contact Officer	Jean Campbell, Chief Finance & Resources Officer, Tel:0141 777 3311 Ext 3221

Purpose of Report	The purpose of this report is to present Audit Scotland's report on 'Health and Social Care Integration – Update on Progress'.
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Recommendations	<p>The Performance Audit & Risk Committee is asked to:</p> <ul style="list-style-type: none"> a) Note the content of the report b) Agree to consider further reports on the progress of the recommendations across all partnership bodies tasked with delivering improvement actions.
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Relevance to HSCP Board Strategic Plan	
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Implications for Health & Social Care Partnership

Human Resources:	
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Equalities:	
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Financial:	
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Legal:	
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Economic Impact:	
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Sustainability:	
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Risk Implications:	
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Implications for East Dunbartonshire Council:	
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Implications for NHS Greater Glasgow &	
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Clyde:	
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Direction Required to Council, Health Board or Both	Direction To:	
	1. No Direction Required	
	2. East Dunbartonshire Council	
	3. NHS Greater Glasgow & Clyde	
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	

MAIN REPORT

- 1.1 Under the direction of the Accounts Commission, Audit Scotland were tasked to undertake three national performance audits of health and social care integration following the introduction on the Act :
- Health and Social Care Integration – published December 2015 and covers progress in the transitional year of Integration Authorities;
 - Update on Progress (**Appendix 1**) – published November 2018 and the subject of this report; and
 - How Resources are used – will report on the impact that integration has had on how health and social care resources are used.
- 1.2 The aim of the second audit is to “*examine the impact public bodies are having as they integrate health and social care services*”. Integration can only make a meaningful difference to the people of Scotland with the commitment of Integration Authorities (IAs), Councils, Health Boards, Scottish Government and COSLA. Overall the report delivers four key messages:
- IAs have introduced more collaborative ways of delivering services and made improvements across a range of areas. This demonstrates that integration can work within the current legislative framework. However, they are operating in an extremely challenging environment and there is much more to be done;
 - Financial planning is not integrated, long term or focused on providing the best outcomes for people who need support. Financial pressures across the organisations making it difficult for IAs to make meaningful change;
 - Strategic planning needs to improve with significant barriers to be overcome, such as: lack of collaborative leadership and strategic capacity; high turnover in IA leadership teams; disagreements over governance arrangements and an inability or unwillingness to share data across partnerships and with the public; and
 - Significant changes are required in the way services are delivered, with all partners working together to be more open and honest about the changes needed to sustain health and care services
- 1.3 As detailed above, one of the key messages is that integration can work and that the Act can be used to advance change. Integration Authorities have started to introduce more collaborative ways of delivering services and have made improvements in several areas, including reducing unplanned hospital activity and delayed discharges.

- 1.4** A significant element of the report discusses the financial position and challenges facing IAs. Integration Authorities are responsible for directing almost £9 billion of health and social care resources, and like their partner organisations have had to find efficiency savings to maintain financial balance. Financial pressures coupled with increased service demands have led to many IAs struggling to achieve a balanced budget, requiring a combination of increased partner contributions, utilisation of reserves if available and implementation of in year recovery plans.
- 1.5** In 2017/18 IAs needed to achieve savings of £222.5m, an increase of 8.4% on the previous year and equivalent to 2.5% of the total allocation to IAs from councils and health boards. The savings target varied across IAs from 0.5% to 6.4% with a number of IJBs agreeing to budgets at the start of a financial year based on a level of unidentified savings. For EDHSCP Board the level of savings required to balance the 2018/19 annual budget was £5m or 3.8% of the available budget, excluding set aside.
- 1.6** The level of reserves also varied with 8 of the 31 IAs not holding any balance and the remaining holding a total of £125.5m or 1.5% of their total income. Exhibit 3 (pg 13) of the report displays the Scotland wide position, with EDHSCP being shown with the 8th highest reserve balance of £4.1m or 2.7% of total income. However it should be noted that this is the total of both earmarked and un-earmarked reserves.

Table 1: Reserves Balances extracted from 2017/18 Annual Accounts

Movements in Reserves During 2017/18	General Fund Balance	Ear-Marked Reserves	Total Reserves
	£000	£000	£000
Opening Balance at 31 March 2017	(2,661)	(2,570)	(5,231)
In Year drawdown of Reserves	0	0	0
Total Comprehensive Income and Expenditure	1,704	(560)	1,144
Increase or Decrease in 2017/18	1,704	(560)	1,144
Closing Balance at 31 March 2018	(957)	(3,130)	(4,087)

- 1.7** Another key element of financial resource is the set aside budget. The Act was intended to help shift resources away from the acute hospital system towards preventative and community based services. The report highlights that *“to date the set aside aspect of the Act is not being implemented”* and this must be addressed given that approximately £809m or 9% of IAs budget resource. The reasons provided for the lack of progress relate to availability of data to analyse set aside activities, a lack of common understanding and agreement on how to identify the set aside budget and a lack of agreement on how to implement this aspect of the legislation. There remain significant pressures on acute budgets which would have to be addressed before there could be any realistic release of resource to fund alternatives within a community setting. The report acknowledges that any reforms would benefit from continued ‘pump priming’ funding to facilitate change such as that provided through the Integrated care Fund and the Social care Fund.
- 1.8** The report also highlights progress IAs have made across the variety of performance targets from the nine national health and well being outcomes to the six national

indicators set by Scottish Government with four of the six key indicators showing improvement. Examples of positive local performance are illustrated across a number of case studies.

- 1.9** There are sixteen report recommendations detailed over six main headings which require to be considered and actioned by IAs, councils, health boards, the Scottish Government and COSLA working together to deliver meaningful change:
- Commitment to collaborative leadership and building relationships;
 - Effective strategic planning for improvement;
 - Integrated finances and financial planning;
 - Agreed governance and accountability arrangements;
 - Ability and willingness to share information; and
 - Meaningful and sustained engagement
- 1.10** All partner organisations will now need to take time to fully consider this report and come together to take forward recommendations to ensure health and social care services are well integrated and support people at the right time in the best setting.

Health and social care series

Health and social care integration

Update on progress

ACCOUNTS COMMISSION 

AUDITOR GENERAL 

Prepared by Audit Scotland
November 2018

The Accounts Commission

The Accounts Commission is the public spending watchdog for local government. We hold councils in Scotland to account and help them improve. We operate impartially and independently of councils and of the Scottish Government, and we meet and report in public.

We expect councils to achieve the highest standards of governance and financial stewardship, and value for money in how they use their resources and provide their services.

Our work includes:

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

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


Auditor General for Scotland

The Auditor General's role is to:

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

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

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

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

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

Contents

Key facts	4
Summary	5
Introduction	8
Part 1. The current position	10
Part 2. Making integration a success	23
Endnotes	40
Appendix 1. Audit methodology	41
Appendix 2. Advisory group members	42
Appendix 3. Progress against previous recommendations	43
Appendix 4. Financial performance 2017/18	47

Audit team

The core audit team consisted of Leigh Johnston, Neil Cartlidge, Christopher Lewis and Lucy Jones, under the direction of Claire Sweeney.

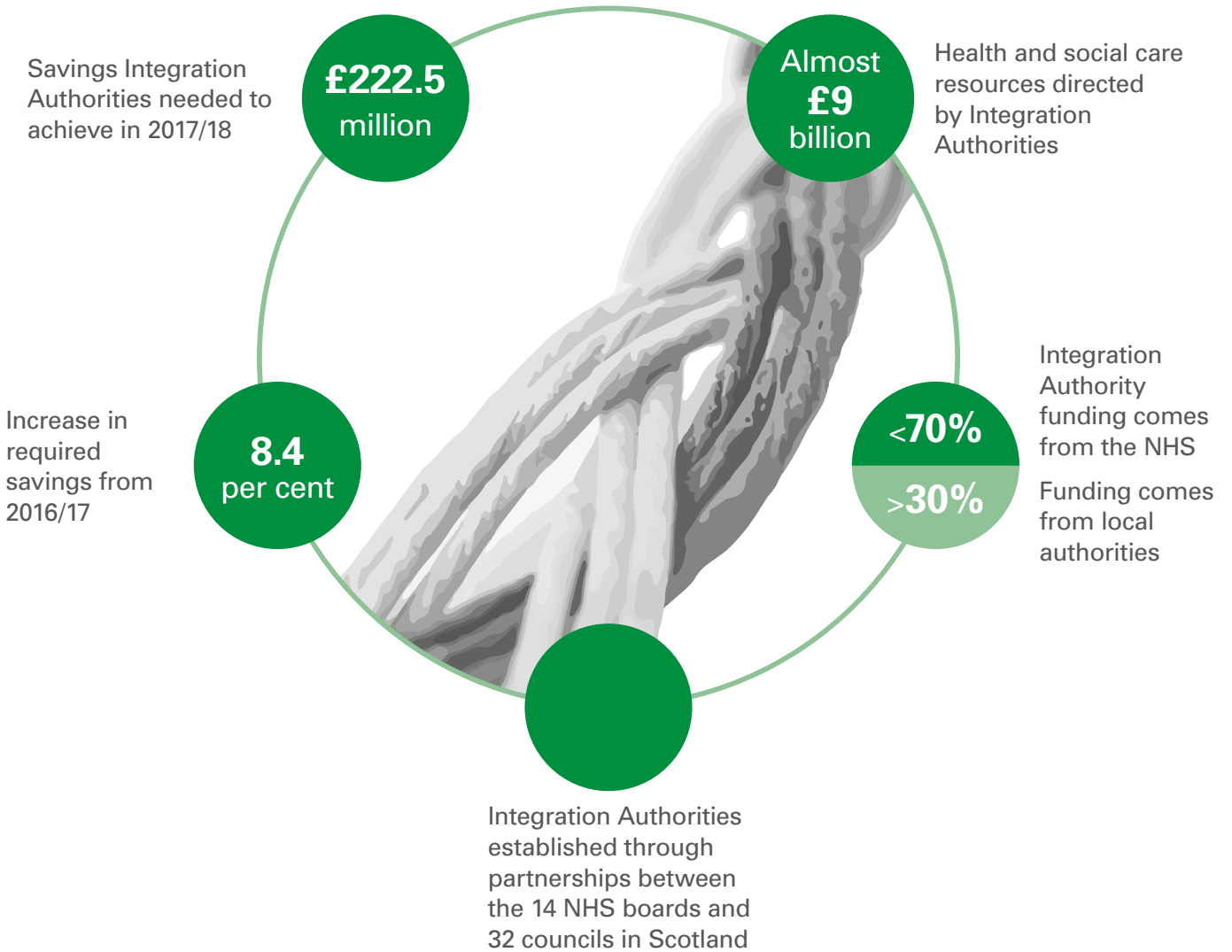
Links

-  PDF download
-  Web link

Exhibit data

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

Key facts



Summary



Key messages

- 1** Integration Authorities (IAs) have started to introduce more collaborative ways of delivering services and have made improvements in several areas, including reducing unplanned hospital activity and delays in discharging people from hospital. People at the end of their lives are also spending more time at home or in a homely setting, rather than in hospital. These improvements are welcome and show that integration can work within the current legislative framework, but IAs are operating in an extremely challenging environment and there is much more to be done.
- 2** Financial planning is not integrated, long term or focused on providing the best outcomes for people who need support. This is a fundamental issue which will limit the ability of IAs to improve the health and social care system. Financial pressures across health and care services make it difficult for IAs to achieve meaningful change. IAs were designed to control some services provided by acute hospitals and their related budgets. This key part of the legislation has not been enacted in most areas.
- 3** Strategic planning needs to improve and several significant barriers must be overcome to speed up change. These include: a lack of collaborative leadership and strategic capacity; a high turnover in IA leadership teams; disagreement over governance arrangements; and an inability or unwillingness to safely share data with staff and the public. Local areas that are effectively tackling these issues are making better progress.
- 4** Significant changes are required in the way that health and care services are delivered. Appropriate leadership capacity must be in place and all partners need to be signed up to, and engaged with, the reforms. Partners also need to improve how they share learning from successful integration approaches across Scotland. Change cannot happen without meaningful engagement with staff, communities and politicians. At both a national and local level, all partners need to work together to be more honest and open about the changes that are needed to sustain health and care services in Scotland.

several significant barriers must be overcome to speed up change

Recommendations

It is not possible for one organisation to address all the issues raised in this report. If integration is to make a meaningful difference to the people of Scotland, IAs, councils, NHS boards, the Scottish Government and COSLA need to work together to address six areas outlined below.

Commitment to collaborative leadership and building relationships

The Scottish Government and COSLA should:

- ensure that there is appropriate leadership capacity in place to support integration
- increase opportunities for joint leadership development across the health and care system to help leaders to work more collaboratively.

Effective strategic planning for improvement

Integration Authorities, councils and NHS boards should work together to:

- ensure operational plans, including workforce, IT and organisational change plans across the system, are clearly aligned to the strategic priorities of the IA
- monitor and report on Best Value in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

The Scottish Government should:

- ensure that there is a consistent commitment to integration across government departments and in policy affecting health and social care integration.

Integrated finances and financial planning

The Scottish Government should:

- commit to continued additional pump-priming funds to facilitate local priorities and new ways of working which progress integration.

The Scottish Government and COSLA should:

- urgently resolve difficulties with the 'set-aside' aspect of the Act.

The Scottish Government, COSLA, councils, NHS boards and Integration Authorities should work together to:

- support integrated financial management by developing a longer-term and more integrated approach to financial planning at both a national and local level. All partners should have greater flexibility in planning and investing over the medium to longer term to achieve the aim of delivering more community-based care.

Integration Authorities, councils and NHS boards should work together to:

- view their finances as a collective resource for health and social care to provide the best possible outcomes for people who need support.

Agreed governance and accountability arrangements

The Scottish Government and COSLA should:

- support councillors and NHS board members who are also Integration Joint Board members to understand, manage and reduce potential conflicts with other roles.

The Scottish Government, COSLA, councils, NHS boards and Integration Authorities should work together to:

- agree local responsibility and accountability arrangements where there is disagreement over interpretation of the Public Bodies (Joint Working) (Scotland) Act 2014 and its underpinning principles. Scenarios or examples of how the Act should be implemented should be used which are specific to local concerns. There is sufficient scope within existing legislation to allow this to happen.

Ability and willingness to share information

The Scottish Government and COSLA should:

- monitor how effectively resources provided are being used and share data and performance information widely to promote new ways of working across Scotland.

The Scottish Government, COSLA, councils, NHS boards and Integration Authorities should work together to:

- share learning from successful integration approaches across Scotland
- address data and information sharing issues, recognising that in some cases national solutions may be needed
- review and improve the data and intelligence needed to inform integration and to demonstrate improved outcomes in the future. They should also ensure mechanisms are in place to collect and report on this data publicly.

Meaningful and sustained engagement


Integration Authorities, councils and NHS boards should work together to:

- continue to improve the way that local communities are involved in planning and implementing any changes to how health and care services are accessed and delivered.
-

Introduction

Policy background

1. The Public Bodies (Joint Working) (Scotland) Act, 2014 (the Act) is intended to ensure that health and social care services are well integrated, so that people receive the care they need at the right time and in the right setting, with a focus on community-based, preventative care. The reforms affect everyone who receives, delivers and plans health and care services in Scotland. The Act requires councils and NHS boards to work together to form new partnerships, known as Integration Authorities (IAs). There are 31 IAs, established through partnerships between the 14 NHS boards and 32 councils in Scotland.

2. As part of the Act, new bodies were created – Integration Joint Boards (IJBs) ([Exhibit 1, page 9](#)). The IJB is a separate legal entity, responsible for the strategic planning and commissioning of the wide range of health and social care services across a partnership area. Of the 31 IAs in Scotland, 30 are IJBs and one area, Highland, continues with a Lead Agency model which has operated for several years. In Highland, the NHS board and council each lead integrated services. Clackmannanshire and Stirling councils have created a single IA with NHS Forth Valley. You can find more information about integration arrangements in our [short guide](#) .

3. Each IA differs in terms of the services they are responsible for and local needs and pressures. At a minimum, IAs need to include governance, planning and resourcing of social care, primary and community healthcare and unscheduled hospital care for adults. In some areas, partners have also integrated children's services and social work criminal justice services. Highland Lead Agency, Dumfries and Galloway IJB, and Argyll and Bute IJB have also integrated planned acute health services. IAs became operational at different times but were all established by April 2016. The policy context for IAs is continually changing, and many policies have an impact on IAs, such as the new GP contract and changes to payments for social care services.

About this audit

4. This is the second of three national performance audits of health and social care integration following the introduction of the Act. The aim of this audit is to examine the impact public bodies are having as they integrate health and social care services. The report sets out six areas which need to be addressed if integration is to make a meaningful difference to the people of Scotland. This audit does not focus in detail on local processes or arrangements and it complements the programme of strategic inspections by the Care Inspectorate and Healthcare Improvement Scotland.¹ [Appendix 1 \(page 41\)](#) has more details about our audit approach and [Appendix 2 \(page 42\)](#) lists the members of our advisory group who provided help and advice throughout the audit.

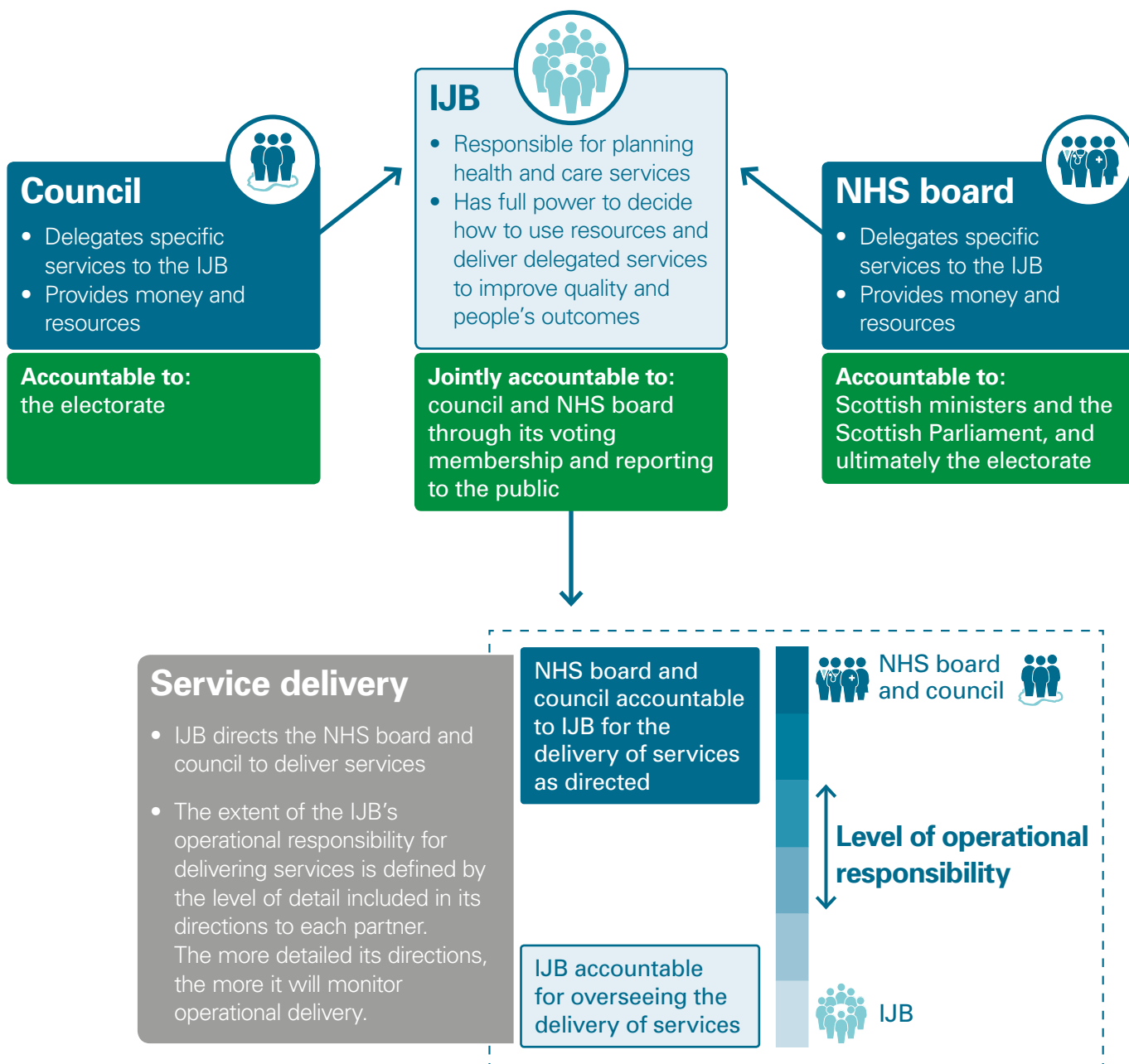


**the reforms
affect
everyone
who receives,
delivers and
plans health
and social
care services
in Scotland**

5. Appendix 3 (page 43) summarises progress against the recommendations in our first audit, which looked at transitional arrangements and highlighted several risks that needed to be addressed.² We will carry out a third audit in this series later in our work programme, which will report on the impact that integration has had and how health and social care resources are used.

Exhibit 1 Integration Joint Boards

There are 30 Integration Joint Boards across Scotland.



Part 1

The current position



Integration Authorities oversee almost £9 billion of health and social care resources

6. Our findings show that integration can work and that the Act can be used to advance change. Although some initiatives to integrate services pre-date the Act, there is evidence that integration is enabling joined up and collaborative working. This is leading to improvements in performance, such as a reduction in unplanned hospital activity and delays in hospital discharges. But there is much more to be done.

7. IAs are responsible for directing almost £9 billion of health and social care resources, money which was previously separately managed by NHS boards and councils ([Exhibit 2, page 11](#)). Over 70 per cent of this comes from the NHS, with the remainder coming from councils. As with councils and NHS boards, IAs are required to find efficiency savings from their annual budgets to maintain financial balance. Demands on services combined with financial pressures have led to many IJBs struggling to achieve this balance, with many needing additional financial contributions from partner organisations.

8. Each IA is underpinned by an integration scheme. This is the agreement between the council and the NHS board which shows how the IA will operate. For example, the scheme sets out arrangements for dealing with any budget overspends, which usually involves implementing a recovery plan. As local government bodies, IJBs can hold reserves if permitted by their integration schemes, although not all schemes allow this. Reserves are amounts of money that are built up from unspent budgets for use in future years. Generally, reserves are used for one of three purposes:

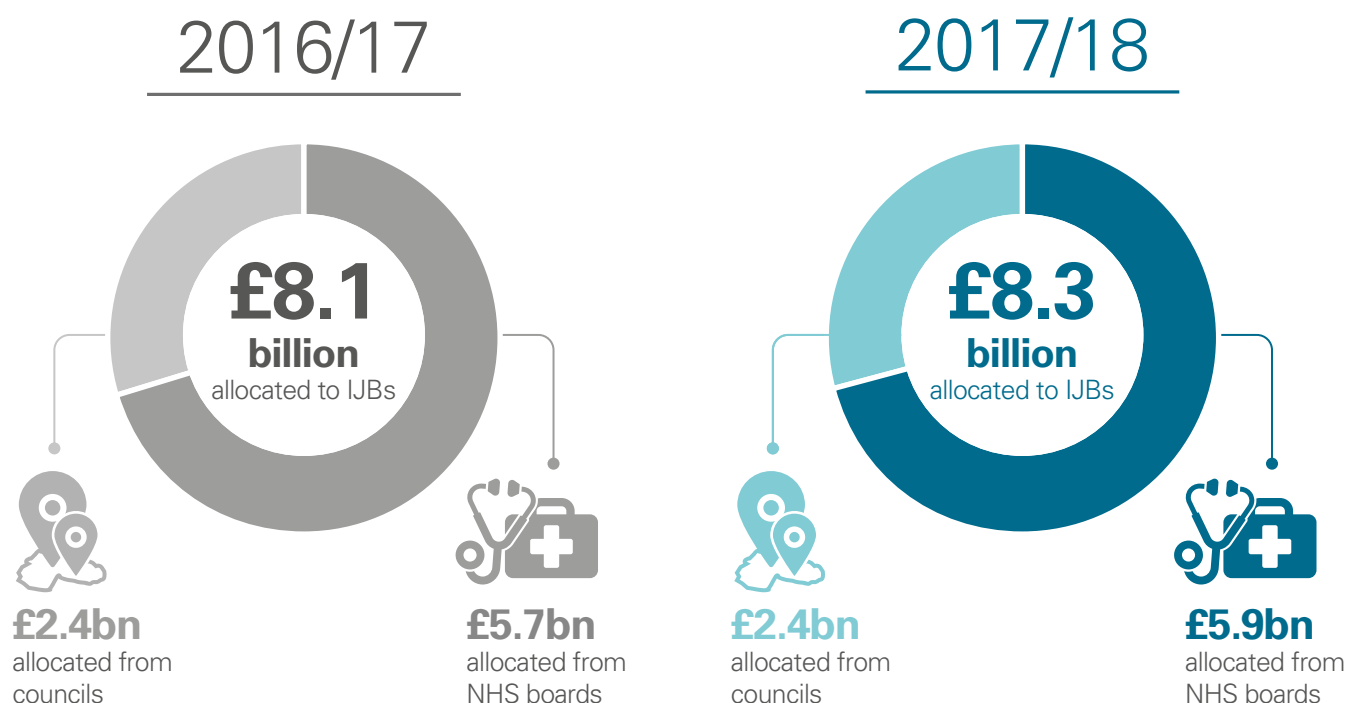
- as a working balance to help prevent the impact of uneven cash flows
- as a contingency to cushion the impact of unexpected events or emergencies
- held to fund known or predicted future requirements – often referred to as ‘earmarked reserves’.³

there is evidence that integration is enabling joined up and collaborative working

Exhibit 2

Resources for integration

IAs are responsible for directing significant health and social care resources.



Lead Agency – the allocation for Highland Health and Social Care Services was:
£595 million in 2016/17 | £619 million in 2017/18

Note: Council allocations in 2016/17 and 2017/18 include criminal justice social work contribution.

Source: Audit Scotland, 2018



Financial pressures make it difficult for IAs to make sustainable changes to the way services are delivered

9. The Act was intended to help shift resources away from the acute hospital system towards preventative and community-based services. However, there is still a lack of agreement about whether this is achievable in practice – or whether rising demand for hospital care means that more resource is needed across the system. We have seen some examples of small-scale changes in the balance of care, which are explored further in [Part 2 \(page 23\)](#). These examples show that change can be achieved, but IAs now need to take the next steps to achieve wider-scale impact on outcomes over the coming years.

10. IAs needed to achieve savings of £222.5 million in 2017/18. This is an increase of 8.4 per cent on the previous year and is 2.5 per cent of the total allocation to IAs from NHS boards and councils. The level of savings, as a percentage of IA income, varied from 0.5 per cent in Moray, Orkney, Renfrewshire and South Lanarkshire, to 5.3 per cent in Shetland and 6.4 per cent in Highland Lead Agency. In several instances, budgets were agreed at the start of the financial year based on achieving savings which had yet to be identified.

Financial position

11. It is not easy to set out the overall financial position of IAs. This is due to several factors, including the use of additional money from partner organisations, planned and unplanned use of reserves, late allocations of money and delays in planned expenditure. This makes it difficult for the public and those working in the system to understand the underlying financial position.

12. In 2017/18, IJBs reported an overall underspend of £39.3 million. This represented 0.4 per cent of their total income allocation for the year.⁴ However, this masks a much more complex picture of IJB finances. [Appendix 4 \(page 47\)](#) sets out more details about the financial position of IJBs in 2017/18. Many IAs have struggled to achieve financial balance at the year-end. The reasons for this vary but include rising demand for services, financial pressures and the quality of financial planning. In 2017/18, this resulted in several IJBs needing additional, unplanned allocations from their partners and adding to, or drawing on, reserves as follows:

- 16 needed additional money from NHS boards amounting to £32.8 million
- ten needed additional money from councils amounting to £18.6 million
- eight drew on reserves amounting to £9.1 million
- 14 put money into reserves, amounting to £41.9 million.

13. Twenty-two IJBs are required by their integration schemes to produce a recovery plan if they forecast an overspend on their annual budget. Several IAs have had to produce recovery plans and are finding it harder to achieve the actions contained within them:

- In 2016/17, 11 IJBs needed to draw up a recovery plan. Of these, four IJBs achieved the actions set out in their recovery plans, but the remaining seven needed additional allocations from either their council or NHS board.
- In 2017/18, 12 IJBs needed to produce a recovery plan but only two achieved their recovery plans in full. In some cases, where additional allocations are required, the integration scheme allowed the NHS board or council to reduce the following year's allocation to the IJB by the same amount. In these circumstances there is a risk that IJBs will not have sufficient resources to deliver the services needed in future years.

14. An IA's integration scheme states how the IA will manage any year-end overspend and the responsibilities of the NHS board and council. For example, Fife IJB's integration scheme states that any overspend will be funded by partner bodies based on the proportion of their current year contributions to the IJB. In 2017/18, this meant that NHS Fife and Fife Council agreed to make additional contributions of 72 per cent and 28 per cent respectively.

15. The Highland Lead Agency model is also facing financial pressures. In 2017/18, NHS Highland overspent on adult social care services by £6 million. This was largely due to pressures on Highland Lead Agency adult social care services. This contributed to NHS Highland needing a loan of £15 million from the Scottish Government in 2017/18. Due to the way the Lead Agency model was established and the underlying agency agreement, the risks all rest with NHS Highland. Any increases in costs must be met by the NHS board.

16. Fourteen IJBs reported underspends in 2017/18 and these have arisen for a variety of reasons, for example: achieving savings earlier than expected; contingencies not being required; slippages in spending plans and projects; and staff vacancies.

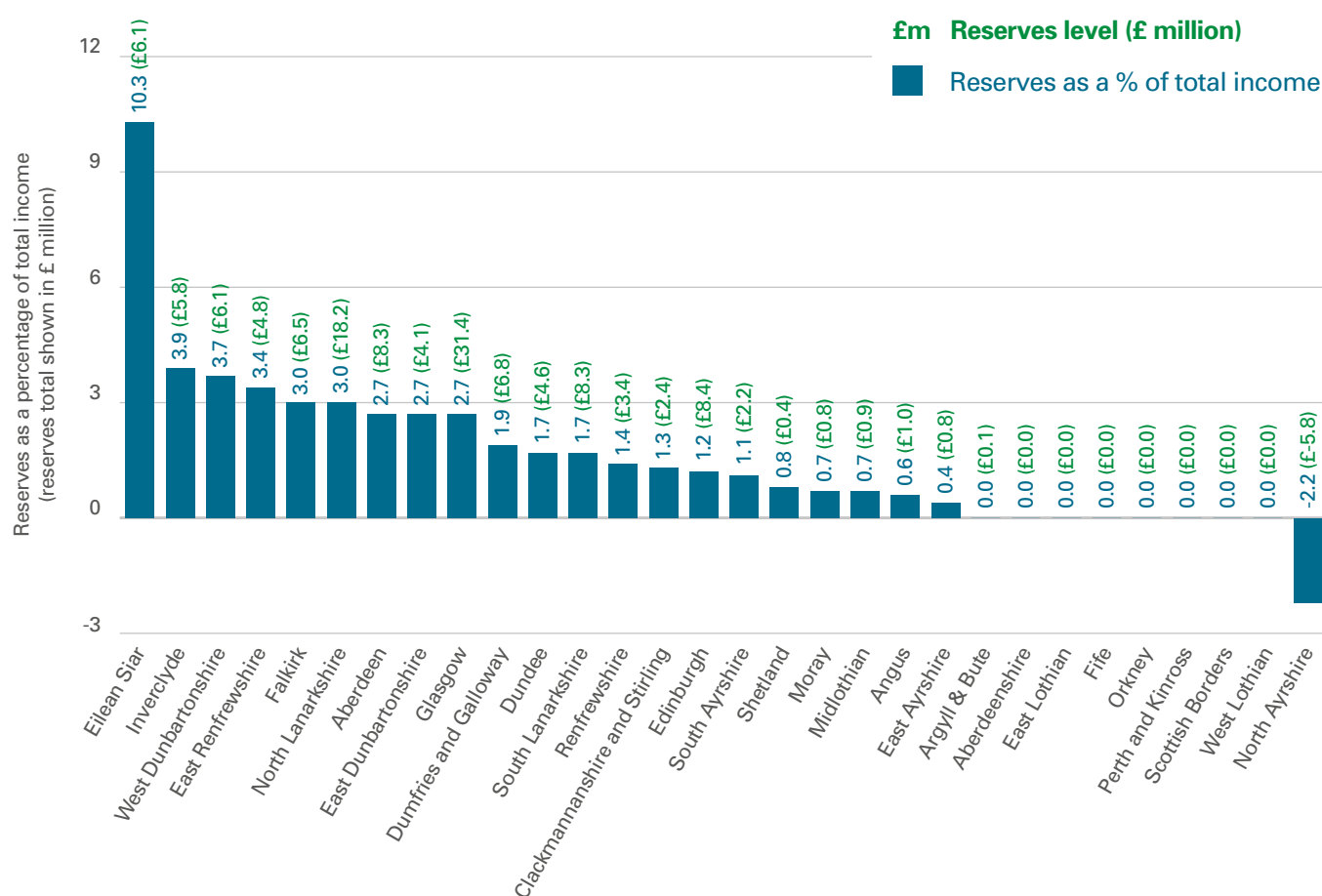
Reserves

17. The level of reserves held varies across IJBs, and not all integration schemes allow IJBs to hold reserves (**Exhibit 3**). In 2017/18, IJBs had built up reserves of £125.5 million, 1.5 per cent of their total income. This is not always a planned approach, and in some areas, reserves have arisen for several reasons including: the IJB receiving a late allocation of money; unspent strategic funding; staff vacancies; or year-end timing differences where money is received and allocated but unspent. Eilean Siar held the highest level of reserves as a percentage of its income at 10.3 per cent. The pressures on IJB budgets and the savings they need to achieve are significant, therefore the level of reserves in 2017/18 is not forecast to continue in future.

Exhibit 3

Reserves held by IJBs in 2017/18

There are significant differences in the levels of reserves held by IJBs.



Hospital services have not been delegated to IAs in most areas


18. A key part of the reforms is that IJBs would direct some services provided directly within acute hospitals, to move care closer to people's homes and provide more joined-up care. Integration schemes, as approved by ministers, state that hospital services will be delegated to the IJB, as required under the Act. However, in practice, in most areas, the services have not been delegated. This has been a major source of debate and disagreement at a national and local level and is a fundamental issue which will hinder IJBs' ability to change the system.

19. The money for functions that are provided by large hospitals but are delegated to IJBs, such as unplanned care, is referred to as a 'set-aside' budget. Instead of paying this money to the IJBs along with payment for other delegated services, it is identified as a budget which should be directed by the IJB. The complexities around accurately preparing set-aside budgets has presented challenges to fulfilling this element of the Act. To date, the set-aside aspect of the Act is not being implemented. In line with Scottish Government guidance, NHS boards continue to manage the set-aside as part of their own resources.

20. In 2017/18, £809.3 million was included within IJBs' budgets for set-aside (where they were able to include a set-aside figure). This is 9.0 per cent of IJBs' income and is therefore a significant element of the health and social care budget that is not being directed by the IJBs. If IJBs are to use resources more strategically to prioritise prevention and care in a community setting, this issue needs to be resolved.

21. There are several reasons why all partners have struggled with this aspect of the Act, including fundamental issues in the data available to analyse set-aside-related activities. However, these technical issues do not appear to be the main issue. The main problem is a lack of common understanding and agreement on how to identify the set-aside budget and shared agreement on how to implement this aspect of the legislation.

Monitoring and public reporting on the impact of integration needs to improve

22. The context for integration is challenging, with many public bodies trying to work in partnership to achieve major changes while at the same time managing rising demand for services, financial pressures and continuing to deliver services and treat people. As we reported in [NHS in Scotland 2018](#) , the number of patients on waiting lists for treatment continues to rise while performance against targets is declining and an increasing number of NHS boards are struggling to deliver with the resources they have.⁵ We have also reported that local government operates in an increasingly complex and changing environment with increasing levels of uncertainty.⁶

23. A significant number of measures are being used to monitor national and local progress which means IAs are reporting against a range of different measures to demonstrate progress ([Exhibit 4, page 16](#)). For the public to understand how the changes are working at a Scotland-wide level, these indicators need to be presented in a clear and transparent way.

24. It is important that the Scottish Government can demonstrate that resources provided have led to improvements in outcomes, in line with its national health and wellbeing outcomes. These outcomes are the Scottish Government's high-level statements of what health and social care partners are attempting to achieve through integration. These national outcomes are not being routinely reported at a national level, although IAs refer to them as part of their annual performance reports.

25. The Scottish Government introduced the National Performance Framework (NPF) in 2007 and launched a new framework in 2018. The NPF is made up of 11 national outcomes, each with indicators and aligned to the United Nations' sustainable development goals. There is a clear alignment between the aims of integration and several of the outcomes and indicators.⁷

26. The Ministerial Strategic Group for Health and Community Care brings together representatives from the Scottish Government, NHS, local government and IAs to monitor a set of six national indicators. These are used as indicators of the impact of IAs ([Exhibit 5, page 18](#)). These measures focus on the aim of integration helping to care for more people in the community or their own homes and reducing unnecessary stays in hospital. While these measures focus on health, performance can only improve with input from health and social care services. One of the six national indicators is supported by two measures: A&E attendances and achievement of the four-hour A&E waiting time target ([3a and 3b at Exhibit 5, page 18](#)).

27. Four of the indicators show improved performance, but there is significant local variation in performance between IAs. The performance measures do not themselves provide a direct indication of whether people's outcomes have improved, although they do represent key aspects of care which should ultimately improve people's lives.

Exhibit 4

Health and wellbeing outcomes and indicators

A significant number of measures are being used to monitor local and national progress.



National Performance Framework

Purpose

To focus on creating a more successful country, with opportunities for all of Scotland to flourish, through sustainable and inclusive economic growth

Values

We are a society which treats all our people with kindness, dignity and compassion, respects the rule of law, and acts in an open and transparent way

11 outcomes and 81 national indicators, for example:

- ✔ **Outcome:** We are healthy and active
- ✔ **Indicators:** Healthy life expectancy, mental wellbeing, healthy weight, health risk behaviours, physical activity, journeys by active travel, quality of care experience, work-related ill health, premature mortality
- ✔ **Sustainable development goals:** gender equality, reduced inequalities, responsible consumption and production, good health and wellbeing



9 national health and wellbeing outcomes

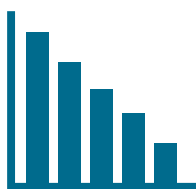
- ✔ People are able to look after and improve their own health and wellbeing and live in good health for longer
- ✔ People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
- ✔ People who use health and social care services have positive experiences of those services, and have their dignity respected
- ✔ Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- ✔ Health and social care services contribute to reducing health inequalities
- ✔ People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
- ✔ People using health and social care services are safe from harm
- ✔ People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- ✔ Resources are used effectively and efficiently in the provision of health and social care services

Exhibit 4 (continued)



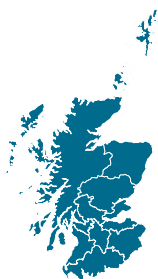
12 principles within the Act

- ✓ Be integrated from the point of view of the people who use services
- ✓ Take account of the particular needs of service users in different parts of the area in which the service is being provided
- ✓ Respect rights of service users
- ✓ Protect and improve the safety of service users
- ✓ Improve the quality of the service
- ✓ Best anticipate needs and prevent them arising
- ✓ Take account of the particular needs of different service users
- ✓ Take account of the particular characteristics and circumstances of different service users
- ✓ Take account of the dignity of service users
- ✓ Take account of the participation by service users in the community in which service users live
- ✓ Is planned and led locally in a way which is engaged with the community
- ✓ Make best use of the available facilities, people and other resources



6 national indicators

- ✓ Acute unplanned bed days
- ✓ Emergency admissions
- ✓ A&E performance (including four-hour A&E waiting time and A&E attendances)
- ✓ Delayed discharge bed days
- ✓ End of life spent at home or in the community
- ✓ Proportion of over-75s who are living in a community setting



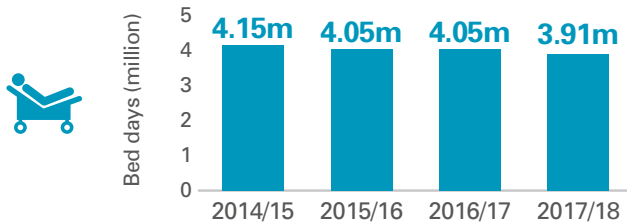
Various local priorities, performance indicators and outcomes

Exhibit 5

National performance against six priority areas

National performance shows signs of improvement in some of the six key national indicators.

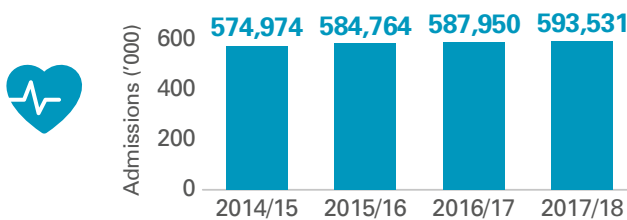
1. Acute unplanned bed days



Integration aims to reduce unplanned hospital activity

The number of acute unplanned bed days has reduced since 2014/15

2. Emergency admissions

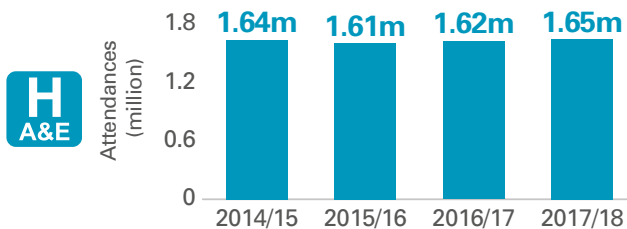


Integration aims to ensure that people's health and care needs are anticipated and planned appropriately, reducing unplanned hospital activity

The number of emergency admissions has risen each year since 2014/15

In 2017/18, local performance varied from 0.08 emergency admissions per head of population in NHS Orkney to 0.15 in NHS Ayrshire and Arran

3a. A&E attendances

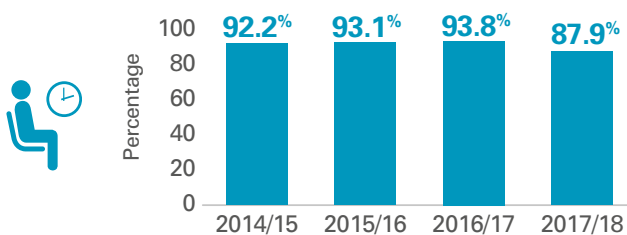


A&E attendances can be an indication of the degree to which community services are helping people receive care in the right place at the right time.

The number of A&E attendances has marginally increased since 2014/15

In 2017/18, local performance varied from 0.2 A&E attendances per head of population in NHS Grampian to 0.4 in NHS Greater Glasgow and Clyde

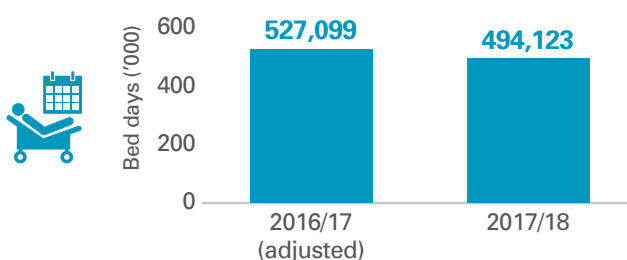
3b. Achievement of the four-hour A&E waiting time target



The achievement of the four-hour waiting time target has declined since 2014/15

Local performance varied in 2017/18 from 98.0% NHS Tayside to 75.4% NHS Lothian

4. Delayed discharge bed days (for population aged 18+)



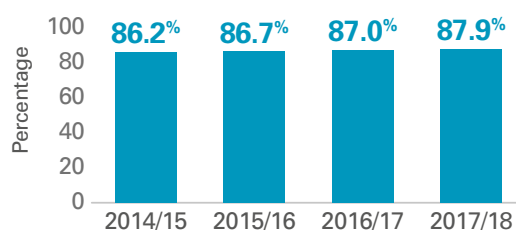
Reducing delays in discharging people from hospital has been a long-standing aim for health and care services. With rising demand, some areas have struggled with this. Due to changes in data collection, comparable data is only available for two years.

Delayed discharge rates have fallen since 2016/17

In 2017/18, local performance varied from 2.5% in Inverclyde to 26.5% in Eilean Siar delayed discharge bed days as a percentage of their population (18+)

Exhibit 5 (continued)

5. End of life spent at home or in the community

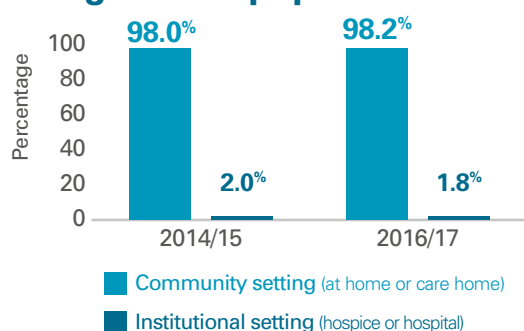


Integration aims to support people with health and care needs in their own home or in a community setting, especially at the end of life.

A gradual increase in the percentage of people's time spent at home or in a homely setting at the end of their life

In 2017/18, local performance varied from 95.1% of people's time spent at home or in a homely setting at the end of their life in Shetland to 85.2% in East Renfrewshire

6. Percentage of 75+ population in a community or institutional setting



Integration aims to shift the balance of care from an institutional setting to a community setting.

There has been a slight increase in the percentage of individuals aged over 75 who are living in a community setting. This is in line with the intentions of the Act.

Notes:

Indicator 1

- These statistics are derived from data collected on discharges from non-obstetric and non-psychiatric hospitals in Scotland. Only patients treated as inpatients or day cases are included. The speciality of geriatric long stay is excluded.
- Bed days for each year have been calculated based on the year in which the bed days were occupied. This differs from other analysis where length of stay or occupied bed days are reported by the year of discharge.
- Unscheduled bed days relate to all occupied bed days within a continuous hospital stay following an emergency or urgent admission.
- The Scotland total presented is the sum of all those resident in IA areas and excludes non-Scottish residents.
- Approximately a quarter of IAs returned figures for people aged over 18 only. Where this is the case, bed days from 2016/17 for people aged under 18 in those partnerships have been applied to 2017/18 figures.
- Based on data submitted to ISD in August 2018.

Indicator 2

- ISD published data as at September 2018.

Indicator 3a

- ISD published data as at August 2018.

Indicator 3b

- ISD published data as at June 2018.
- Performance for the month ending March for each year.

Indicator 4

- ISD published data as at September 2018.
- 2016/17 figures adjusted to reflect revised definitions across the whole year.

Indicator 5

- ISD published data as at October 2018.

Indicator 6

- Percentage of 75+ population in a community or institutional setting:
 - Community includes the following:
 - Home (unsupported) – refers to the percentage of the population not thought to be in any other setting, or receiving any homecare, on average throughout the year.
 - Home (supported) – refers to the percentage of the population estimated as receiving any level of homecare. Estimated from social care census carried out at the end of the reporting year (eg, Census carried out in March 2014 used to estimate home (supported) population during 2013/14).
 - Resident in a care home – based on care home census at the end of the reporting year (eg, Census at 31 March 2014 used to estimate 2013/14 care home population). The care home data is based on long-stay residents only. The proportion of incomplete long-stay residents aged 75+ cannot be calculated. Therefore, a scaling factor, based on the 65+ proportions, has been employed for the 75+ data. This assumes that there is the same degree of incompleteness in the census data returned for adults in each of the age bands.
 - Institutional includes the following:
 - Average population in hospital/hospice/palliative care unit throughout the year.
 - Hospital includes both community and large/acute hospitals.
 - Hospice activity is based on SMR records and will be incomplete as not all hospices submit this information.
- Figures provided by ISD.

General

- Population figures used taken from the National Records of Scotland mid-2017 estimates published in 2018.
- Figures relate to all ages unless otherwise stated.



Integration Authorities' performance reports show local improvement

28. IAs are required to publish annual performance reports which contain information on local priorities and a range of local initiatives ([Exhibit 6](#)). These reports are an important way for IAs to inform the public about how well they have been performing against their stated priorities. The improvements that are set out in the performance reports are welcome and current pressures across the system have made them difficult to achieve. However, core indicators of performance are not improving in all areas of Scotland and nationally it is clear that there is much more to be done.

Exhibit 6

Examples of impact from integration

IAs have set out a number of local improvements in their performance reports.



Prevention and early intervention

Dumfries and Galloway

The D&G Handyvan provides information, advice and practical assistance with adaptations to people's homes. This is available to disabled people of any age and older people aged 60 and over. People are also supported to access financial assistance for major adaptations. This service helps people to feel more confident about continuing to live independently in their own home and to feel safe and secure in their home. People are less likely to have a fall, have improved health and wellbeing, and have a better quality of life. Often adaptations support people to be better connected with their friends and family and their wider community. 1,626 referrals were received during 2017/18. These resulted in 2,149 tasks being carried out by the service. 808 people were referred to prevent a fall, 577 people for home security, 16 people for minor adaptations and 225 people for small repairs.

Dundee

Social prescribing 'Sources of Support' (SOS) is one means of supporting people to better manage their health conditions. Link workers, working within designated GP practices, take referrals for people with poor mental health and wellbeing affected by their social circumstances and support them to access a wide range of non-medical services and activities that can help. In 2017/18, 256 patients were referred to three link workers and 220 people were supported. An external evaluation demonstrated that the service had a positive impact on both clients and on GPs themselves. 65 per cent of patient goals were met and 84 per cent had some positive outcome, including decreased social isolation, improved or new housing, financial and benefits issues being addressed, and increased confidence, awareness and self-esteem.

Outcomes from a GP perspective include reduced patient contact with medical services, providing more options for patients, raising awareness of non-clinical services, and increased GP productivity. 2017/18 saw a major scale-up of the SOS scheme through the Scottish Government Community Link Worker programme, extending the service from four GP practices to 16.



Delays in people leaving hospital

East Ayrshire

The Red Cross Home from Hospital Service supported about 1,700 people in 2017/18. The service is delivered across Ayrshire and Arran from University Hospitals Crosshouse and Ayr and supports people to be discharged as early as possible, reducing their length of stay and re-settling them in their home. Once home, the service helps to prevent falls and reduce social isolation, supporting people to regain their confidence, skills for living independently and organises telecare to support families to continue to care. A total of 1,730 bed days have been saved, equivalent to £302,750. 73 admissions to hospital have been avoided, and 625 bed days saved, equivalent to £109,375.

Perth and Kinross

There have been increases in staffing within social care discharge teams, Perth Royal Infirmary liaison services, and care home nursing. This, alongside improved funding procedures for care home placements, has supported speedier discharge to a care home setting or repatriation to such. There has been a reduction of 2,391 (12.5 per cent) delayed discharge bed days between 2016/17 and 2017/18 to 16,785.

Exhibit 6 (continued)



Preventing admission to hospital

East Dunbartonshire

Rapid Response Service has established a different referral route for patients between A&E and the Community Rehabilitation Team to provide next-day response. During 2017/18, the service prevented approximately 33 per cent of people referred being admitted to hospital.

South Ayrshire

The Intermediate Care Team provide rapid multidisciplinary team support to people to support them to return home from acute hospital and to remain at home through GP referral. In particular, they have worked closely to establish pathways with the Combined Assessment Unit to prevent admission. The service provided by the Intermediate Care Team resulted in 674 hospital admissions being avoided and 301 early supported discharges during 2017/18. It is estimated locally that each avoided hospital admission saves five hospital bed days and each supported discharge saves three hospital bed days. Overall, it is estimated that the intervention provided by the Intermediate Care Team saved 3,370 bed days due to avoided admissions and 903 bed days due to early supported discharges.

Aberdeenshire

Set up in 2016, Aberdeenshire's Virtual Community Ward (VCW) aims to avoid unnecessary hospital admissions through bringing together multidisciplinary health and social care teams who provide care for patients who need regular or urgent attention. This GP-led approach involves the teams working closely together, generally meeting daily under a huddle structure. They identify and discuss vulnerable/at risk patients and clients, and coordinate, organise and deliver services required to support them. The VCW identifies individuals who need health and social care services at an earlier stage, which can improve patient outcomes and experience. Based on an evaluation carried out by the VCW team, 1,219 hospital admissions have been avoided because of the VCWs.



Referral/ care pathways

Aberdeenshire

During 2017/18 a test of change was carried out in one GP practice to trial people's first appointment with a physiotherapist rather than a GP. Ongoing evaluation suggests that this has been successful and has proved popular with patients who now have immediate access to a physiotherapist for assessment and advice. If follow up is required, this can be booked at the time. 221 people have been directed to the physiotherapist first; only 58 per cent required a face-to-face appointment and 26 per cent were discharged following telephone advice.

Renfrewshire

Over the past three years, the Primary Care Mental Health Team (Doing Well) has introduced a self-referral route to the service. This has led to a decrease in clients attending a GP to be referred to the mental health team. The number of self-referrals to the service has increased from 207 in 2013/14 to 1,237 in 2017/18. This self-referral route has successfully redirected work away from GP surgeries.

Midlothian

An advanced practitioner physiotherapist for Chronic Obstructive Pulmonary Disease (COPD) was appointed to support people attending hospital frequently because of their COPD to help them manage their symptoms at home and avoid admission to hospital. In the first year the service has worked with 65 patients and successfully avoided 30 hospital admissions. This delivered a potential reduction of 520 days spent in hospital by Midlothian residents and a much better patient experience. It was also a more cost-effective approach to delivering services for the partnership.

Exhibit 6 (continued)



Reablement

Falkirk

A Reablement Project Team (RPT) was developed in Social Work Adult Services Assessment and Planning service in January 2017 to test out various reablement approaches and processes. The team consists of occupational therapists (with community care worker background) and social care officers. The reablement team support service users for up to six weeks. Individuals are reviewed on a weekly basis and care packages are adjusted as the person becomes more independent. Fewer people required intensive packages at the end of six weeks, which has freed up staff time and has reduced the use of external providers. Early indications suggest this work has led to a £200,000 reduction in purchasing care from external homecare providers.

Scottish Borders

The Transitional Care Facility based within Waverley Care Home is a 16-bed unit which allows older people to regain their confidence and independence so that they can return to their own homes following a stay in hospital. The facility is run by a multidisciplinary team of support workers, allied health professionals and social workers. 81 per cent of individuals discharged from Transitional Care return to their own homes and the hospital readmission rate for these individuals is six per cent.



Pharmacy

South Lanarkshire

The pharmacy plus homecare initiative has created an opportunity to amend consultant and GP prescribing practices. A reduction in prescribing can lead to less homecare visits. The IA estimates that savings could be in the region of £1,800 per patient (within the trial).

Angus

The Angus IA has improved how care homes manage medication. A new process developed by a Locality Care Home Improvement Group with GPs and pharmacy has led to zero medication waste in care homes.

Part 2

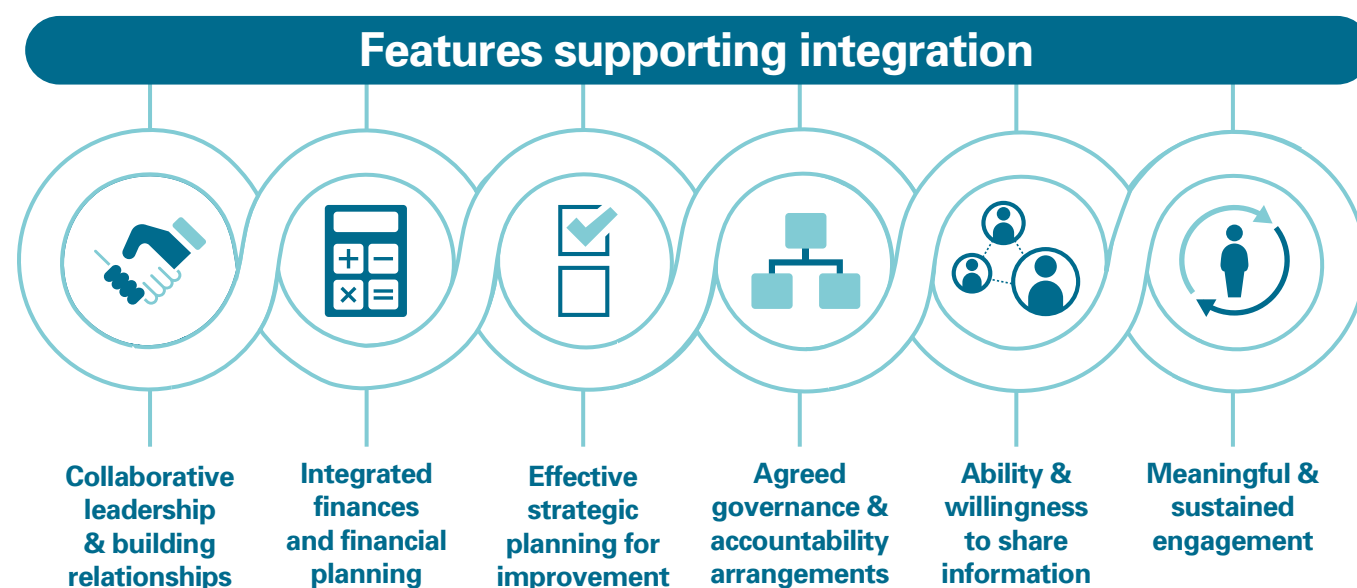
Making integration a success

29. IAs are addressing some significant, long-standing, complex and inter-connected issues in health and social care. Our work has identified six key areas that, if addressed, should lead to broader improvements and help IAs to take positive steps toward making a systematic impact on health and care outcomes across their communities ([Exhibit 7](#)).

Exhibit 7

Features central to the success of integration

Six areas must be addressed if integration is to make a meaningful difference to the people of Scotland.



Source: Audit Scotland

A lack of collaborative leadership and cultural differences are affecting the pace of change

30. High-quality leadership is a critical part of the success of an organisation or programme of reform. Given the complexity of health and social care integration, it is important that leaders are highly competent, have capacity to deliver and are well supported. For transformation to succeed, the right leadership and strategic capacity need to be in place. Without this, the reforms will not succeed. We identified several risks in this area which need to be addressed:

- A significant number of IAs have had leadership changes with 57 per cent having had changes in their senior management team. As at October 2017, seven IJBs have a different Chief Officer (CO) in post than two years previously.
- There is significant variation in the role and remuneration of COs and Chief Financial Officers (CFO). Many have dual roles with positions held in partner organisations and there is a mix of full and part-time CFOs. This is a significant challenge, given the scale of the task facing IAs and the strategic role COs and CFOs have in directing change. In 2017/18, £3 million was spent on IJBs' CO remuneration and there are differences in salary levels, in part reflecting differences in roles and responsibilities.
- There is evidence of a lack of support services for IAs, in relation to HR, finances, legal advice, improvement, and strategic commissioning. This will limit the progress that they are able to make. It is important that the partner bodies support the IJB, including support services.

31. Top-down leadership which focuses on the goals of a single organisation does not work in the context of integration. NHS Education Scotland has described 'systems leaders' as having an ability to 'have a perspective from the wider system. They recognise that it is necessary to distribute leadership responsibilities to bring about change in a complex interdependent environment...They change the mind-set from competition to cooperation. They foster dialogue... which can result in new thinking... When leadership involves such a collective endeavour, the way people see their accountability matters.'⁸ A lack of collaborative systems leadership and difficulties in overcoming cultural differences are proving to be significant barriers to change.

32. Leaders from all partners are operating in a complex and continually changing landscape and, without appropriate support in place, cannot fulfil their role effectively. Leaders need support if they are to deliver public services to improve wider outcomes and work collaboratively across organisational boundaries. This is hard to achieve, especially where there have been changes in key staff and local politicians, and in the context of the current financial and performance pressures. Accountability arrangements are important to encourage and incentivise the right kinds of leadership characteristics.

33. Cultural differences between partner organisations are proving to be a barrier to achieving collaborative working. Partner organisations work in very different ways and this can result in a lack of trust and lack of understanding of each other's working practices and business pressures. In better performing areas, partners can identify and manage differences and work constructively towards achieving the objectives of the IA. Overcoming cultural differences and improving understanding of each other's businesses will help partner organisations progress towards integration, particularly regarding integrated finances. Joint leadership development for people working in NHS boards, councils and IJBs can help with this. [Exhibit 8 \(page 25\)](#) provides an overview of the common leadership traits which are important in integrating health and social care services.

Exhibit 8

Traits of effective collaborative leaders

There are a number of leadership traits which are important in integrating health and social care services.



Influential leadership

- Clear and consistent message
- Presents a positive public image
- Ability to contribute towards local and national policy
- Shows an understanding of the value of services



Ability to empower others

- Encourages innovation from staff at all levels
- Non-hierarchical and open to working alongside others
- Respectful of other people's views and opinions
- Inspiring to others
- Creates trust
- Willing to work with others to overcome risks and challenges



Promotes awareness of IA's goals

- Confidence and belief in new technology to facilitate progress
- Facilitates planning of sustainable services
- Recruitment of staff to fit and contribute to a new culture
- Sets clear objectives and priorities for all
- Develops widespread belief in the aim of the integrated approach to health and social care



Engagement of service users

- People who use services feel able to contribute to change
- Ability to facilitate wide and meaningful engagement
- Open to and appreciative of ideas and innovation
- Ensures voices are heard at every level
- Transparent and inclusive



Continual development

- Encourage learning and development, including learning from mistakes
- Belief in training and understanding of who could benefit from it
- Encourage innovation, debate and discussion
- Driven to push for the highest quality possible

34. We have seen examples of good collaborative and whole-system leadership, including in Aberdeen City, where relationships have been built across the partnership. Although differences of opinion still exist and there is healthy debate, Aberdeen City is now better placed to implement widespread changes to improve outcomes. We saw:

- the promotion of a clear and consistent message across the partnership
- a willingness to work with others to overcome differences
- recruitment of staff to fit and contribute to a new culture
- development of openness and appreciation of ideas
- encouragement of innovation, learning and development, including learning from mistakes.

35. The Scottish Government and COSLA are co-chairing a group involving leaders from across councils and NHS boards. The aim of the group is to identify and overcome barriers to integration. The group has produced a joint statement on integration, confirming the shared responsibility of the Scottish Government, NHS Scotland and COSLA for ensuring the successful integration of Scotland's health and social care services. The statement acknowledges that the pace of integration needs to improve, and that the group needs to work together to achieve integration and to overcome challenges to better meet people's health and social care needs. The group is developing further support and training to support leadership for integration. The Scottish Government and COSLA are also co-chairing an Integration Review Reference Group. This group is reviewing progress on integration and will report its findings to the Ministerial Strategic Group for Health and Community Care. The group will conclude its work in January 2019. We will continue to monitor any actions resulting from the work of the group.

Integration Authorities have limited capacity to make change happen in some areas

36. IJBs are very small organisations, all of which have a CO and a CFO. Not all IJBs have the support they need, for example only half of IJBs have a full-time CFO and there have been difficulties in filling those posts in some areas. Each IJB has a chair and vice chair, but we have been told that many IJBs rely on its members working much more than contracted hours, and chairs and vice chairs have told us that they struggle to attend to IJB business during contracted time. Each IJB is made up of voting and non-voting members.

37. Typically, an IJB meets about six times a year. The IJB also has one or more Strategic Planning Group, which are consulted and give feedback on strategic plans and significant changes to integrated functions. For this structure to work, the IJB needs to draw on, and be supported by, skills and capacity from its partner NHS board and council. This can lead to a reliance on information and advice being provided by the statutory partner organisations which influences the decisions made by the IJB. In areas where information is being shared across the partnership, we can see that more progress is being made with integration. We saw this happening in Aberdeen City IJB, where senior officer and finance officer groups bring together staff from across partner organisations to share information and skills which are essential for joint decision-making. If this does not happen, the IJB has less capacity to make change and address challenges.



What is integration?
A short guide to the integration of health and social care services in Scotland



IJB membership
(page 10)

38. We saw several barriers affecting the way that IJBs are operating, and more action is needed to increase knowledge and understanding of those involved in the decision-making process:

- Topics for discussion at IJB and committee meetings are affected by problems with both the lack of time available and with people's knowledge.
- IJB papers are often lengthy and issued to members within timescales that do not allow for proper consideration.
- Papers are often technical and contain complicated financial information that lay representatives and representatives from voluntary sector bodies may struggle to understand.
- Officers are limited in the time available to provide IJBs with information. Many officers of the IJB fulfil their role alongside roles held within statutory partner bodies.
- High turnover of people in key positions in IJBs has affected the skills available and has led to a lack of continuity and extra time being spent in building trust and relationships.

Good strategic planning is key to integrating and improving health and social care services

39. In the past, health and social care services have not linked the resources they have to their strategic priorities or longer-term plans. IAs still have work to do to ensure that priorities are linked to available resources, and to demonstrate that new ways of working will be sustainable over the longer term. IAs can only achieve this change with the support and commitment of NHS boards and councils.

40. IJBs, with the support of council and NHS board partner bodies, should be clear about **how** and **when** they intend to achieve their priorities and outcomes, in line with their available resources; and ultimately how they intend to progress to sustainable, preventative and community-based services. This includes working with NHS boards and councils to: agree which services will be stopped or decommissioned to prioritise spend; plan effective exit strategies from current ways of delivering services; and being clear how they will measure improvements in outcomes. Exit strategies are an important element in the ability to move from one service provision to another.

41. Scenario planning will help IAs build a picture of what they will need in the future. This involves looking at current trends, such as the effects of an ageing population, current lifestyles and future advances in health and social care. IAs should then use this analysis to anticipate potential changes in future demand for services and any related shortfalls in available finances. Strategic planning groups of the IJB have a role to play in ensuring the needs of the community are central to service decisions ([Case study 1, page 28](#)).

Case study 1



Shetland Scenario Planning

As part of its Strategic Commissioning Plan, the Shetland IA identified a growing gap between service demand and resources. To support strategic planning, NHS Shetland hosted a session with health and social care staff, IJB representatives, NHS board representatives, councillors, community planning partners, third-sector organisations and representatives of people using services. It considered several high-level scenarios:

1. the lowest level of local healthcare provision that it could ever safely and realistically imagine being delivered on Shetland 5-10 years from now
2. a lower level of local healthcare provision in 5-10 years than it has now on Shetland – a 'step down' from where it is now in terms of local service delivery
3. a higher level of local healthcare provision in 5-10 years than it has now on Shetland – a 'step up' from where it is now in terms of local service delivery
4. a future that describes the highest level of local healthcare provision that it could ever realistically imagine being delivered on Shetland 5-10 years from now.

The group then concentrated on scenarios 2 and 3 and explored them in more detail.

This systematic approach towards strategic planning, involving a wide variety of stakeholders, allowed them to build consensus on the main priorities of the IJB. The key outputs from the scenario planning exercise involved clear actions that were linked to a wide range of plans and policies. The key messages from the scenario planning formed discussion points within the IJB meetings. Actions identified were then incorporated into the business programme and an action tracker is a standing agenda item.

Source: Shetland IJB, 2018

42. Although strategic planning is the statutory responsibility of the IAs, councils and NHS boards should fully support the IJB and provide the resources needed to allow capacity for strategic thinking. In addition, the Scottish Government has an important role to play in leading and enabling change to take place. There must be a consistent message and understanding of integration, but this is not always the case. For example, the current move towards some aspects of health planning taking place at a regional level is causing uncertainty for IAs. Many IAs are unclear as to how this fits with the need for local strategic planning and decision-making. For IAs to think long term, they must have confidence that Scottish Government policy will support integrated thinking.

43. Strategic planning also helps to encourage and promote joined-up working and a commitment to scaling up new ways of working. Angus IJB has shown a strong long-term commitment to its enhanced community support model. This has now been implemented in three of its four locality areas and therefore has the potential for long-term impact on people's outcomes ([Case study 2, page 29](#)).

Case study 2



Angus – Enhanced community support model

Angus IJB's Enhanced Community Support (ECS) workstream involves several multi-professional teams working together, including the third-sector. The teams provide care and support in people's own homes so that, where possible, hospital admission is avoided. As a result, staff can be more proactive, coordinate care and make referrals for additional support more quickly. The teams also hold weekly meetings to review the care that is being provided in a more coordinated way.

ECS has increased community and primary care capacity leading to an average of 37 empty hospital beds across Angus per day in 2017. This helped the IJB to close 21 of its 126 community hospital inpatient beds which are no longer needed. ECS has improved hospital readmission rates. It has also improved prevention and early intervention activity through an increase in the number of anticipatory care plans.


ECS has led to a more joined-up approach between the professional disciplines which has improved referral times and access to support. This has allowed people to be more independent, access local services and be supported to stay in their homes or a homely setting for longer.

The success of this approach has allowed the IJB to roll ECS out to three of its four localities, with plans to roll out to the final locality during 2018/19. The localities that have adopted this approach for the longest have seen improvements in the average length of stay and a reduction in the number of hospital admissions for people aged over 75.

Source: Angus IJB, 2018

44. A small number of IAs do not have detailed implementation/commissioning plans to inform their strategic plan. Of those which do, about half of these provide a link to resources. More needs to be done to show how the shift from the current ways of working to new models of care will happen and when positive changes to people's lives will be achieved.

45. Workforce pressures are a clear barrier to the implementation of integration plans and workforce planning is a particularly important element of strategic planning. Workforce planning remains the formal responsibility of councils and NHS boards. However, IJBs need to work closely with their partners to ensure that their plans for service redesign and improvement link with and influence workforce plans. IAs must be able to demonstrate what skills are required to ensure they can deliver services in the right place at the right time. IAs identify not being able to recruit and retain the workforce they need as a risk. The contribution of the third and independent sector should be part of workforce planning.

46. All three parts of the Health and Social Care National Workforce Plan have now been published, with the final part on the primary care workforce published in April 2018.⁹ In our 2017 report, [NHS workforce planning](#) , we recommended that there is a need to better understand future demand and to provide a breakdown of the cost of meeting this demand.¹⁰ We will publish a further report on workforce planning and primary care in 2019.

Housing needs to have a more central role in integration

47. Not enough links are being made between housing and health and social care which will improve outcomes and wellbeing. Housing services are an integral part of person-centred approaches and the wider delivery of health and social care integration. All IAs are required to include a housing contribution statement in their strategic plans and housing representation is mandatory on Strategic Planning Groups. [Case study 3](#) illustrates strategic thinking within Glasgow City IJB which has used housing as a central aspect of health and social care. Three-quarters of IJBs reported some involvement of housing services in the planning of integrated health and social care services, although we found that the extent of this involvement varied greatly between partnerships.

Case study 3



The Glasgow Housing Options for Older People (HOOP) approach

The HOOP approach involves a small team working closely with social work, health and Registered Social Landlords (RSLs). The approach aims to: ensure a smooth transition for people from hospital to a homely setting; work closely with RSLs to prioritise people who are experiencing a delay in being discharged from hospital; develop knowledge of housing stock availability; and provide reciprocal information about RSLs tenants in hospital.

The team has worked on about 1,200 cases with surgeries in 19 sites across seven hospitals, six social work offices and six intermediate care units. The outcomes of the approach include helping:

- older people make informed choices along with their families, irrespective of tenure issues
- older people to return home or to community settings supported by a care package
- to reduce delayed discharge where there are housing issues
- prevent hospital admission and readmission, supporting older people with housing issues remain in the community
- secure appropriate accommodation for older people across the city suitable for their medical needs
- to increase knowledge of Glasgow's complex housing landscape among social workers and health professionals
- housing colleagues increase their knowledge about social work and health assistance to support older people returning home from hospital
- to future proof the city's new build investment by sharing information on customer needs and demand.

Source: Glasgow City IJB, 2018

Longer-term, integrated financial planning is needed to deliver sustainable service reform

48. Partners are finding it very difficult to balance the need for medium- to long-term planning, typically three to five years and five years plus, alongside annual settlements, current commitments and service pressures. We have called for longer-term financial planning in the health sector and local government for many years. While all IAs have short-term financial plans, only a third have medium-term plans and there were no longer-term plans in place at the time of our fieldwork. This is a critical gap as the changes under integration are only likely to be achieved in the longer term.

49. The Accounts Commission has previously reported that the 'Evidence from councils' annual audit reports generally demonstrates good medium-term (three to five years) financial planning, with some councils using scenario planning to provide a range of options'.¹¹ IAs should draw on the experience from councils to inform development of longer-term financial plans.

50. There is little evidence that councils and NHS boards are treating IJBs' finances as a shared resource for health and social care. This is despite the requirement to do this in the legislation, and budget processes set out in integration schemes describing budget-setting based on need. Partners must work with the IJBs to establish an approach to financial planning that considers the priorities of health and social care in the local community. Councils and NHS boards can be unwilling to give up financial control of budgets and IJBs can struggle to exert their own influence on the budget-setting process.

51. National data on the balance of spending between institutional care and care in the community is only available up to 2015/16. While this does not reflect any impact from IAs, it shows that the balance of spending changed little between 2012/13 to 2015/16 ([Exhibit 9, page 32](#)). Although this data is still collated, it is no longer published. This data should be publicly available and is a helpful indicator of whether IAs are influencing the shift of resources.

52. In October 2018, the Scottish Government published its *Medium Term Health and Social Care Financial Framework*.¹² The Framework is intended to help partners to improve strategic planning. It covers the period 2016/17 to 2023/24, and sets out trends in expenditure and activity, future demand and the future shape of health and social care expenditure.

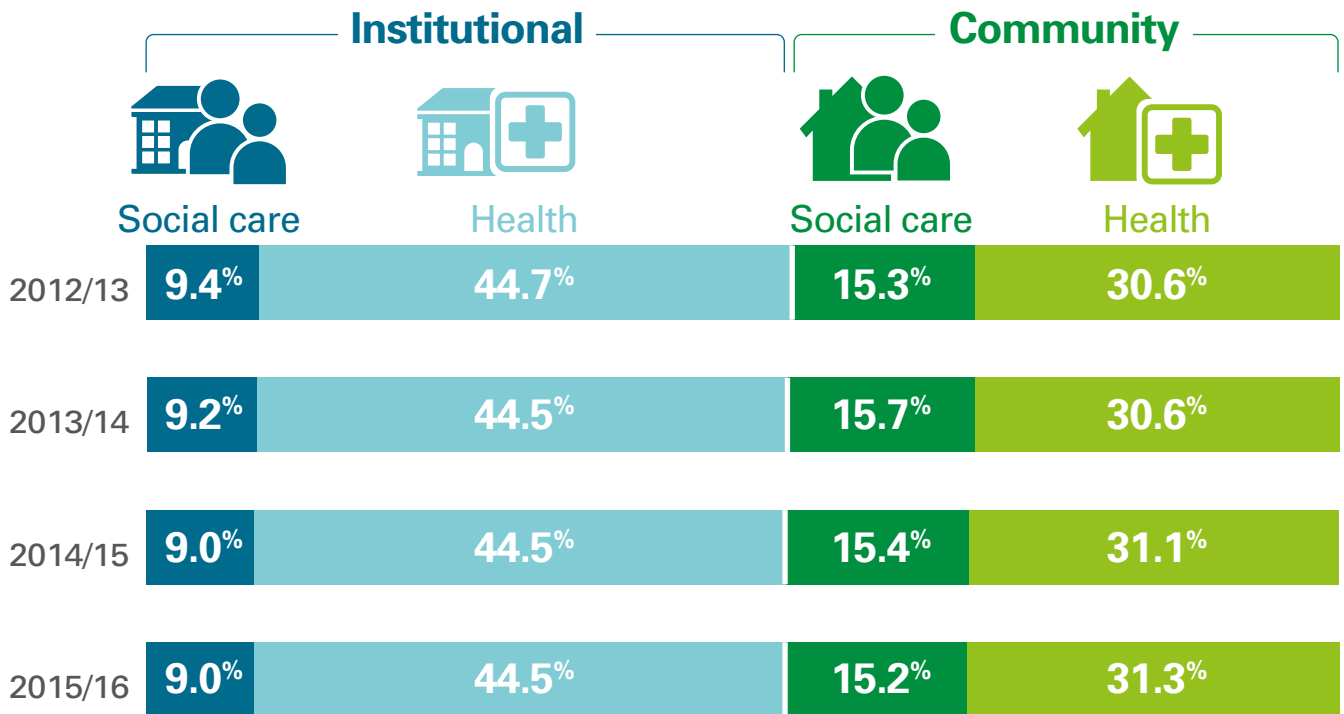
53. Attempts at integrating health and social care go back several years and it is not possible to identify the full cost of the reforms. This, in part, is due to the scale of the reforms and the interconnectedness with the rest of the health and social care system.

54. Due to ongoing financial pressures, most new service initiatives have been funded using additional financial support from the Scottish Government, rather than through the re-distribution of health and social care resources. Therefore, there should be an ongoing commitment from the Scottish Government to provide continued additional funding over coming years. This will provide financial stability to IAs while they implement new ways of working and plan how to redirect funding from current services.

Exhibit 9

The percentage of expenditure on institutional and community-based care

The percentage of expenditure on institutional and community-based care remained static between 2012/13 – 2015/16.



Source: Information Services Division, 2018



55. Major reforms have benefited from a degree of ‘pump priming’ money to help with change. In 2017/18, IAs total income included national funding which has been directed through NHS budgets, of:

- £100 million from the Integrated Care Fund to help shift the balance of care
- £30 million to help tackle delayed discharges
- £250 million to support payment of the living wage and help establish integration in its first year. This increased by £107 million in 2017/18.

56. The ring-fencing of funding intended to support delegated functions has not helped IAs’ efforts to redirect resources, reducing their ability to use their resources flexibly. There are examples of small-scale transfers of resources and we appreciate that more time is needed for IAs to achieve this change ([Case study 4, page 33](#)). IAs need to demonstrate how they will sustain any improvements if specific dedicated funding is no longer available.

Case study 4



South Lanarkshire redirecting resources to provide more community-based care

In 2017, South Lanarkshire IJB decided to close 30 care of the elderly beds within Udston Hospital and invest in alternative community-based models of care. An assessment of need found that two-thirds of individuals on the ward could have been better cared for within a community setting. Recurring funding of about £1 million per annum was released as a result. The IJB planned for £702,000 of this to be redirected to community-based services, such as homecare and district nursing to build the area's capacity to support more people at home. To achieve this:

- engagement plans were developed to ensure people using care and their families, staff and elected members of the Udston area were involved in the changes
- financial modelling was undertaken to understand the profile of people on the ward and reallocate resources to more appropriate, alternative health and social services
- the IA worked in partnership with NHS Lanarkshire to ensure good governance.

The £702,000 provided a degree of financial flexibility to further develop intermediate care services and increase community-based rehabilitation services. The IJB plans to redesignate the Udston beds for use by step-down intermediate care patients to support a reduced reliance on the hospital and residential care.

Source: Bed Modelling in South Lanarkshire, IJB board paper, 30 October 2017

Agreeing budgets is still problematic

57. Fifteen IAs failed to agree a budget for the start of the 2017/18 financial year with their partners. This is partly down to differences in the timing of budget settlements between councils and NHS boards. It can also be due to a lack of understanding between councils and NHS boards of each other's financial reporting, accounting arrangements and the financial pressures faced by each. This lack of understanding can cause a lack of trust and reluctance to commit funds to an integrated health and social care budget.

58. There are difficulties with short-term and late budget settlements, but this should not preclude longer-term financial planning. IAs will only be able to plan and implement sustainable services if they are able to identify longer-term costs and funding shortfalls. This will also help to plan effective exit strategies from current services and larger-scale transfers of resources to community-based and preventative services.

It is critical that governance and accountability arrangements are made to work locally

59. Integrating services is a significant challenge, particularly when partners are dealing with current demand and constrained resources, while trying to better understand how services need to change. The Act should be a basis for all local partners to come together to implement changes. A perceived lack of clarity in the Act is adding to local disagreements and is delaying integration. This lack of clarity and misunderstanding is evident even among people working at senior levels and can impede good relationships.

60. Having a clear governance structure where all partners agree responsibility and accountability is vital. Disagreements can be particularly apparent when it is perceived that accountability for a decision rests with individuals who no longer have responsibility for taking them. Chief executives of councils and NHS boards are concerned that they will be held accountable for failures in how services are delivered when they are no longer responsible for directing those services. In practice, partners need to set out how local accountability arrangements will work. Integration was introduced to shift from a focus on what worked for organisations to what works for the person who needs a health and social care service. Applying this approach should help partners to implement the Act. In some areas partners are working through governance challenges as they implement the Act, and more should be done to share this experience.

61. Our first report on the integration of health and social care recommended that integration partners 'need to set out clearly how governance arrangements will work in practice...This is because there are potentially confusing lines of accountability...People may also be unclear who is ultimately responsible for the quality of care.' Clarity is still needed for local areas over who is ultimately responsible for service performance and the quality of care. In some instances, this uncertainty is hampering decision-making and redesign of services provision. Not enough has been done locally to address this.

62. IJBs have a commissioning role but most IJB COs also have delegated operational responsibility for those functions and services that are delegated to the IJB, with the exception of acute care. There are difficulties in understanding how the 'operational responsibility' aspect works in practice. Auditors report that members of IA leadership teams have differing views about governance, especially clinical governance, and roles and responsibilities. In some areas, councils and NHS boards are putting in place additional layers of reporting as if each were accountable for the actions of the IJB. The IJB approach was introduced in part to simplify arrangements, not to add complexity. There are also significant concerns about the impact of integration on the rest of the acute hospital system.

63. It is the IJB's role, through the CO, to issue directions to its partner council and NHS board about service delivery and allocation of resources. This can be made more difficult by disagreements about governance arrangements. It is complicated further by the reporting lines of the CO, who directly reports to both chief executives of the council and NHS board. COs have reported that it can be difficult to direct those who are effectively their line managers. This reinforces the need for strong relationship building and the establishment of a collective agreement over policy direction, funding arrangements and vision for integration.

Decision-making is not localised or transparent in some areas

64. The Act envisaged that decision-making would be devolved as locally as possible. In some areas, IAs, councils and NHS boards have not yet devolved decision-making in the spirit of the Act and locality plans and management structures are still in development. Officers, staff and local service providers have reported that this is because of a risk-averse response to integration that sees NHS boards and councils retain central control over decision-making. Decision-making by IAs is often influenced by statutory partners' priorities. Often, IJB members rely on their statutory partners for information, advice and policy formulation rather than taking the lead on planning and implementing new ways of providing services.

65. There are examples of IAs working hard to establish decision-making arrangements in their partnership. Aberdeen City has put in place governance systems to encourage and enable innovation, community engagement and participation, and joint working. This should leave it well placed for progressing integration and implementing new services in its community ([Case study 5](#)). We have also seen how IAs such as South Lanarkshire and Dundee City are beginning to develop locality-based approaches to service delivery ([Case study 6, page 36](#)).

Case study 5



Governance arrangements in Aberdeen City IA

Aberdeen City IJB worked with the Good Governance Institute to develop its risk appetite statement and risk appetite approach. The IJB wanted to consider which decisions and risks should, and importantly those which should not, be considered by the IJB. The idea was to ensure there was capacity for decisions to be made locally, so that staff could influence the outcomes of individuals by ensuring that care was tailored to individual needs. Staff and managers say they now feel trusted to make decisions and implement new ideas to benefit individuals in their communities.

The IJB considers that it has demonstrated an aspiration to develop and encourage innovation in local service provision, and local managers and staff understand that decision-making within localities and input of ideas is welcomed and encouraged within agreed risk parameters. Aberdeen City has worked hard to build relationships and trust throughout the partnership. It accepts that achieving its priorities will involve balancing different types of risk and that there will be a need to balance the relationship between different risks and opportunities. There is also an acceptance and tolerance that new ideas will not always be successful.

Source: Aberdeen City IJB, 2018

Case study 6



Locality approach in South Lanarkshire

In 2017, South Lanarkshire IJB realigned its management structure around its four localities. Each locality has a manager responsible for a range of multidisciplinary teams and a health and social care budget. Moving the management of services to a locality level has empowered local teams to review the models of care in their area to see what fits best for the local community. A public forum in each locality gives the local community a voice in shaping local services. Each locality has produced a local strategic needs assessment setting out local needs and priorities and directing attention towards more locally specific outcomes. A 'community first' model of care places the emphasis on developing more community capacity and support.

Staff report that multidisciplinary working and, where possible, co-location, has improved communication and learning across disciplines. They have better knowledge of skills within the wider integrated team, allowing the most appropriate professional to see people at the right time. Working with separate IT systems is a source of frustration and requires less efficient work arounds. Another challenge is balancing trying to change at pace with a need to maintain day-to-day workload. Teams have taken an incremental approach to change, starting with a small number of staff and people using the health and social care services, and, if the new model goes well, gradually increasing this until the change becomes normal practice.

Source: North Lanarkshire IJB, 2018

Best value arrangements are not well developed

66. As IJBs are local authority bodies, the statutory duty of Best Value applies to them. This means that IJBs, from the outset, must clearly demonstrate their approaches to delivering continuous improvement. In July 2017, IJBs submitted their first annual performance reports in accordance with statutory requirements. One of the reporting requirements is that they demonstrate Best Value in the delivery of services.

67. We found that some aspects of Best Value are widely covered within IJBs' annual performance reports and annual accounts, including financial planning, governance and use of resources. About half of all IJBs had a section in their annual performance reports setting out how they intended to demonstrate the delivery of Best Value. Overall the coverage varies between IJBs and is often not in enough detail to allow the public to judge the IJB's activity on continuous improvement.

IAs are using data to varying degrees to help plan and implement changes to services but there are still gaps in key areas

68. Information Services Division (ISD) is part of NHS National Services Scotland, a special NHS board. ISD provides Local Intelligence Support Team (LIST) analysts to each IA area, along with social care information known as SOURCE. Using a LIST analyst to tailor and interpret local data helps IAs to better understand local need and demand and to plan and target services. LIST also works with Community Planning Partnerships in several areas including care for prison leavers presenting to the Homeless Service and children affected by parental imprisonment.

69. Part of the work IAs are doing, supported by the LIST, is to better understand how to support the top two per cent of people using services who account for 50 per cent of hospital and GP prescribing expenditure. By doing this, they can better direct resources and take preventative steps to ensure these users receive more targeted care. This prevents unnecessary hospital admissions and improves personal outcomes through providing more appropriate care in a homely setting.

An inability or unwillingness to share information is slowing the pace of integration

70. There are several areas which need to further improve to help IAs and their council and NHS board partners make better use of data. These include:

- GP practices agreeing data-sharing arrangements with their IA
- IAs being proactive about sharing performance information, ideas and new practice with other IAs
- IAs and ISD agreeing data-sharing protocols for using data in national databases
- IAs identifying gaps in data about community, primary care and social care services and establishing how this information will be collected. This is something we have highlighted in several of our previous reports
- improving consistency in IAs' data, making comparisons easier.

71. Sharing of information, including both health and performance information, is a vital part of providing effective care that is integrated from the point of view of the people who use services. It is also vital in helping to anticipate or prevent need. Throughout our work we were told of examples where this was not happening in practice, because of local systems or behaviours. Examples include: GP practices being unwilling to share information from new service pilots with other IAs; IAs themselves being unwilling to share performance and good practice information with others; and difficulties in setting up data-sharing agreements between IAs and ISD. Different interpretations of data protection legislation are not helping with the ease with which information is being shared.

72. NHS and social care services are made up of many different specialties and localities, often with different IT systems, for example, systems to record X-ray results or record GP data. Many of these systems have been built up over years and commissioned separately for different purposes. Some services still rely on paper records.

73. This disjointedness has an impact on people who need care and on the ability of health and care professionals to provide the best support that they can. For example, people with multiple and complex health and care conditions can have to explain their circumstances to many different professionals within a short space of time. This can delay people getting the help they need, waste resources and gets in the way of care provision being more responsive to people's needs. Local data-sharing arrangements need to be in place so that professionals can appropriately share and protect the data they hold.

74. Time and money are being spent on fixing local IT problems when national solutions should be found. Local fixes are being put in place to help overcome data-sharing barriers. This includes bringing teams of staff together under one roof, so

they can discuss individual cases, rather than relying on electronic systems such as internal emails to communicate. Local areas are spending time and money implementing solutions which may continue to be incompatible in the future. There is a need for a coordinated approach to the solution, which includes the need to consider a national, single solution for Scotland.

75. New IT systems and technology are crucial to implementing new ways of working. For example, many areas are beginning to introduce virtual means of contacting people using care services, such as video links to people's homes so they do not have to visit a health or care centre. To do this successfully, a reliable communication infrastructure is needed, particularly in rural areas.

76. In April 2018, the Scottish Government published *Scotland's Digital Health & Care Strategy: Enabling, Connecting & Empowering*. As part of this, a new national digital platform is to be developed to enable the sharing of real-time data and information from health and care records as required, across the whole care system. We will monitor developments as part of our work programme.

Meaningful and sustained engagement will inform service planning and ensure impact can be measured

77. IAs were set up to have active public involvement, for example through the make-up of their boards and requirements that they publish and engage with communities about their plans. We found some good local examples of engagement. From our analysis of IA strategic plans, we saw evidence of community engagement that influenced the IA's priorities ([Case study 7, page 39](#)). Levels of ongoing engagement, and how much it shapes service redesign, are more difficult to judge, but several IAs explicitly mention the importance of engagement and see it as a priority.

78. Several third and independent sector organisations reported that they do not feel that IAs seek or value their input, although they have innovative ways to improve local services that will positively affect the lives of local people. Providers believe that service decisions are based on the funding available over the short term, rather than the needs of the community. Third-sector providers also report that there is often not time to attend engagement meetings, gather information for consultations or research lengthy committee papers. Therefore, IAs have a responsibility to help them become involved and to work with them earlier. IAs must discuss potential changes to services and funding with providers as early as possible.

79. Early engagement with staff, as with the public, has reduced since IAs published strategic plans. Staff want to know how they are contributing to the progress of integration. More communication and involvement will both help increase knowledge of the services available across partnerships and help overcome cultural differences and reluctance to accept change in ways of working.

80. Throughout this report we have recognised the challenging context IAs are operating in. This is inevitably having an impact on the extent to which they can meaningfully engage communities in discussions about improvements to services. IAs need to have in place wide-ranging and comprehensive arrangements for participation and engagement, including with local communities. Where local arrangements for engagement have been shown to work, these should continue. Engagement does not have to be managed and directed solely by the IA. If a local department or service has established relationships and means of engaging with third and independent sector providers which have proved successful, these should continue as before.

Case study 7



Edinburgh IJB: public engagement

The enhanced and proactive engagement approach adopted by Edinburgh IJB facilitated the involvement of the voluntary sector organisations in the co-production of strategic planning. Via the Edinburgh Voluntary Organisation Council, which sits on the IJB board as a non-voting member, the IJB invited the Lothian Community Health Initiatives' Forum (LCHIF) onto its Strategic Planning Groups (SPG). This allowed the LCHIF to get involved in developing the IJB's five strategic Commissioning Plans: Older People, Mental Health, Physical Disabilities, Learning Disabilities, and Primary Care.

LCHIF was subsequently invited to be part of the Older People's and Primary Care Reference Groups. Through involvement on the two reference groups, LCHIF and its members were able to contribute to the work that most reflected the services being delivered by them. The initial involvement of LCHIF on the SPG led to further engagement with other key influencing groups and networks which they felt ultimately benefited the sector, the forum and its members.

In addition to this involvement, the IJB has also embarked upon a review of its grants to the third-sector. This has been done in full collaboration and partnership with the third-sector. Through the SPG, a steering group was appointed, again with the involvement of LCHIF. This involvement contributed to a commitment being made to establish a grants forum in recognition of the ongoing dialogue that is required to ensure that prevention, early intervention and inequalities remains a priority for the IJB.







Source: Edinburgh IJB, 2018.

81. In September 2017, the Scottish Parliament's Health and Sport Committee published *Are they involving us? Integration Authorities' engagement with stakeholders*, an inquiry report on IAs' engagement with stakeholders.¹³ The Committee also found a lack of consistency in stakeholder engagement across IAs. While some areas of good practice were cited, the Committee heard concerns over engagement being 'tokenistic', 'overly top down' and 'just communicating decisions that had already been made'. The Committee argued that a piecemeal approach to engagement with stakeholders cannot continue and that meaningful engagement is fundamental to the successful integration of health and social care services.

82. There is also a role for the Scottish Government in continuing to develop how learning from successful approaches to integration is shared across Scotland. IAs are not being proactive about sharing success stories and the principles behind the planning and implementation of new ways of working which have worked well. Much could be learnt from the work done to date in local areas and IAs should be encouraged to engage with each other and share knowledge and performance information.

Endnotes



- 1 More details about the joint inspections are available at the [Care Inspectorate website](#) .
- 2 [Health and social care integration](#) , Auditor General and Accounts Commission, December 2015.
- 3 *English local authority reserves*, Chartered Institute of Public Finance and Accountancy, June 2015.
- 4 This takes account of North Ayrshire IJB, which was the only IJB to have an accumulated negative reserve balance. This amounted to £5.8 million and was because of overspends in social care services that were not funded by additional allocations from the NHS board or council.
- 5 [NHS in Scotland 2018](#) , Auditor General, October 2018.
- 6 [Local government in Scotland: Challenges and performance 2018](#) , Accounts Commission, April 2018.
- 7 National Performance Framework, Scottish Government, June 2018.
- 8 *Systems thinking and systems leadership*, NHS Education for Scotland, 2016.
- 9 *National Health and Social Care Workforce Plan Part 3 – improving workforce planning for primary care in Scotland*, Scottish Government, April 2018.
- 10 [NHS workforce planning](#) , Auditor General, July 2017.
- 11 [Local government in Scotland: Challenges and performance 2018](#) , Accounts Commission, April 2018.
- 12 *Medium Term Health and Social Care Financial Framework*, Scottish Government, October 2018.
- 13 *Are they involving us? Integration Authorities' engagement with stakeholders*, Health and Sport Committee, Scottish Parliament, September 2017.

Appendix 1

Audit methodology

Our objective: To examine the impact public bodies are having as they work together to integrate health and social care services in line with the Public Bodies (Joint Working) (Scotland) Act 2014.

Our audit questions:

- What impact is integration having and what are the barriers and enablers to this change?
- How effectively are IAs planning sustainable, preventative and community-based services to improve outcomes for local people?
- How effectively are IAs, NHS boards and councils implementing the reform of health and social care integration?
- How effectively is the Scottish Government supporting the integration of health and social care and evaluating its impact?

Our methodology:

- Reviewed documents, such as integration schemes, IAs' strategic plans, IJBs' annual audit reports, annual performance reports, national performance data and other key documents including the Scottish Government's National Health and Social Care Financial Framework.
- Interviews, meetings and focus groups with a range of stakeholders including third-sector and independent sector providers. Our engagement involved hearing about experiences of engaging with IAs and how services had changed through integration.
- Interviews at four case study sites – Aberdeen City IJB, Dundee City IJB, Shetland Islands IJB and South Lanarkshire IJB. We met with:
 - Chief Officers and Chief Finance Officers
 - Chairs and vice-chairs of IJBs
 - NHS and council IJB members
 - Chief social work officers
 - IJB clinical representatives (GP, public health, acute, nursing)
 - IJB public representatives (public, carer and voluntary sector)
 - Heads of health and social care, nursing, housing and locality managers and staff
 - NHS and council chief executives and finance officers
 - IT, communications and organisational development officers.

Appendix 2

Advisory group members



Audit Scotland would like to thank members of the advisory group for their input and advice throughout the audit.

Member	Organisation
Alison Taylor	Scottish Government
Alistair Delaney	Healthcare Improvement Scotland
Allison Duncan	IJB Vice Chair
Eddie Fraser	IJB Chief Officer
Fidelma Eggo	Care Inspectorate
Gerry Power	Health and Social Care Alliance
Jeff Ace	NHS Chief Executive
John Wood	Convention of Scottish Local Authorities (COSLA)
Julie Murray	Society of Local Authority Chief Executives
Robin Creelman	IJB Vice Chair
Tracey Abdy	IJB Chief Finance Officer

Note: Members sat in an advisory capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

Appendix 3

Progress against previous recommendations



Recommendations

Progress



Scottish Government should:

- work with IAs to help them develop performance monitoring to ensure that they can clearly demonstrate the impact they make as they develop integrated services. As part of this:
 - work with IAs to resolve tensions between the need for national and local reporting on outcomes so that it is clear what impact the new integration arrangements are having on outcomes and on the wider health and social care system.
- monitor and publicly report on national progress on the impact of integration. This includes:
 - measuring progress in moving care from institutional to community settings, reducing local variation in costs and using anticipatory care plans
 - reporting on how resources are being used to improve outcomes and how this has changed over time
 - reporting on expected costs and savings resulting from integration.
- continue to provide support to IAs as they become fully operational, including leadership development and sharing good practice, including sharing the lessons learned from the pilots of GP clusters.

IAs are reporting locally on outcomes but this is not being drawn together to give a national picture of outcomes for health and social care.

We found there are a significant number of indicators and measures being used nationally and locally to understand whether integration is making a difference and to monitor changes. But, for the public to understand how the changes are working at a Scotland-wide level, these indicators need to be presented in a clear and transparent way.

The Scottish Government has introduced a series of national outcomes for health and social care. The outcomes are not being routinely reported at a national level.

The savings estimated to be made from integration were expected to derive from a reduction in unplanned bed days, fewer delayed discharges, improved anticipatory care and less variation in bed day rates across partnerships. The savings from these have not been specifically monitored by the Scottish Government, although actual and projected performance across these measures is reported to the Scottish Government's Ministerial Steering Group.

Some leadership development has been commissioned from the Kings Fund by the Integration Division at Scottish Government but there is a lack of joint leadership development across the health and social care system to help to embed and prioritise collaborative leadership approaches.

There is an appetite for examples of good practice from local partnerships but still a lack of good learning resources.

**Recommendations****Progress****Integration Authorities should:**

- | | |
|--|--|
| <ul style="list-style-type: none"> • provide clear and strategic leadership to take forward the integration agenda; this includes: <ul style="list-style-type: none"> – developing and communicating the purpose and vision of the IJB and its intended impact on local people – having high standards of conduct and effective governance, and establishing a culture of openness, support and respect. | <p>We found that a lack of collaborative leadership and cultural differences are proving to be significant barriers to change in some areas.</p> |
| <ul style="list-style-type: none"> • set out clearly how governance arrangements will work in practice, particularly when disagreements arise, to minimise the risk of confusing lines of accountability, potential conflicts of interests and any lack of clarity about who is ultimately responsible for the quality of care and scrutiny. This includes: <ul style="list-style-type: none"> – setting out a clear statement of the respective roles and responsibilities of the IJB (including individual members), NHS board and council, and the IJB's approach towards putting this into practice – ensuring that IJB members receive training and development to prepare them for their role, including managing conflicts of interest, understanding the organisational cultures of the NHS and councils and the roles of non-voting members of the IJB. | <p>There is a lack of agreement over governance and a lack of understanding about integration which is acting as a significant barrier to progress in some areas.</p> <p>There are still circumstances where clarity is needed over who is ultimately responsible for service performance and the quality of care. In some instances, this uncertainty is hampering decision-making and redesigning how services are provided. Not enough has been done locally to address this.</p> |
| <ul style="list-style-type: none"> • ensure that a constructive working relationship exists between IJB members and the chief officer and finance officer and the public. This includes: <ul style="list-style-type: none"> – setting out a schedule of matters reserved for collective decision-making by the IJB, taking account of relevant legislation and ensuring that this is monitored and updated when required – ensuring relationships between the IJB, its partners and the public are clear, so each knows what to expect of the other. | <p>IAs have helped to improve engagement with the public and providers in the local area in some instances but there is more to do.</p> |
| <ul style="list-style-type: none"> • be rigorous and transparent about how decisions are taken and listening and acting on the outcome of constructive scrutiny, including: <ul style="list-style-type: none"> – developing and maintaining open and effective mechanisms for documenting evidence for decisions – putting in place arrangements to safeguard members and employees against conflict of interest and put in place processes to ensure that they continue to operate in practice – developing and maintaining an effective audit committee – ensuring that effective, transparent and accessible arrangements are in place for dealing with complaints. – ensuring that an effective risk management system is in place. | <p>We found that decision-making is not localised or transparent in some areas and risk management arrangements are not well developed.</p> |



Recommendations



Progress

- | | |
|--|--|
| <ul style="list-style-type: none"> • develop strategic plans that do more than set out the local context for the reforms; this includes: <ul style="list-style-type: none"> – how the IA will contribute to delivering high-quality care in different ways that better meets people’s needs and improves outcomes – setting out clearly what resources are required, what impact the IA wants to achieve, and how the IA will monitor and publicly report their progress – developing strategies covering the workforce, risk management, engagement with service users and data sharing, based on overall strategic priorities to allow the IA to operate successfully in line with the principles set out in the Act and ensure these strategies fit with those in the NHS and councils – making clear links between the work of the IA and the Community Empowerment (Scotland) Act and Children and Young People (Scotland) Act. | <p>IAs are beginning to link their resources to strategic priorities but more needs to be done to show when their planned outcomes will be achieved. They also need to show how the shift from the current ways of working to new models of care will happen.</p> |
| <ul style="list-style-type: none"> • develop financial plans that clearly show how IAs will use resources such as money and staff to provide more community-based and preventative services. This includes: <ul style="list-style-type: none"> – developing financial plans for each locality, showing how resources will be matched to local priorities – ensuring that the IJB makes the best use of resources, agreeing how Best Value will be measured and making sure that the IJB has the information needed to review value for money and performance effectively. | <p>There is some evidence of small-scale transfers of resources, but most IAs have funded changes to services using ring-fenced funding, such as specific additional integrated care funding provided by the Scottish Government. This is instead of shifting resources from an acute setting, such as hospitals, to community settings such as local clinics and GP surgeries. While this may have achieved performance improvement in things such as delayed discharges, ring-fenced funding may not be available long term. Therefore, IAs need to ensure the financial sustainability of ongoing support for changes made.</p> <p>Financial planning is not integrated, or long term and financial pressures make meaningful change hard to achieve.</p> <p>Arrangements for understanding and measuring Best Value arrangements are not well developed.</p> |
| <ul style="list-style-type: none"> • shift resources, including the workforce, towards a more preventative and community-based approach; it is important that the IA also has plans that set out how, in practical terms, they will achieve this shift over time. | <p>We found there has been limited change in how resources are being used across the system at this stage – see above.</p> |

Cont.

**Recommendations****Progress****Integration Authorities should work with councils and NHS boards to:**

<ul style="list-style-type: none"> recognise and address the practical risks associated with the complex accountability arrangements by developing protocols to ensure that the chair of the IJB, the chief officer and the chief executives of the NHS board and council negotiate their roles in relation to the IJB early in the relationship and that a shared understanding of the roles and objectives is maintained. 	<p>We found a lack of agreement over governance and a lack of understanding about integration remain significant barriers in some areas.</p> <p>There are still circumstances where clarity is needed over who is ultimately responsible for service performance and the quality of care. In some instances, this uncertainty was hampering decision-making and redesigning how services are provided. In our opinion, not enough has been done locally to address this.</p>
<ul style="list-style-type: none"> review clinical and care governance arrangements to ensure a consistent approach for each integrated service and that they are aligned to existing clinical and care governance arrangements in the NHS and councils. 	<p>Auditors report that members of IA leadership have differing views about governance, especially clinical governance, and roles and responsibilities.</p>
<ul style="list-style-type: none"> urgently agree budgets for the IA; this is important both for their first year and for the next few years to provide IAs with the continuity and certainty they need to develop strategic plans; this includes aligning budget-setting arrangements between partners. 	<p>We found that at present, not all councils and NHS boards view their finances as a collective resource for health and social care. Some councils and NHS boards are still planning budgets around their own organisations rather than taking account of their IJBs local strategic priorities. The ambition for integration is that the health and social care resources in the local area would be brought together and used to deliver integrated services with improved outcomes for people. While this is happening in some areas, councils and NHS boards in other areas can be unwilling to give up financial control of budgets and IJBs can struggle to exert influence over their budgets. Some IAs have little or no involvement in the budget-setting process.</p> <p>At a very basic level IJBs struggle in some areas to agree budgets. Fourteen IJBs failed to agree a budget for the start of the 2017/18 financial year.</p>
<ul style="list-style-type: none"> establish effective scrutiny arrangements to ensure that councillors and NHS non-executives, who are not members of the IJB board, are kept fully informed of the impact of integration for people who use local health and social care services. 	<p>We have seen that IJB board papers are shared with council and NHS board partner organisations. In some areas though, rather than streamlining governance and scrutiny arrangements, councils and NHS boards are putting in place additional layers of reporting as if each were accountable for the actions of the IJB.</p>
<ul style="list-style-type: none"> put in place data-sharing agreements to allow them to access the new data provided by ISD Scotland. 	<p>IAs and ISD are have difficulties in agreeing data-sharing protocols for using national databases.</p>

Appendix 4

Financial performance 2017/18

IJB	Position (pre additional allocations) Overspend/ (underspend)	Additional allocation/ (reduction)		Use of reserves	Year-end position Deficit/ (Surplus)
	(£million)	Council (£million)	NHS board (£million)	(£million)	(£million)
Aberdeen City	2.1	0	0	2.1	0
Aberdeenshire	3.5	1.5	2.0	0	0
Angus	(0.4)	0	0	0	(0.4)
Argyll and Bute	2.5	1.2	1.4	0	0
Clackmannanshire and Stirling	1.1	0	0	1.1	0
Dumfries and Galloway	(2.5)	0	0	0	(2.5)
Dundee City	2.5	0	2.1	0.4	0
East Ayrshire	3	2.2	1.3	0	(0.5)
East Dunbartonshire	1.1	0	0	1.1	0
East Lothian	0.7	0.6	0.1	0	0
East Renfrewshire	(0.4)	0	0	0	(0.4)
Edinburgh	7.4	7.2	4.9	0	(4.7)
Eilean Siar	(3.0)	0	0	0	(3.0)
Falkirk	1.3	0	1.4	0.2	(0.3)
Fife	8.8	2.5	6.4	0	0
Glasgow City	(12.0)	0	0	0	(12.0)
Inverclyde	(1.8)	0	0	0	(1.8)
Midlothian	(0.7)	0.2	0	0	(0.9)
Moray	1.9	0	0	1.9	0
North Ayrshire	3.5	0	1.0	0	2.6
North Lanarkshire	(11.7)	0	0.6	0	(12.3)
Orkney	0.7	0.2	0.5	0	0
Perth and Kinross	(1.4)	(2.6)	1.3	0	0
Renfrewshire	4.8	2.7	0	2.1	0
Scottish Borders	4.5	0.3	4.2	0	0
Shetland	2.4	(0.3)	2.9	0	(0.2)
South Ayrshire	0.3	0	0	0.3	0
South Lanarkshire	(1.2)	0	1.0	0	(2.2)
West Dunbartonshire	(0.6)	0	0	0	(0.6)
West Lothian	1.8	0	1.8	0	0

Note: Arithmetic differences arising from roundings.

Source: Audited Integration Authority annual accounts, 2017/18

Health and social care integration

Update on progress

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Agenda Item Number:

**EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE, AUDIT & RISK
COMMITTEE**

Date of Meeting	19 December 2018
Subject Title	Inspection Reports undertaken by the Care Inspectorate - John Street House, Meiklehill and Pine View.
Report By	David Aitken, Joint Service manager – Adult Services
Contact Officer	Caroline Sinclair, Head of Mental Health, Learning Disability, Addiction & Health Improvement

Purpose of Report	The purpose of this report is to update the Audit & Risk Committee on recent inspection reports undertaken within our adult residential care homes for adults with learning disabilities.
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Recommendations	The Performance Audit & Risk Committee is asked to: a) Note the content of this report and attached Inspection reports from the Care Inspectorate.
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Implications for Health & Social Care Partnership

Human Resources:	N/A
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Equalities:	N/A
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Financial:	N/A
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Legal:	N/A
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Economic Impact:	N/A
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Sustainability:	N/A
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Risk Implications:	N/A
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Implications for East Dunbartonshire Council:	Inspection reports demonstrate sustained high performance within John Street House and improved grades within Meiklehill/Pine View
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Implications for NHS Greater Glasgow & Clyde:	As above
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Direction Required to Council, Health Board or Both	Direction To:	
	1. No Direction Required	X
	2. East Dunbartonshire Council	
	3. NHS Greater Glasgow & Clyde	
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	

MAIN REPORT

- 1.1** There are three residential homes within East Dunbartonshire which are operated by East Dunbartonshire HSCP/Council; John Street House, Pine View and Meiklehill, all three are registered with the Care Inspectorate and are regularly inspected in line with their registration requirements.
- 1.2** Meiklehill and Pine View are registered together following the HSCP/Council assuming responsibility for Pine View from the National Autistic Society (NAS) in 2017. The Care Inspectorate completes and publishes one inspection report which encompasses both services.
- 1.3** John Street House is registered as a care home for eleven adults with a learning disability and Pine View/Meiklehill for up to five adults.
- 1.4** The Pine View service is based near Canniesburn in Bearsden. Pine View provides care and support service to adults with the most particularly complex and challenging learning disabilities and associated autistic spectrum disorder. Residents within Pine View customarily require two to one supports at all times, and their care requires to be managed with particularly high levels of routine and adherence to very specific support plans. John Street House is located within Kirkintilloch and provides a more independence focused support and preparation for greater independent living where possible.
- 1.5** John Street, Meiklehill and Pine View were all inspected in September/October of this year and updated grades for the services have now been published on the Care Inspectorate website and within the attached inspection reports.

2.0 Inspection Reports

- 2.1** Care and Inspectorate reports focus upon four distinct areas; quality of care and support, quality of environment, quality of staffing, and quality of management and leadership, and grades from 1-6 are assessed against each category with 6 being the highest; rated 'Excellent'.
- 2.2** John Street Inspection reports have consistently reflected a high standard of care and performance with consistent high quality grades of 5 'Very Good' established across the service. The unannounced inspection undertaken on the 27th September 2018 focused upon two areas 'Care and Support' and 'Management and Leadership' and 'Very Good' (5) was awarded against both categories.

- 2.3 Key strengths highlighted within John Street House were the very positive outcomes for people living within John Street, and the consistently very positive feedback reflected by residents and their families.
- 2.4 In this most recent inspection report John Street was awarded grades of 'Very Good' (5) for both 'Care and Support' and 'Management and Leadership' with no formal notifications of Requirements or Recommendations.
- 2.5 In respect of Meiklehill/Pine View previous grades from 2017 were; 3 'Adequate' for 'Quality of Staffing', 4 'Good' for 'Quality of Management and Leadership' and 5 'Very Good' for 'Quality of Care and Support'.
- 2.6 Meiklehill/Pineview were inspected on the 11th October against the same elements of care, and the grades have now improved significantly since moving to HSCP/Council delivery from NAS. Improvement has been established across 'Quality of Staffing', and 'Quality of Management and Leadership' which have both now graded 5 'Very Good' and quality of 'Care and Support' has maintained the existing 'Very Good'.
- 2.7 The inspection report details significant improvements and enhanced management arrangements and safeguarding of the adults within this service.
- 2.8 Previous formal Recommendations and Requirements were noted to have been actioned by HSCP/Council management and there were no formal Recommendations or Requirements made by the Care Inspectorate following the most recent inspection in October.
- 3.0 Conclusion**
- 3.1 Inspection reports have been completed in respect of all of our residential services for adults with learning disabilities. The inspection visits were unannounced and were undertaken in September and October of this year.
- 3.2 The residents within these services are some of our most vulnerable citizens who require significant care and support at all times. The quality of our residential services remains very high and positive reports have again been published by the Care Inspectorate in respect of all of these services following inspection.
- 3.3 John Street has maintained particularly high performance standards and 'Very Good' grades across the service and the inspectors have found significant improvements within Pine View and Meiklehill following the HSCP/Council assuming responsibility from the National Autistic Society for the Pine View service in 2017. This has been reflected in the achievement of equivalent 'Very Good' 5 grades for this service across all areas, which is now in line with those within John Street house.
- 3.4 The registered manager for the services continues to develop the service's performance improvement framework and works alongside the Care Inspectorate to seek to achieve further improvements towards achieving 'Excellent' 6 grades in future inspections.

John Street House Care Home Service

38 John Street
Kirkintilloch
Glasgow
G66 2HE

Telephone: 0141 777 7708

Type of inspection:

Unannounced

Completed on:

27 September 2018

Service provided by:

East Dunbartonshire Council

Service provider number:

SP2003003380

Service no:

CS2003000797

About the service

John Street House is a small care home for 11 adults who have learning disabilities. The service is located in a residential area of Kirkintilloch. It is near to public transport links and some local shops. It is operated by East Dunbartonshire Council. The service has been registered with the Care Inspectorate since 1 April 2011.

The building is purpose-built and the accommodation is all at ground level. There are two spacious lounge areas, a central communal dining room, eleven en-suite bedrooms and three small kitchen areas. There is also a large kitchen that staff use to prepare meals for people.

One of the small kitchens can be used by people who live in the service to be supported by staff to prepare meals. There are laundry facilities where people can do their own washing and ironing with support from staff if needed.

There is a large landscaped garden to the rear of the property with a pleasant seating area. There is also a small garden to the side of the home.

John Street House aims to provide a 'safe and homely environment to live in, trained and experienced staff, support to achieve independence, the opportunity to use communal facilities, support to develop and maintain local supports and friendships and the opportunity to integrate with the community'.

At the time of the inspection eight people were living in the service.

What people told us

For this inspection we received views from five people using the service, of which, one person completed one of our questionnaires. We also spoke with three relatives of people living in the service and received four questionnaires completed by family members on behalf of individuals living at John Street House.

Overall, people expressed very positive views about the quality of care and support the service provided. -

Comments from people living in the service and from relatives included: -

"I do my own laundry. I'm starting to my own cooking." (person living in service). -

"Staff are excellent and go the extra mile." (relative). -

"I enjoy my music and going to the gym" (person living in the service). -

"It is a shining example of kind, personal and exemplary care" (relative). -

Self assessment

The service had not been asked to complete a self assessment in advance of the inspection. We looked at their own improvement plan and quality assurance paperwork. These demonstrated their priorities for development and how they were monitoring of the quality of the provision within the service.

From this inspection we graded this service as:

Quality of care and support	5 - Very Good
Quality of environment	not assessed
Quality of staffing	5 - Very Good
Quality of management and leadership	not assessed

What the service does well

We evaluated two quality themes, the quality of care and support and the quality of staffing at this inspection. We found that the service was performing at a very good standard against both quality themes.

As noted at the last inspection, we saw and heard about many positive outcomes for people living in the service. Examples included very good staff support to help people engage with their local community through social, leisure and volunteering activities. Staff were also very good at supporting people to maintain strong family ties. It was particularly pleasing to note how staff supported residents to keep in touch with their friends who had moved on from the service.

People that we spoke were keen to share their experiences of going on holiday, of being included in decisions about further improving their environment and taking part in birthday celebrations. These were a strong indication that staff put people's choices and preferences at the heart of the service provision. The service provided a good balance of support and encouraged people to take positive risks that were well planned. Examples included cooking and accessing the community independently,

Feedback about the quality of care and support and the quality of staff was consistently very positive. One relative said "staff go above and beyond to support and care for residents.

Nothing is too much trouble for staff." A resident who completed a questionnaire strongly agreed that staff treated people well and with respect.

Staff were very good at promoting people's choices and preferences. Staff achieved this using a consistent person-centred approach. We also observed staff to interact with people in a way that was patient, dignified and took account of their individual needs.

The service continued to be very good at supporting people who had lived in the service for a number of years. The staff team was small, knowledgeable and had worked in the service for a long time. This meant that staff supported people well because they knew them and understood their needs. Residents, relatives and staff all recognised this as a major strength of the service.

Staff that we spoke with and who completed our questionnaires, (six people responded), were very positive about the support they had from senior staff and the manager. A staff member commented "this is a first rate residential service".

We checked how the service kept people safe. We sampled the provider's systems to safely manage medication, safeguard people's money and manage accidents and incidents. We concluded that the service did all three well. We were also satisfied that the provider recruited staff appropriately, conducting relevant background checks before employing new staff.

Another important development was the service's introduction of Anticipatory Care Plans. This is about supporting individuals to think ahead about their changing health needs.

It's also about knowing how to use services better and it helps people make choices about their future care. Many people with long term conditions or chronic health problems can benefit from having an Anticipatory Care Plan.

What the service could do better

There had been an improvement in the way that the service was detailing important information in personal plans and in the way that staff used individual risk assessments. However, a small number of support plans were not as up to date as they should have been. It is important that staff support is informed by plans that are current for all people living the service. The manager agreed to address this.

We discussed how staff who administered medication to manage pain could improve how they recorded the effect of the analgesia given. This would give staff a clear picture of the effectiveness, (or not), of pain relief. It would also be an additional prompt for staff to seek further medical advice if necessary.

The service manager was developing the use of additional learning resources for staff. The service planned to use these resources to compliment current mandatory training and e-learning. We will look at progress with this at the next inspection of the service.

We reminded the manager about our notification guidance in relation to accidents and incidents. This was to ensure that the service notified us about all occurrences that we should be informed about.

Requirements

Number of requirements: 0

Recommendations

Number of recommendations: 0

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com.

Inspection and grading history

Date	Type	Gradings
23 Aug 2017	Unannounced	Care and support 5 - Very good Environment Not assessed Staffing Not assessed Management and leadership 5 - Very good
24 Aug 2016	Unannounced	Care and support 5 - Very good Environment Not assessed Staffing 5 - Very good Management and leadership Not assessed
27 Jul 2015	Unannounced	Care and support 5 - Very good Environment 5 - Very good Staffing 5 - Very good Management and leadership 4 - Good
1 Dec 2014	Unannounced	Care and support 5 - Very good Environment 5 - Very good Staffing 5 - Very good Management and leadership 5 - Very good
30 Jun 2014	Unannounced	Care and support 5 - Very good Environment 5 - Very good Staffing 4 - Good Management and leadership 3 - Adequate
22 Feb 2014	Unannounced	Care and support 5 - Very good Environment 5 - Very good Staffing 4 - Good Management and leadership 3 - Adequate
26 Apr 2013	Unannounced	Care and support 3 - Adequate

Date	Type	Gradings
		Environment 4 - Good Staffing 2 - Weak Management and leadership 3 - Adequate
28 Apr 2012	Unannounced	Care and support Not assessed Environment 5 - Very good Staffing 5 - Very good Management and leadership Not assessed
24 Dec 2011	Unannounced	Care and support 5 - Very good Environment Not assessed Staffing Not assessed Management and leadership 5 - Very good
26 Jan 2011	Unannounced	Care and support 6 - Excellent Environment Not assessed Staffing Not assessed Management and leadership Not assessed
23 Jul 2010	Announced	Care and support 6 - Excellent Environment Not assessed Staffing Not assessed Management and leadership 5 - Very good
16 Mar 2010	Unannounced	Care and support 6 - Excellent Environment Not assessed Staffing 5 - Very good Management and leadership Not assessed
26 Nov 2009	Announced	Care and support 6 - Excellent Environment Not assessed Staffing 5 - Very good Management and leadership Not assessed
11 Nov 2008	Announced	Care and support 5 - Very good Environment 5 - Very good Staffing 5 - Very good Management and leadership 5 - Very good
20 Mar 2009	Unannounced	Care and support 6 - Excellent

Date	Type	Gradings						
		<table> <tr> <td data-bbox="603 226 1114 264">Environment</td> <td data-bbox="1123 226 1283 264">6 - Excellent</td> </tr> <tr> <td data-bbox="603 271 1114 309">Staffing</td> <td data-bbox="1123 271 1283 309">Not assessed</td> </tr> <tr> <td data-bbox="603 315 1114 353">Management and leadership</td> <td data-bbox="1123 315 1283 353">Not assessed</td> </tr> </table>	Environment	6 - Excellent	Staffing	Not assessed	Management and leadership	Not assessed
Environment	6 - Excellent							
Staffing	Not assessed							
Management and leadership	Not assessed							

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0345 600 9527

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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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Meiklehill Housing Support Service

East Dunbartonshire Council HQ
Southbank Marina
12 Strathkelvin Place
Kirkintilloch
G66 1TJ

Telephone: 0141 578 0274

Type of inspection:

Announced (short notice)

Completed on:

11 October 2018

Service provided by:

East Dunbartonshire Council

Service provider number:

SP2003003380

Service no:

CS2004058395

About the service

The Care Inspectorate regulates care services in Scotland. Information about all care services can be found on our website at www.careinspectorate.com

This service was previously registered with the Care Commission and transferred its registration to the Care Inspectorate on 1 April 2011.

Meiklehill provides a housing support service and a support service (care at home). It is registered to provide a service to adults with learning disabilities living in their own homes and in the community. The provider is East Dunbartonshire Council.

The service operates from two locations in East Dunbartonshire. One part of the service supports one individual in their own home in Kirkintilloch. The other part of the service, Pineview, is located in a house in Bearsden that has the capacity to support three people.

There was one person living in Kirkintilloch and two people living in Pineview at the time of our inspection. Pineview was integrated into the registration for Meiklehill when East Dunbartonshire Council took over its operation in December 2016 from another organisation. For the purpose of this report, we will refer to each part of the service as Kirkintilloch and Pine View.

The aims of the service include supporting the individual to achieve increased independence, use community resources, maintain local supports and friendships and make use of and be part of the local community.

What people told us

For this inspection, we received views from several people using the service. One person gave their views in a care standards questionnaire that we sent to the service. We also spoke with three people using the service when we visited.

We spoke to two family members by telephone. We also received three completed questionnaires from relatives of people who used the service.

Everyone that we spoke with, and who completed a questionnaire, was very positive about the quality of care and support that the service provided.

Anonymised and paraphrased comments from relatives of people living in the service included:

"We are very satisfied with the care and support our relative receives from the staff and the organisation."

"The service is absolutely superb and meets all my relative's needs. There is fantastic, well-trained staff that provide my relative with a terrific life."

"I am completely satisfied that all my relative's needs are met and that he/she is happy. The care is of the highest quality."

Self assessment

The service had not been asked to complete a self assessment in advance of the inspection. We looked at their own improvement plan and quality assurance paperwork. These demonstrated their priorities for development and how they were monitoring the quality of the provision within the service.

From this inspection we graded this service as:

Quality of care and support	5 - Very Good
Quality of staffing	5 - Very Good
Quality of management and leadership	5 - Very Good

Quality of care and support

Findings from the inspection

We found that the care provided to people living in the service was very good. Relatives that we spoke with, and who completed feedback questionnaires, were also very positive about the quality of care and support the service provided.

The service engaged and communicated very well with people they supported and their families. Care reviews that we sampled were current and included important contributions from people living in the service and/or their families. This meant that people who used the service were closely involved in day-to-day decisions about the planning and delivery of their own care and support.

The service's approach to recording personal planning was well detailed and the information current. This included risk assessments that were person-centred and relevant to individual activities. This meant that staff used care plans that were accurate and that were very good at informing their day-to-day practice.

This in turn helped staff support people to achieve their individual goals and to maximise their potential. We saw very good examples of staff, in Pineview and Kirkintilloch, supporting people to take part in structured, well-organised care. These activities took account of individual preferences and also promoted healthy lifestyle choices. It was evident that this resulted in positive outcomes for people. Examples included decreased episodes of stress/distress and participation in a wider range of activities inside and outside of the service.

Staff were very good at supporting people's healthcare needs. This included preventative health screening such as breast and bowel screening as well as responding appropriately if someone was unwell. The service had well-established links with healthcare professionals meaning that staff knew who to seek advice from when this was needed. The service also had good systems in place to support people to get their prescribed medication.

We recommended that the service starts discussing the introduction of anticipatory care plans (ACPs) with families. Anticipatory care planning is about helping people think ahead and understand their health needs better. It's about knowing how to use services better and it helps people make choices about their future care. We signposted the service to additional information about ACPs.

Requirements

Number of requirements: 0

Recommendations

Number of recommendations: 0

Grade: 5 - very good

Quality of staffing

Findings from the inspection

The provider employed staff who worked in a close and collaborative way. This meant that communication - between staff about their work was very good. Staff were very good at supporting people with complex needs - and helping them to realise their potential. This resulted in positive outcomes for people living in the service. -

Staff were also very good at reflecting on their approaches to care to try to consistently achieve these positive - outcomes. The service team had a clear focus and staff were very good at adapting their approaches to - individual care when needed. -

One staff member commented: "We work very closely as a team, which over the last year has become stronger, - due to consistency and effort of all." Another member of staff said: "It is a very good/positive working - environment." -

The quality and frequency of staff training and supervision had improved since we last inspected the service. The - manager acknowledged that this could improve further and he was taking appropriate action to address this. - Staff spoke positively about the quality of training and its relevance to their roles. -

However, some staff were not familiar with the Health and Social Care Standards and their relevance to their - work. The manager had shared copies of these with staff but we suggested that there needed to be more focus - on how the standards were applied across the service. -

Staff training included face-to-face learning and online learning (e-learning). In Pineview, staff had limited - access to a computer as the service only had one which was used by staff for a range of tasks. Staff would - benefit from having access to an alternative computer for learning. -

Feedback from relatives about the quality of the staff team was consistently very positive. Relatives commented - that: -

"Staff are second to none." -

"Staff are dedicated to promoting our relative's potential to live a fulfilling life in the community." -

We observed staff supporting people in a dignified and respectful way. -

Requirements

Number of requirements: 0

Recommendations

Number of recommendations: 0

Grade: 5 - very good

Quality of management and leadership

Findings from the inspection

There was very good management oversight of both service locations. The registered manager was accessible to both Kirkintilloch and Pineview and had frequent contact with staff in both areas. The manager of the service was also the manager of another registered care service. This allowed him to introduce good practices and systems that worked well in the other service, to both Meiklehill and Pineview.

Staff confirmed that they had good access to guidance and support from senior staff. We also received positive feedback from relatives about the management team. Senior staff were clear about the professional standards expected by all staff and provided good role models to staff.

The provider recruited new staff using appropriate procedures. This meant that people were employed only after the service had interviewed them, assessed their abilities and carried out relevant background checks.

We examined how the service supported and safeguarded people with their medication and to manage their money. Overall, the systems in place were very good.

Our sampling of accident and incident records indicated that staff were managing and recording them well. However, the service was under-reporting relevant accidents and incidents to us. We directed staff to our notification guidance. The manager agreed to provide staff with an update on our guidance.

Requirements

Number of requirements: 0

Recommendations

Number of recommendations: 0

Grade: 5 - very good

What the service has done to meet any requirements we made at or since the last inspection

Previous requirements

There are no outstanding requirements.

What the service has done to meet any recommendations we made at or since the last inspection

Previous recommendations

Recommendation 1

The provider should ensure that all staff in Pineview participate in key training in a timely way. The service should develop and implement a staff training plan that is relevant to the needs of people using the service. Such a plan should also be linked to the individual learning objectives for each staff member.

National Care Standards Care at Home, Standard 4 - Management and staffing arrangements.

This recommendation was made on 21 December 2017.

Action taken on previous recommendation

This recommendation has been met. Staff opportunities to take part in training that was relevant to their roles had improved since we last visited the service.

Recommendation 2

The service should ensure that staff are supervised in line with organisational policy. It should ensure the recording of sessions reflects the discussions that take place.

National Care Standards Care at Home, Standard 4 - Management and Staffing arrangements.

This recommendation was made on 1 October 2015.

Action taken on previous recommendation

This recommendation has been met with one area for improvement outstanding. The service manager had a clear plan in place to address this. This will ensure that all staff have the same opportunities to participate in staff supervision in line with the provider's own policy. We will look at the outstanding area for improvement again at the next inspection of the service.

Complaints

There have been no complaints upheld since the last inspection. Details of any older upheld complaints are published at www.careinspectorate.com

Enforcement

No enforcement action has been taken against this care service since the last inspection.

Inspection and grading history

Date	Type	Gradings
1 Nov 2017	Unannounced	Care and support 5 - Very good Environment Not assessed Staffing 3 - Adequate Management and leadership 4 - Good
24 Oct 2016	Announced (short notice)	Care and support 5 - Very good Environment Not assessed Staffing 5 - Very good Management and leadership Not assessed
17 Aug 2015	Announced (short notice)	Care and support 5 - Very good Environment Not assessed Staffing 4 - Good Management and leadership 4 - Good
31 Jul 2014	Unannounced	Care and support 5 - Very good Environment Not assessed Staffing 4 - Good Management and leadership 4 - Good
5 Dec 2013	Announced (short notice)	Care and support 4 - Good Environment Not assessed Staffing 3 - Adequate Management and leadership 3 - Adequate

Date	Type	Gradings	
8 Feb 2013	Unannounced	Care and support Environment Staffing Management and leadership	4 - Good Not assessed 3 - Adequate 3 - Adequate
23 Jul 2010	Announced	Care and support Environment Staffing Management and leadership	6 - Excellent Not assessed 6 - Excellent Not assessed
7 Jan 2010	Announced	Care and support Environment Staffing Management and leadership	6 - Excellent Not assessed 5 - Very good 5 - Very good
12 Jun 2008		Care and support Environment Staffing Management and leadership	5 - Very good Not assessed 5 - Very good 5 - Very good

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**EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE, AUDIT & RISK
COMMITTEE**

Date of Meeting	19th December 2018
Subject Title	HSCP Commissioning Spend 2013/14 – 2017/18
Report By	Jean Campbell, Chief Finance & Resources Officer
Contact Officer	Gillian Healey, Team Leader – Planning & Commissioning (Tel: 0141 777 3074)

Purpose of Report	The purpose of this report is to provide an analysis of commissioned spending across the HSCP over a five year period.
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Recommendations	The Performance Audit & Risk Committee is asked to: a) Note and consider the contents of this report.
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Relevance to HSCP Board Strategic Plan	The commissioning of services is critical to the delivery of the functions delegated to the partnership but also to deliver on the strategic priorities agreed for the partnership.
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Implications for Health & Social Care Partnership

Human Resources:	Nil
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Equalities:	Nil
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Financial:	The levels of commissioned spend is increasing in response to demographic increases, increases in the pay to workers within this sector through the Scottish Living Wage and represents a key element in the balance of services delivered across the HSCP. Specifically, spend is increasing as a result of more transitions coming through and work is being done to scope out the impact this is going to have over the next five years, the growing older population (particularly amongst the 75+ / 85+ populations), the lack of local resources meaning that more services are being commissioned out with the local authority area, the implementation of the Scottish Living Wage has introduced a 2.8% increase on care costs for 18/19 which has also had an impact on the budget for adult care services.
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Legal:	Nil
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Economic Impact:	Nil
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Sustainability:	Nil
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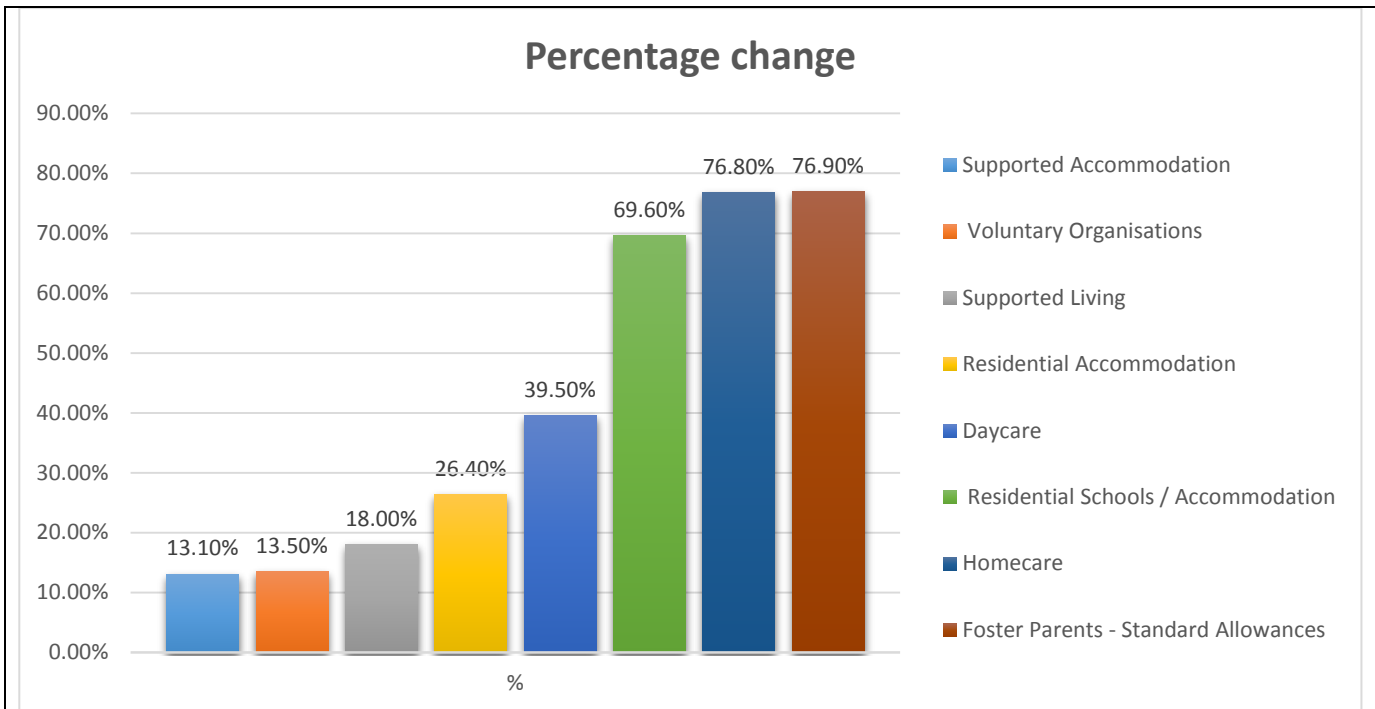
Risk Implications:	Nil	
Implications for East Dunbartonshire Council:	Commissioning of services rests largely with the Council and the way in which services are commissioned requires to be considered in the context of financial constraint, the need to be more efficient, the redesign of services which may require further investment or dis-investment in this area.	
Implications for NHS Greater Glasgow & Clyde:	There are limited amounts of commissioned services through the NHS, however this needs to be considered in the context of the overall commissioning landscape and which compliments that done within the Council.	
Direction Required to Council, Health Board or Both	Direction To:	
	1. No Direction Required	
	2. East Dunbartonshire Council	
	3. NHS Greater Glasgow & Clyde	
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	x

MAIN REPORT

- 1.1 The commissioning landscape has grown over the last five years with an increasing reliance on the 3rd and independent sectors to deliver services across the health and social care partnership. This falls predominantly within the Social Work arena with small pockets of commissioning within the community health budget in relation to the health improvement agenda (reduced from £300k in 2015/16 to £184k in 2017/18 – largely due to the one off nature of some of the funding streams which supported these initiatives and the tightening of budgets lessening the ability for year on year support from surpluses).
- 1.2 The Social Work commissioning element of the HSCP budget totals £51.5m from a total Gross Budget (excl income) of £73.4m. This represents 70% of the Total SW Budget for 2018/19 being spent on commissioning the 3rd, independent and private sectors.
- 1.3 The tables below represents the main areas for this Social Work commissioning over the five year period since 2013/14. Other areas of expenditure include adoption allowances, kinship carers, payments to other local authorities, payment to other bodies which have been excluded from this analysis.
- 1.4 Spend over the last 5 years - agencies & other bodies
- The information detailed in this report is based on spend over the last five years; including the cost and the percentage change over this time. The table below details the headline spend, but there is a further breakdown throughout the report based on care group spend and other models of care.

Expenditure Area	Sum of 2013/14 Actuals	Sum of 2017/18 Actuals	% change
Voluntary Organisations	£1,921,434	£2,181,363	13.5%
Residential Schools / Accommodation	£1,661,977	£2,819,193	69.6%
Daycare	£2,872,010	£4,007,811	39.5%
Foster Parents - Standard Allowances	£1,068,896	£1,890,711	76.9%
Homecare	£4,349,902	£7,689,727	76.8%
Residential Accommodation	£13,085,565	£16,533,623	26.4%
Supported Accommodation	£6,526,898	£7,382,271	13.1%
Supported Living	£5,057,789	£5,966,466	18.0%
Grand Total	£36,544,470	£48,471,165	32.6%

- 1.5 The highest percentage of change over this time has been mainly within Homecare and the Foster Parent standard allowances, with the lowest changes in supported accommodation and voluntary organisations. Homecare includes the Care at Home and Housing Support framework, which has increased year on year due to local demand changes resulting from the demographic pressures for the 75+ / 85+ age group, increases to the Scottish Living wage and a continuing shift in the level of in house / purchased care at home provision in response to these demands.
- 1.6 The increase in Foster Parent standard allowances is due, in part, to the parity between kinship care and fostering and the introduction of the same allowance for both along with increasing numbers of children being accommodated over the period.
- 1.7 Supported accommodation has, and should remain more static due to the fixed number of resources available. Any cost increases within supported accommodation are due to the implementation of the Scottish Living Wage (SLW) and increases in specific care packages arising from increased needs and increasing frailty with age within the learning disability population. The biggest spend under Supported Accommodation is within Learning Disability.
- 1.8 Across Daycare, Homecare, Residential, Supported Accommodation and Supported Living the greatest increases are across older people and learning disability. The development of a new children with disabilities respite facility in 2015 has seen an increase in the level of spend under supported accommodation for Children's services.
- 1.9 The spend in relation to residential accommodation relates in the main to older people services and in response to a significant increase in the number of older adults within East Dunbartonshire. The increase in residential accommodation is due to the number of individuals going into Care Homes and the use of residential facilities out with East Dunbartonshire for learning disabilities, mental health and physical disabilities.
- 1.10 There is a lack of residential resource for these care groups within East Dunbartonshire which is also the same across supported accommodation. The use of residential now also includes the use of facilities such as Rainbow House for substance misuse; there is also spend included under supported living.



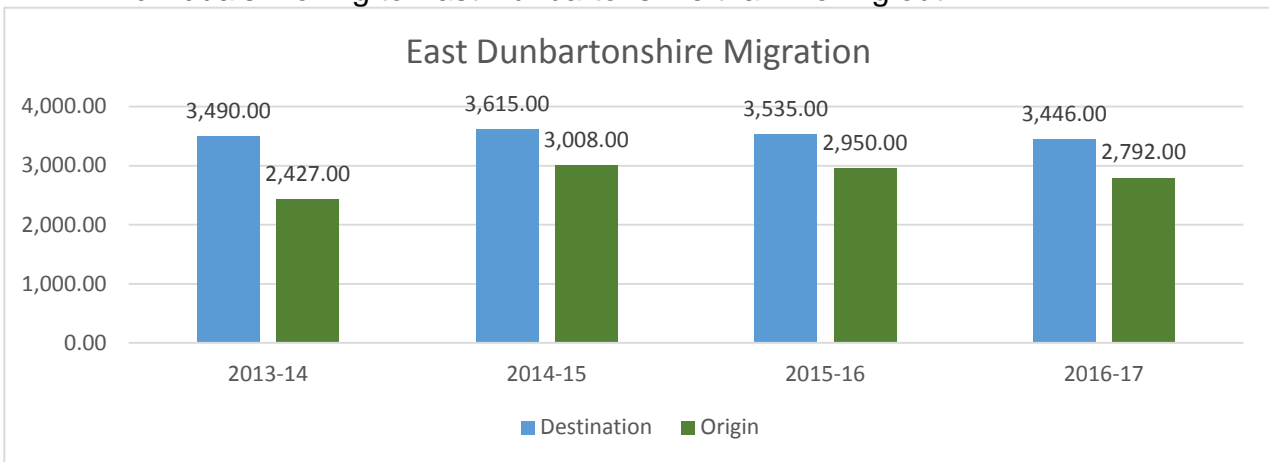
1.11 The percentage change, as above ranges from 13% to nearly 80% and in most cases the projected spend is increasing for 2018/19 compared to spend for 2017/18. There is however a projected decrease in Foster Parent – standard allowances and supported living, both of which have been on the increase previously. These are the projections based on period 7 data so this could change by the end of the financial year and spend may be higher. The projected reduction for fostering is due to specific efficiencies achieved during 2018/19 in the way fostering placements are commissioned with a number of foster carers moving from private agencies to become East Dunbartonshire carers.

Expenditure Area	Sum of 2017/18 Actuals	Sum of Projection at P07
Voluntary Organisations	£2,181,363	£2,876,978
Residential Schools / Accommodation	£2,819,193	£2,859,483
Daycare	£4,007,811	£4,079,435
Foster Parents - Standard Allowances	£1,890,711	£1,778,077
Homecare	£7,689,727	£8,109,578
Residential Accommodation	£16,533,623	£17,568,458
Supported Accommodation	£7,382,271	£7,679,044
Supported Living	£5,966,466	£5,746,289
Total	£48,471,165	£50,699,362

1.12 Residential schools / Accommodation have increased significantly since 2013/14 with a spend of over £1.5 million, this could be due to the increased use of the Scotland Excel framework for residential placements. These out of area placements are being made due to a lack of local resources that meet these more complex care needs.

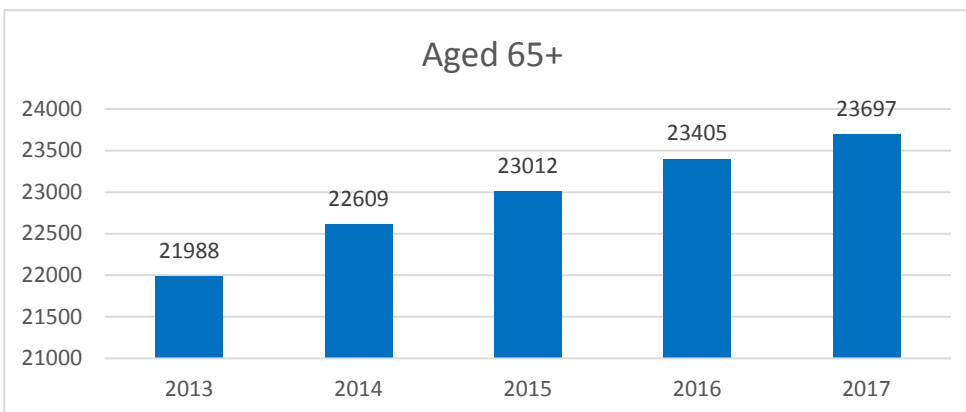
1.13 Families are also moving to East Dunbartonshire to access specialist school provision and thereafter access to local resources to support individuals with learning disabilities.. The chart below shows the migration patterns in and out of East

Dunbartonshire from 2013-14 till 2016-17, during this time there have been 2,909 more individuals moving to East Dunbartonshire than moving out.



1.14 Demand for day care services is also increasing across children and young people, older people, learning disability, mental health and physical disability; with learning disability having the highest increase. This could be due to a number of factors such as the growing older population in East Dunbartonshire and the increasing levels of complexity coming through transitions where children previously supported within education, now require meaningful supports during the day.

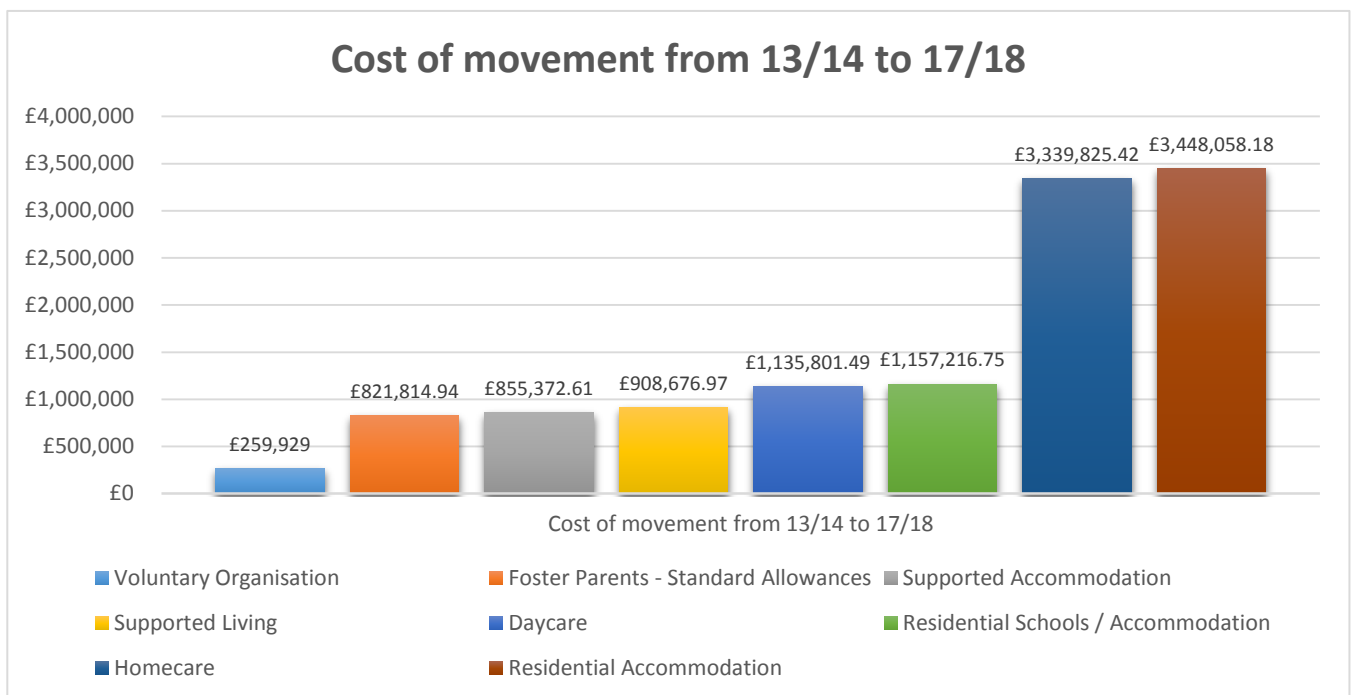
1.15 The growing older population is detailed in the chart below, as we can see there has been an increase of 1,709 over 65's since 2013-14. The over 65's are approximately 20% of the population, service spend will be impacted due to the size of this demographic. These increases are more extreme for the 75+ / 85+ population with more complex needs and co-morbidities.



1.16 The cost of movement from 2013-14 till 2017-18 totals £10,509,549.61, with the greatest increases in spend under residential accommodation and homecare. Increases in each of these areas are due to the increasing demand for support across over 65's and we need to take into consideration that a percentage of the 2,909 net migration into East Dunbartonshire will be using services.

Expenditure Area	Cost of movement from 13/14 to 17/18
Voluntary Organisation	£259,929
Residential Schools / Accommodation	£1,157,216.75
Daycare	£1,135,801.49
Foster Parents - Standard Allowances	£821,814.94
Homecare	£3,339,825.42
Residential Accommodation	£3,448,058.18
Supported Accommodation	£855,372.61
Supported Living	£908,676.97

1.17 The demand across all these budgets has been and will continue to increase due to factors such as the implementation of the Scottish Living Wage, the increase in the older adults population, more complex needs for transitions and the lack of local resources to meet these needs.

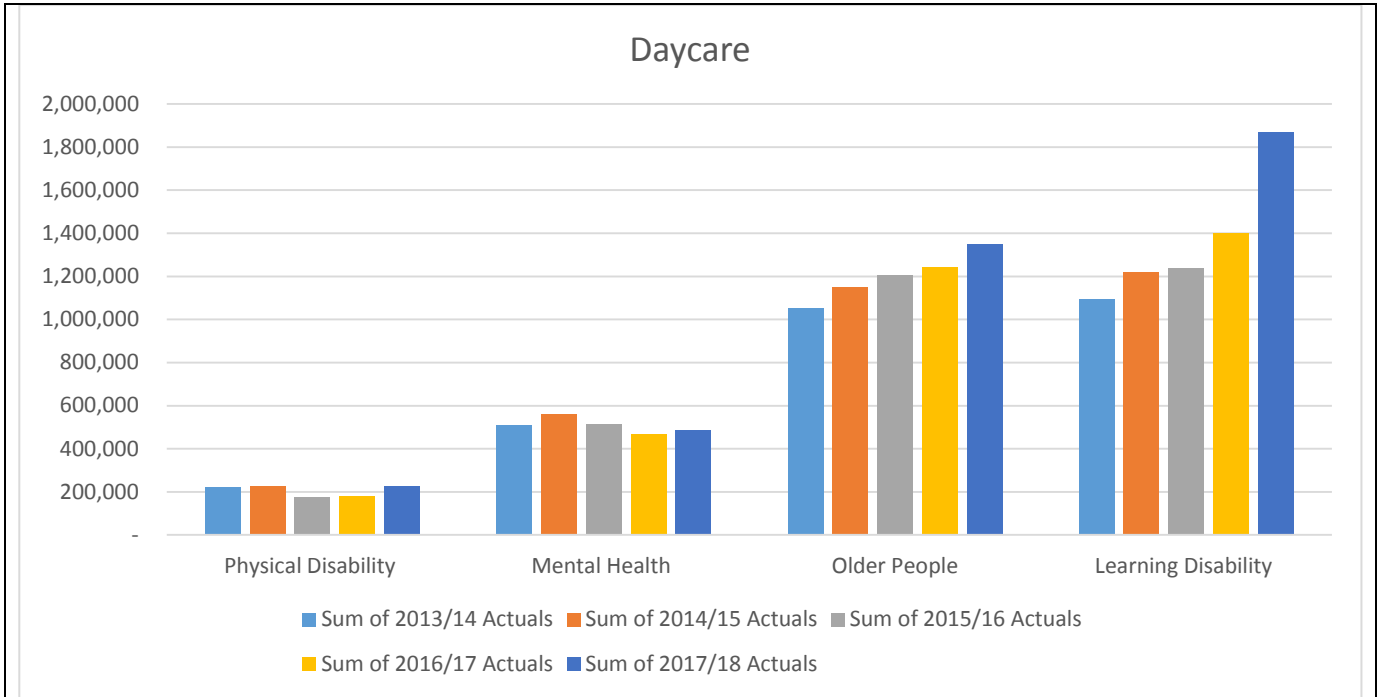


1.18 The table below shows the highest levels of spend under each budget with the uppermost spend under each highlighted. As we can see these relate to older people and learning disability. These care groups are the largest population demographics in East Dunbartonshire, which shows in the service spend.

Expenditure Area	Movement from 13/14 to 17/18
C&F - Residential Schools	£1,157,216.75
Resources Management	£1,157,216.75
Daycare	£1,135,801.49
Older People	£299,933.87
Learning Disability	£774,090.04
Foster Parents - Standard Allowances	£821,814.94
Childcare Planning/Placement	£824,342.32
Homecare	£3,339,825.42
Children & Young People	£351,169.33
Older People	£2,333,600.85
Learning Disability	£184,203.96
Mental Health	£19,262.24
Physical Disability	£477,562.48
Residential Accommodation	£3,448,058.18
Drugs & Addiction	£51,344.57
Children & Young People	£9,906.74
Older People	£2,361,530.28
Learning Disability	£469,236.23
Mental Health	£321,811.54
Supported Accommodation	£855,372.61
Learning Disability	£509,351.53
Mental Health*	£86,701.91
Physical Disability	£215,871.78
Respite Unit - Buttercups House	£228,215.00
Supported Living	£908,676.97
Children & Young People	£100,328.75
Older People	£394,716.58
Learning Disability	£308,972.06
Mental Health	£167,880.47
*this individual has been placed within an LD resource with a varied registration	

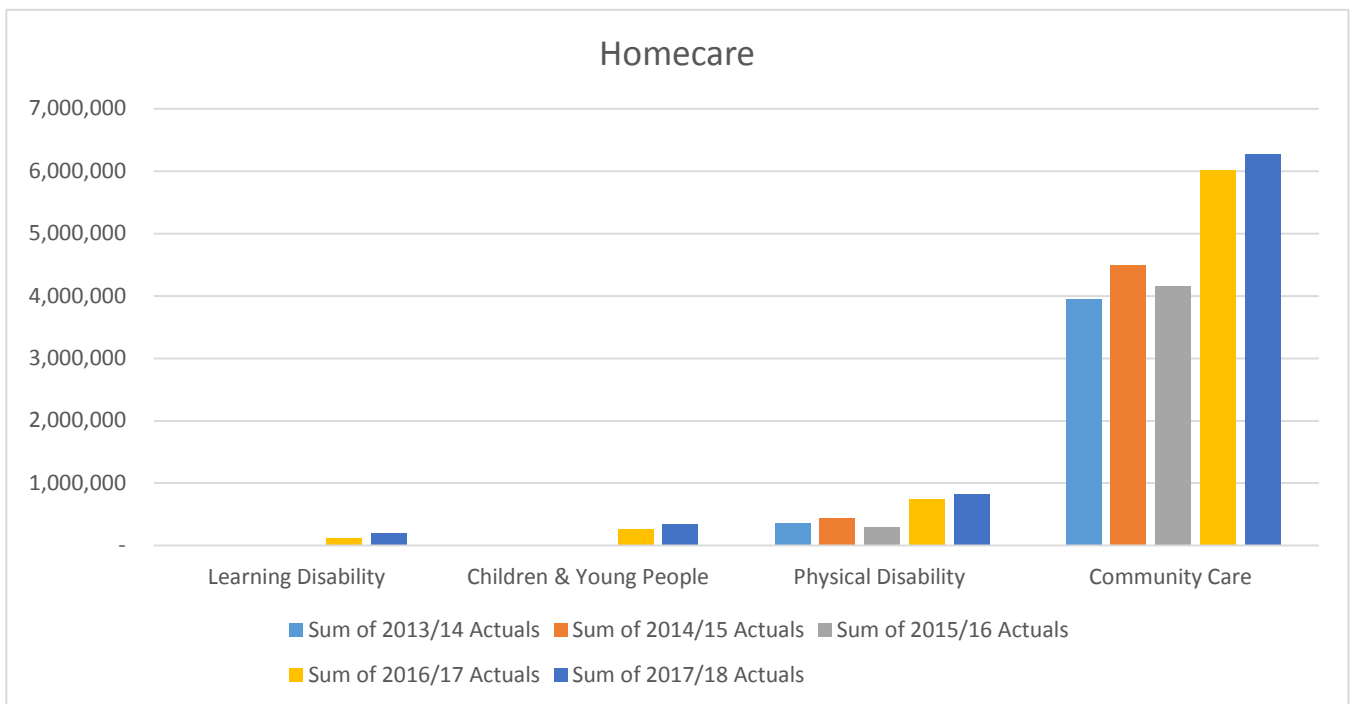
1.19 Daycare

From the table below we can see that there has been an increase in spend for older people and learning disability, with physical disability daycare remaining more static. There has been a decrease in mental health daycare and this is due to a reduction in funding to EDAMH following a service review during 2017/18. Under learning disability there is internally provided building based daycare delivered via Kelvinbank or external to East Dunbartonshire through Scottish Autism's Abbie Centre. The daycare under mental health is centred on universal services such as EDAMH, EDICT and the Rosebank Allotment run by Carr Gomm. Unless an individual is over 65 with mental health, there is no care group specific building based Daycare. Daycare for older people is largely purchased from Oakburn, Whitehill Court and Birdston.



1.20 Homecare

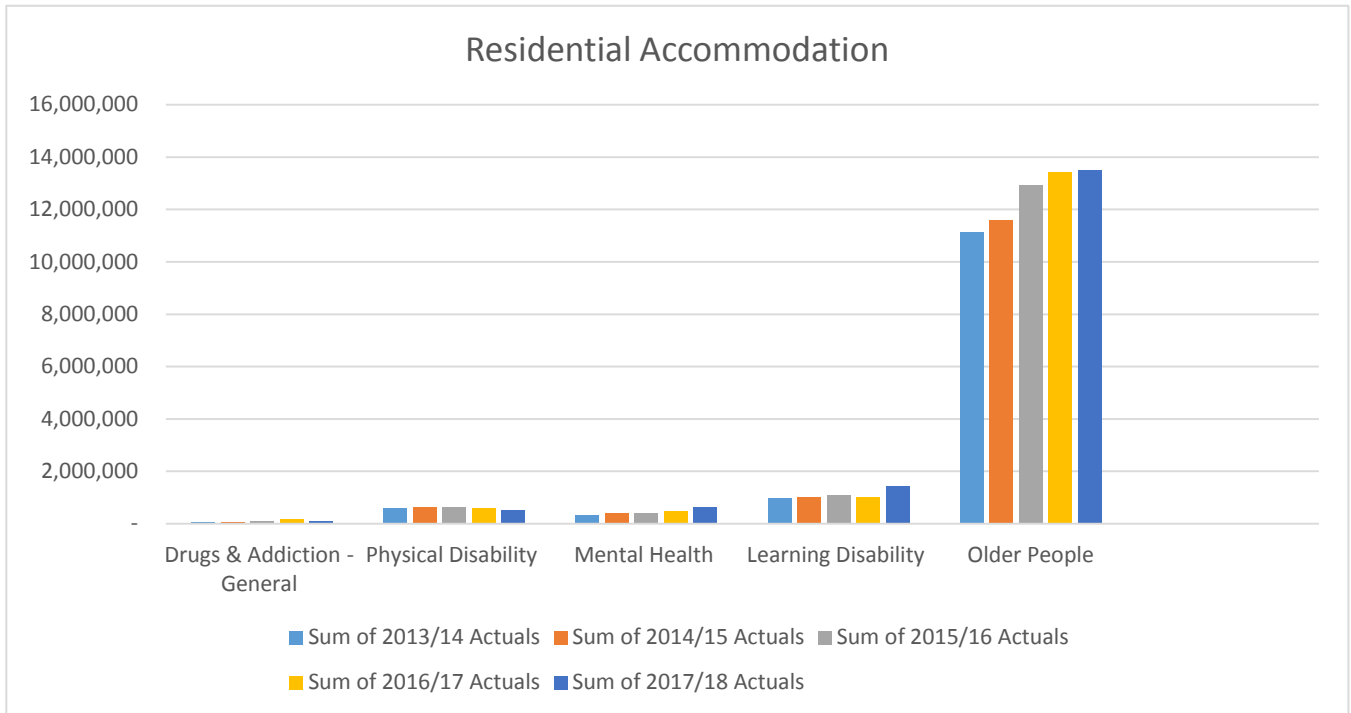
Spend on homecare shows a different picture for learning disability as the spend is relatively low, this can be due to care being provided by parents and carers or the individuals are more likely to access residential or supported accommodation so would not require to access homecare. As expected the spend is the highest within older people, again rising year on year, except a slight drop in 2015/16.



1.21 Residential accommodation

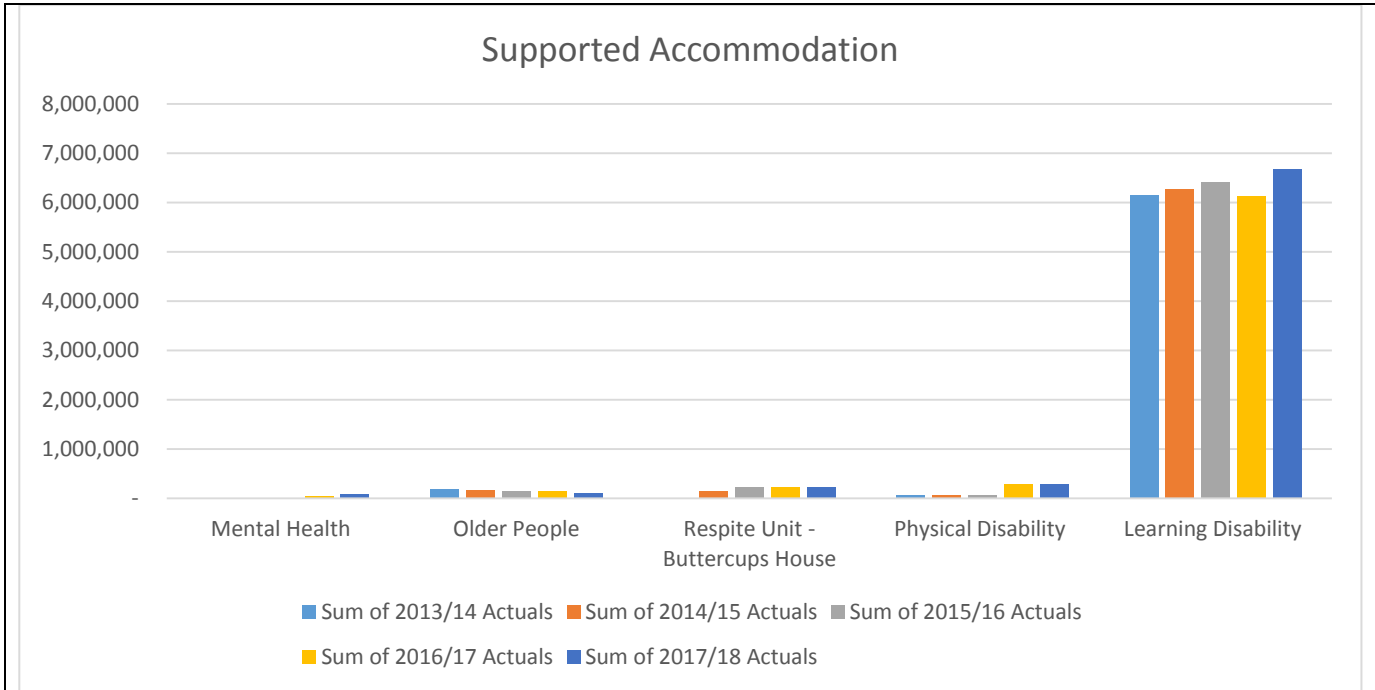
Residential accommodation again is highest within older people, this is down to the number of individuals over 65 going into care homes, both local and out with the ED area. The spend for residential for drug & addiction is all out with the authority and is

very low, this spend is mostly around placements in services like Rainbow House or specialist care homes such as Greencross and Southview that cater for alcohol related brain damage. Mental health residential placements are provided in Ashfield House run by Richmond Fellowship or out with the ED area due to a limited local resource. Again mental health and physical disability are lower in this area due to the models of care not necessarily fitting the needs of the individuals in these care groups.



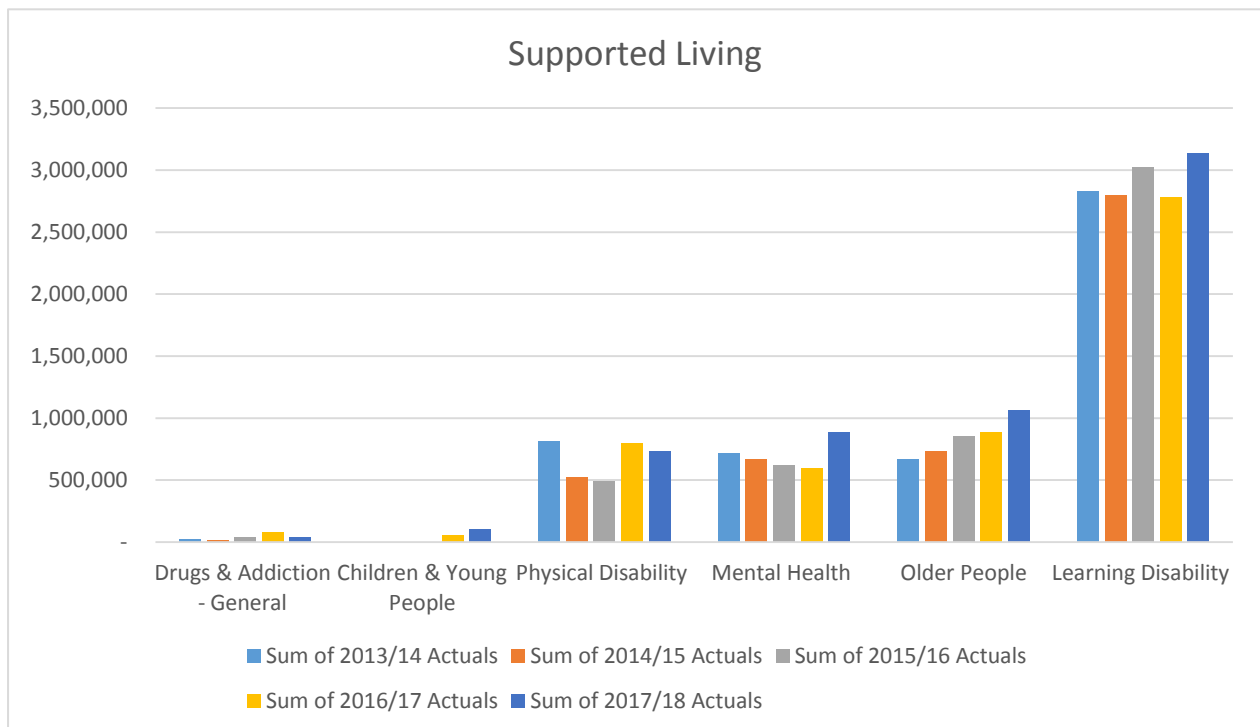
1.22 Supported Accommodation

Supported accommodation spend is mainly focused around learning disability where ED has organisations such as Key Housing, Cornerstone, Real Life Options and Quarriers who have several services across the area. The spend has remained fairly static, only changing when individuals needs may have changed or when the SLW was implemented. Supported Accommodation for Children relates to respite delivered within Buttercups, a respite unit for children with disabilities that was commissioned in 2015 to secure local provision where previously this was provided out with the area. There is still some use of external respite services for this care group based on the level of complexities of some cases.



1.23 Supported Living

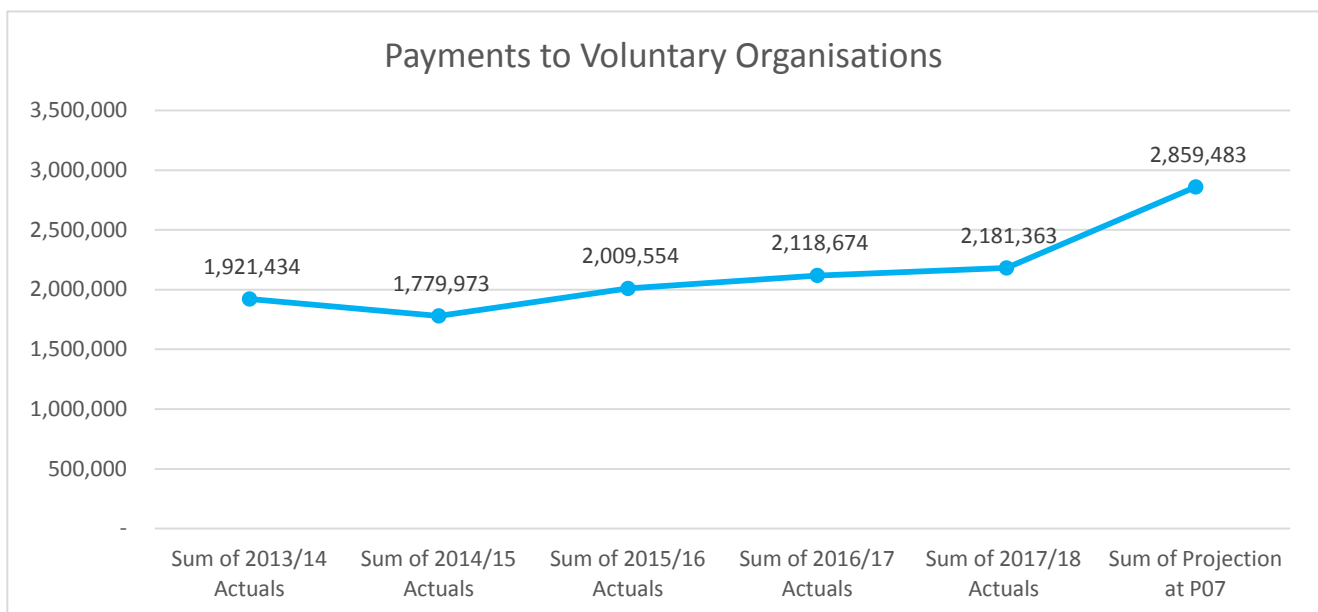
Again the highest spend is within learning disability, which is in place rather than homecare. This support is being provided predominantly via the Care at Home Framework. We can see that there was little to no spend for drug & addiction and children & young people previously, this was down to the fact neither care group was represented on the previous framework. There is roughly the same spend within older people, mental health and physical disability as this model suits each of these care groups and enables individuals to live at home longer. The organisations on the framework range from providers like Clyde, Carewatch, Allander and Delight to more service specific providers like Key, Richmond Fellowship, Cornerstone and Quarriers.



1.24 As we can see from these charts, older people and learning disability care groups show the greatest spend across most models and have more models of support to choose from; and a lot more of the support is provided locally. Investment is required locally to develop services for other care groups in order to reduce the spend on external placements, this would also reduce transport costs and provide more local investment in East Dunbartonshire as an area.

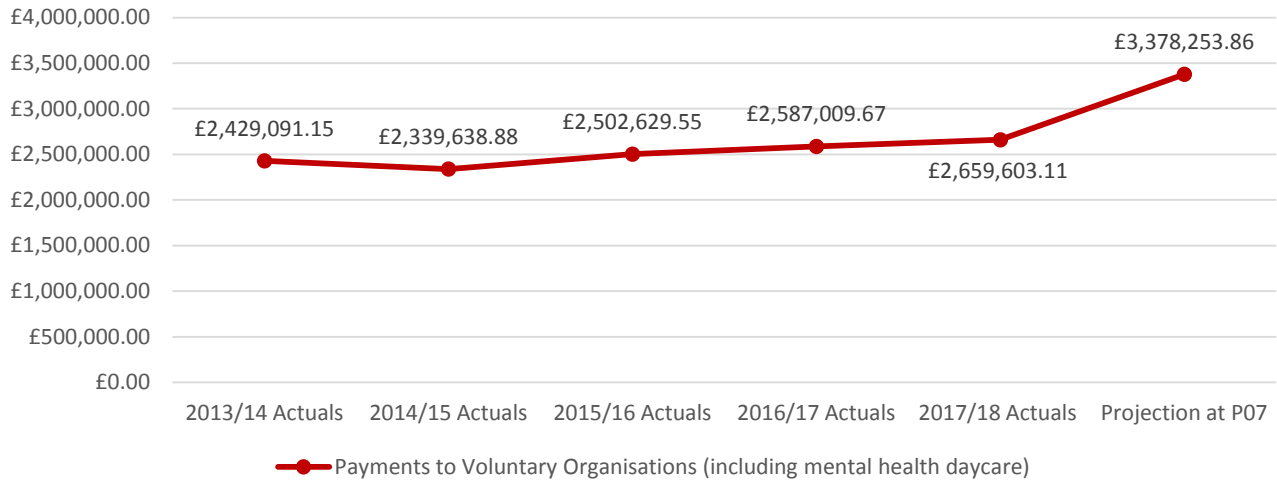
1.25 Voluntary Organisations

Payments to voluntary organisations have been increasing since 2015-16 and the total movement between 2013/14 to 2017/18 has been £259,929. The projected spend to voluntary organisations for 2018/19 is £2,859,483, which is an increase of £938,049 since 2013/14.

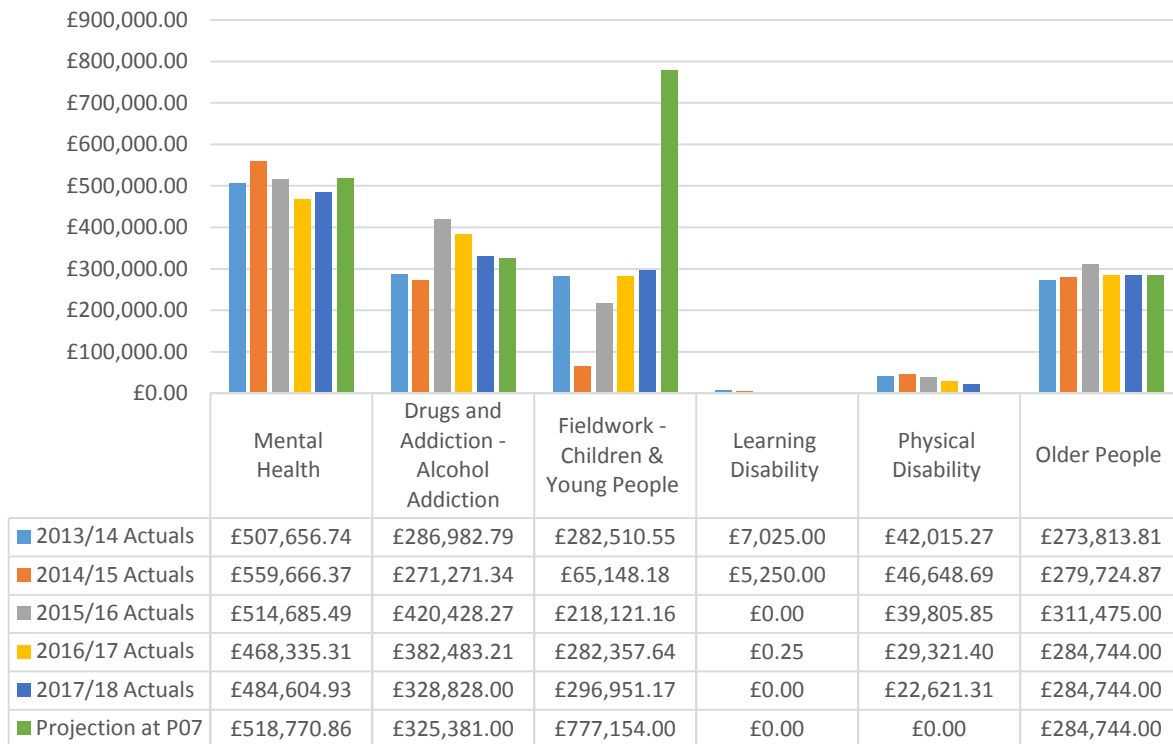


1.26 The projection for 2018/19 includes costs associated with developments within Children's Service to assess parenting capacity and family functioning therapy services. The above chart differs from the payments to voluntary organisations on the chart below which contains the spend in mental health daycare, which also comes under payments to voluntary organisations.

Payments to Voluntary Organisations (including mental health daycare)



Voluntary Organisation Spend (Including Mental Health Daycare)



1.27 The chart above is a snapshot of the voluntary organisation spends over care groups. Mental health payments to voluntary organisations tend to come under the daycare budget as this spend is on services like EDAMH, EDICT, Richmond Fellowship Connections and Rosebank Allotments (Carr Gomm). The spend within mental health is projected as £11,114 higher than 2013/14 and £33,168 higher than 2017/18 where there had previously been a reduction.

- 1.28 As we can see the spend via this budget is low to non-existent for learning disability, this is due to the models of support being more accommodation based, or internal building based daycare.
- 1.29 The voluntary sector spend for addictions is again, based around specialist services, such as Addaction, Scottish Families Affected by Drugs and Alcohol and GRACE.
- 1.30 Children and young people spend is primarily based on services like PCAS (Parental Capacity Assessment Service), FFT (Functional Family Therapy Service) and Action for Children's Canal Project. The spend within mental health is projected as £11,114 higher than 2013/14 and £33,168 higher than 2017/18 where there had previously been a reduction.
- 1.31 The spend in older people has been consistent over this five year period as this covers the Ceartas Advocacy service.

**EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PERFORMANCE, AUDIT & RISK
COMMITTEE**

Date of Meeting	19th December 2018
Subject Title	HSCP Transformation Plan 2018/19 Update
Report By	Jean Campbell, Chief Finance & Resources Officer
Contact Officer	Jean Campbell, Chief Finance & Resources Officer (Tel: 601 3221)

Purpose of Report	To update the Committee on the delivery of the Transformation Plan for the HSCP for 2018/19.
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Recommendations	The Partnership Board is asked to: a) Note the update to the HSCP Transformation Plan for 2018/19
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Relevance to HSCP Board Strategic Plan	The Strategic Plan sets out the priorities and ambitions to be delivered over the next three years to further improve the opportunities for people to live a long and healthy life. The transformation or annual business plan sets out the priorities which will be delivered during 2018/19 in furtherance of the strategic priorities set out in the Strategic Plan.
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Implications for Health & Social Care Partnership

Human Resources	None
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Equalities:	None
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Financial:	None
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Legal:	None
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Economic Impact:	None.
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Sustainability:	None.
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Risk Implications:	None
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Implications for East Dunbartonshire Council:	None.
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Implications for NHS Greater Glasgow & Clyde:	None.
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Direction Required to Council, Health Board or Both	Direction To:	
	1. No Direction Required	<input type="checkbox"/>
	2. East Dunbartonshire Council	<input type="checkbox"/>
	3. NHS Greater Glasgow & Clyde	<input type="checkbox"/>
	4. East Dunbartonshire Council and NHS Greater Glasgow and Clyde	<input checked="" type="checkbox"/>

1.0 MAIN REPORT	
1.1	The Transformation Plan for 2018/19 sets out the priorities which will be taken forward during 2018/19 in achievement of the outcomes set out in the Strategic Plan 2018/2021.
1.2	An update on the progress of the delivery of this plan is attached as Appendix 1 .
1.3	The partnership have established a Transformation Programme Board to oversee this programme of work involving the partnership's senior management Team (SMT) along with key stakeholders within the constituent bodies, staff side representatives and service user and carer representation.
1.4	There has been a process of prioritising work to ensure that key aspects of the programme are delivered and resources directed accordingly. There are a number of areas dependant on national work progressing or where they are board wide initiatives where the pace of progress is not entirely within the control of the partnership and this has been reflected within the update.
1.5	The Transformation Board also provides oversight of the savings programme for the partnership in the delivery of a balanced budget for 2018/19. This is further supported by the establishment of an integrated finance & monitoring group in collaboration with Finance and Transformation leads within the partner organisation.
1.6	The successful delivery of transformation is dependent on working in partnership with our key partners and a number of workstreams are aligned to the processes embedded within each constituent body and are supported by Council Transformation teams and wider GG&C teams.

- 1.7 The Transformation Plan has been categorised to identify where priorities relate to service transformation, service improvement, national / local policy development and accessibility / eligibility.
- 1.8 The Plan also has also been aligned to the level of financial investment within each area and where there is expected to be efficiencies delivered from the ongoing review work.
- 1.9 There are a total of 41 priorities to be delivered within the transformation plan for 2018/19:-
- 27 (20) are considered at Green status – on track or delivered
 - 12 (16) are considered Amber status – work is underway with some risk or delay to delivery
 - 2(1) are considered red status – more significant risks / delays to delivery
 - 1 – not applicable

Health & Social Care Partnership

ANNUAL BUSINESS DEVELOPMENT PLAN

(Transformation Plan)

2018/2019

Update – December 2018

SUMMARY OF PRIORITIES/DELIVERABLES FOR 2018/19

Service Area Priorities/Deliverables	Project Code / type	Status	Update	Financial Implications
Children's Services Project				
<ul style="list-style-type: none"> Develop sustainable services for school age children in line with national recommendations 	CHSP01 / National Policy development	Amber	Individuals identified to undertake school nursing training, funding available to to backfill post, timeline developed, scoping of local provision underway.	Current Investment - £0.061m Financial Efficiency – none expected
<ul style="list-style-type: none"> Implement new model of childhood immunisation programme 	CHSP02 / Service Transformation	Amber	Option for Bishopbriggs identified – reviewing facility and potential for alternatives, storage options to be explored.	Current Investment - £0.061m Financial Efficiency – none expected
<ul style="list-style-type: none"> Implement the Health Visiting Universal Pathway 	CHSP03 / National Policy Development	Red	Caseload numbers reducing in line with agenda. Issue in respect of regarding of HV's to Band 7 and affordability locally to meet this cost – impact assessment required.	Current Investment - £1.37m Financial Efficiency – none expected
<ul style="list-style-type: none"> Enhance support for young pregnant women and young parents in line with the recommendations from the National Pregnancy & Parenthood in Young People's Strategy 	CHSP04 / National policy Development	Green	Sexual Health Strategy approved through IJB, action plan under development – due Dec 2018	Current Investment – staff time resource Financial Efficiency – none expected
<ul style="list-style-type: none"> Improve transition arrangements for children moving from children to adult services 	CHSP05 / Service Transformation	Amber	Improvements to process for transitions complete – wider service review to scope future service delivery model to be progressed.	Current Investment - £0.56m Financial Efficiency – none expected for 2018/19, significant future cost pressures expected, potential future cost avoidance.
<ul style="list-style-type: none"> Improve supportive placement for looked after children within East Dunbartonshire 	CHSP06 / Service Transformation	Green	Shift in balance of care achieved – increasing number of local foster carers with further recruitment campaign underway.	Current Investment - £4.6m Financial Efficiency - £0.3m expected for 2018/19

			Efficiency delivered in year.	
<ul style="list-style-type: none"> Prevent children reaching the thresholds for specialist SW provision utilising prevention approaches 	CHSP07 / Service Transformation	Green	Scoping underway of services available – links to vol / 3 rd sector and commissioning team to develop asset map.	Current Investment - £0.84m Financial Efficiency – none expected for 2018/19
<ul style="list-style-type: none"> Extend provision young people who are looked after children up to 25yrs to meet legislative requirement 	CHSP08 / National Policy development	Green	Scoping completed, continuing care policy developed. Placements continuing and financial implication factored into 19/20 budget considerations. Carers re-assessed and re-categorised where required. Links to wider Corporate Parenting Group.	Current Investment - tbc Financial Efficiency - none expected for 2018/19
<ul style="list-style-type: none"> Develop alternatives to secure accommodation for vulnerable young women 	CHSP09/ Service Transformation	Green	Scoping work completed – exploring viability of developing alternative models. Links to local / national forums to explore models. National resource under development to support young people with MH issues.	Current Investment - £0.25m Financial Efficiency - none expected for 2018/19
Adult Services Project				
<ul style="list-style-type: none"> Develop sustainable services for people with LD. 	ADSP01/ Service Transformation	Amber	Council 10-stage transformation project – stage 5 options appraisal. Slower than expected progress with Strategic Review process. Review of sleepovers underway to identify potential use of technology. Pace of change to be accelerated and consideration of bespoke projects due to breadth and complexity of wider programme.	Current Investment - £14.5m Financial Efficiency - £0.15m expected for 2018/19, efficiencies to be scoped for 19/20.
<ul style="list-style-type: none"> Support individuals with autism in line with national recommendations 	ADSP02 / National Policy development	Green	10 Year Strategy in place. Progress on delivery being reviewed, action plan for next round of priority areas to be developed and will be	Current Investment - tbc Financial Efficiency - none expected for 2018/19

			submitted to HSCP Board - business as usual.	
<ul style="list-style-type: none"> Support adults with Mental ill-health to live as independently as possible within their community 	ADSP03 / Service Transformation	Green	Linked to GG&C MH Strategy and use of SG Action 15 monies. Financial framework now finalised, local plan developed within monies available. Final plan submitted to SG and will be at HSCP Board 15 Nov 2018. Next stage is to focus on Adult inpatient re-balancing.	Current Investment - £3.95m Financial Efficiency - £0.05m
<ul style="list-style-type: none"> Support individual, families and communities experiencing alcohol related harm 	ADSP04 / Service Transformation	Green	Dedicated post recruited to support better pathways for service users between the social work, clinical teams and hospital where required and ensures that a more joined up and holistic service provision is established. Council transformation project – yet to commence to review EDADs structure. Additional ADP monies received and plan developed to implement additional services. Return submitted to SG 2 Nov 2018. Service development session undertaken 2 Nov 2018 and team action plan for further service development drawn up. Review of ADP delivery model not progressing.	Current Investment - £1.36m Financial Efficiency - £0.015m
<ul style="list-style-type: none"> Redesign and implement locally a smoking cessation services in line with the NHS GGC Tobacco Review. 	ADSP05 / Service Transformation	Green	Review complete, wider GG&C implementation having an impact locally.	Current Investment - £0.3m Financial Efficiency – none expected for 2018/19
<ul style="list-style-type: none"> Fairer Access to Community Care Policy 	ADSP06 / Accessibility / Eligibility	Green	Draft policy approved for 3 month consultation by HSCP on 15 Nov 2018.	Current Investment - £15.6m Financial Efficiency – none expected for 2018/19, efficiencies to be scoped for 19/20.

<ul style="list-style-type: none"> Review the provision of respite to carers and develop a Short Breaks Strategy for East Dunbartonshire 	ADSP07 / Policy Development	Green	Carers Act Implementation Group established and progressed eligibility criteria and adult support plan. Carers Strategy under development to include statement on Short Breaks.	Current Investment - £0.369m funding through the SG. Financial Efficiency – none expected for 2018/19.
Older People's Services Project				
<ul style="list-style-type: none"> Further develop supports for those with dementia, and their carers 	OPSP01/ Service Transformation	Amber	This item will be re-initiated in January 2019 via the revised East Dunbartonshire Local Dementia Strategy Group.	Current Investment - tbc Financial Efficiency – none expected for 2018/19
<ul style="list-style-type: none"> Develop a range of services to support more effective, timeous discharge from hospital 	OPSP02 / Service Transformation	Green	Business Case for the creation of our Home For Me – Integrated Community Frailty Assessment and Response Team has been developed. Purpose of this team is to respond to people at risk of admission and/or who require to discharge from hospital in a timely and safe manner. Improvement measurement will be in line with agreed unscheduled care targets.	Current Investment - £13.4m Financial Efficiency - none expected for 2018/19, efficiencies to be scoped for 19/20. Additional investment from Delayed Discharge budget of £300,000 in 2019/20
<ul style="list-style-type: none"> Develop a continuum model of intermediate care to help prevent avoidable hospital admission and support people to receive care within their community 	OPSP03 / Service Transformation	Green	See above – the Home for Me service delivers the continuum approach to intermediate care from increased services at home through to care home based intermediate care	Current Investment - £0.345m Financial Efficiency - none expected for 2018/19 Additional investment from Delayed Discharge budget of £300,000 in 2019/20
<ul style="list-style-type: none"> Work with the Care Home Sector to develop an enhanced model of service provision 	OPSP04/ Service Transformation	Green	Care Homes ANP and Additional Care Homes Liaison Nurse capacity approved and being put in place. Caring Together Steering Group has been set up and virtual team is being brought together – business plan in place. SOP being drawn up to	Current Investment - £13.9m Financial Efficiency - none expected for 2018/19, efficiencies to be scoped for 19/20. Additional investment of

			govern work of the team, in addition to evaluation framework to measure impact against intended outcomes.	£105000 from delayed discharges budget in 2019/20.
<ul style="list-style-type: none"> Develop and deliver early intervention, preventative approaches to support older people to remain in the local community. 	OPSP05/ Service Transformation	Amber	Local Area Co-ordinations expected to be in post in February 2019. Revised model of older people's day care provision in the East Locality has been developed and engagement processes with service users, carers and providers has begun. Fill paper to IJB in January 2019. Implementation of new model planned for completion in June 2019.	Current Investment - £1.4m Financial Efficiency - none expected for 2018/19, efficiencies to be scoped for 19/20.
<ul style="list-style-type: none"> Review current provision and improve accessibility to health and social care services for the aging population in custody. 	OPSP06/ National Policy Development	N/A	The work stream is on hold awaiting finalised guidance from the Scottish Government.	Current Investment - tbc Financial Efficiency - none expected for 2018/19
<ul style="list-style-type: none"> Develop and promote a range of preventative and sustainable approaches to self management and anticipatory care 	OPSP07/ Service Transformation	Green	Focus is on implementation of Anticipatory Care Planning with agreed cohort of individuals (including care home residents, people in intermediate care, people with dementia and people with unstable LTCs. Work plan has been developed for roll out based on agreed summary ACP.	Current Investment - tbc Financial Efficiency - none expected for 2018/19 Anticipated share of inward investment of c. £100K across GG&C by Macmillan focussed on ACPs for people in receipt of palliative care towards end of life planning.
<ul style="list-style-type: none"> Promote independence through the uptake of telecare and telehealth solutions through the implementation of the Assistive Technology Strategy 	OPSP08 / Service Transformation	Green	Assistive Technology Strategy approved through IJB, action plan being has been developed, inclusive of a comprehensive communication plan. All actions are on track. Joint action group with EDC corporate colleagues in place to manage the transformation change from	Current Investment - £0.2m Financial Efficiency - none expected for 2018/19, efficiencies to be scoped for 19/20. £18,157.50 additional funding

			<p>analogue to digital for community alarms.</p> <p>Thinking session planned for January 2019 to refine the scope of our Technology Enabled Care/ Digitalisation programme with support from EDC Change Team and the Scottish Government Digital Office.</p>	<p>secured from the national technology enabled care programme has been secured for 2019/20 to pilot ARMED technology response to falls prevention and extended GPS.</p>
<ul style="list-style-type: none"> Review homecare services to deliver a sustainable model ensuring an agreed balance of in/house /external provision 	OPSP09/ Service Transformation	Green	<p>Formal Service Review is underway via EDC Transformation Process. Review is at stage 4 of 10 stage process, with options for the future being developed and appraised – intended conclusion by January 2019 for changes to be implemented 2019. This will include delivery of the Care Inspectorate inspection requirements and the implantation of the new Care At Home Framework.</p>	<p>Current Investment - £13m</p> <p>Financial Efficiency - none expected for 2018/19, efficiencies to be scoped for 19/20.</p>
<ul style="list-style-type: none"> Improve the effectiveness and efficiency of services by maximising opportunities for integrated service delivery 	OPSP10 / Service Transformation	Amber	<p>Review of all rehabilitation and enablement services to be initiated following completion of the Homecare Review – aim is to implement an integrated community rehabilitation and enablement service in 2019/20. This is linked to the intended review of services for people with disabilities across children and adult services, and the developed of the integrated Home for Me service.</p>	<p>Current Investment - £2.95m</p> <p>Financial Efficiency - none expected for 2018/19, efficiencies to be scoped for 19/20.</p>
<ul style="list-style-type: none"> Develop and enhance support for those requiring Palliative Care 	OPSP11/ Service Transformation	Amber	<p>National Group in place – local action plan being developed through Palliative Care Group. Local reinvigoration of this agenda required to ensure action is focussed and delivers improvement on our current high levels of performance in this area.</p>	<p>Current Investment - tbc</p> <p>Financial Efficiency - none expected for 2018/19.</p>

<ul style="list-style-type: none"> Review and develop the strategic relationship between the HSCP and housing sector, particularly in relation to housing for older people and those with physical disabilities 	OPSP12/ Service Transformation	Green	Research proposal to consider the housing needs of older people and those with disabilities has been initiated jointly between HSCP, Housing and Planning. Final specification for research agreed and goes out to tender in January 2019.	Current Investment - tbc Financial Efficiency - none expected for 2018/19.
Primary Care Services Project				
<ul style="list-style-type: none"> Enhance support to primary care by implementing the new GP Contract for Scotland in East Dunbartonshire 	PCSP01/ Service Transformation	Amber	Currently recruiting for the MDT for practices. Scoping ideas on accommodation to support the community treatment and care service	Current Investment - £0.8m available through the SG. Financial Efficiency - none expected for 2018/19.
<ul style="list-style-type: none"> Enhance collaboration in primary care by strengthening GP Cluster arrangements 	PCSP02/ Service Transformation	Green	CQLs/PQLs continue to meet regularly to develop and monitor quality improvement work. with representation from the HSCP if and when required.	Current Investment - tbc Financial Efficiency - none expected for 2018/19.
<ul style="list-style-type: none"> Review and further develop the Primary Care Wellbeing project 	PCSP03/ Service Transformation	Green	Pilot project has commenced and service being delivered across a number of settings; GP Practices, community venues, 3 rd sector organisation, service users homes, Kirkintilloch Job centre.	Current Investment - tbc Financial Efficiency - none expected for 2018/19.
<ul style="list-style-type: none"> Participate in and implement resulting actions for East Dunbartonshire from the GG&C Out of Hours Review 	PCSP04/ Service Transformation	Green	Proposed model – OOH walk in to cease. Calls for OOH support to be reviewed. Standby contract extended. Re-patriation of OOH nurses locally – needs to be sufficient to deliver.	Current Investment - tbc Financial Efficiency - none expected for 2018/19.
<ul style="list-style-type: none"> Achieve prescribing finalise balance and improve prescribing efficiency 	PCSP05/ Service Transformation	Amber	Work is underway to review expenditure of prescribing, maximise use of formula medications, reduce waste and increase compliance with agreed targets to reduce costs and improve patient safety. Pressures on budget relate to volume of	Current Investment - £18.7m Financial Efficiency - none expected for 2018/19.

			prescribing.	
Criminal Justice Services Project				
<ul style="list-style-type: none"> Lead the Community Planning partnership response to new Community Justice arrangements 	CJSP01/ Service Transformation	Green	<p>Partnership meetings re-established governance arrangements established. 3 year 2018 - 2021 Community Justice Outcomes Improvement Plan (CJOIP) drafted and out for consultation with partners and stakeholders. 1year Delivery Plan 2018/19 drafted and out for consultation. Annual report for 2017/18 drafted. Invited 3 third sector organisations onto partnership Cross partnership representation established - Empowered; ADP; CLD. Multi team briefing sessions delivered.</p>	<p>Current Investment - £0.7m Financial Efficiency - none expected for 2018/19 – ring fenced funding.</p>
Oral Health Services Project				
<ul style="list-style-type: none"> Further improve dental services for priority groups 	OHSP01/ Service Improvement	Green	<p>Visited 96% of GDP's practices in East Dunbartonshire between June17-July 18.</p> <p>All Nurseries and Schools are offered support to deliver a daily tooth brushing programme.</p> <p>Centralised Caring for Smiles training is offered to all care homes on an ongoing basis.</p> <p>Registrar project commenced</p> <p>Support has been provided to services who support priority groups i.e. Homeless Services, Prisons, St Mary's Secure Unit</p>	<p>Current Investment - tbc Financial Efficiency - none expected for 2018/19.</p>

<ul style="list-style-type: none"> Review the balance and proportionality of oral health improvement programmes across adult and child services 	OHSP02/ Service Improvement	Green	<p>In East Dunbartonshire 89.6% of Children are registered with a dentist (compared to 93.9% Scotland; 93.4% GG&C)</p> <p>In East Dunbartonshire 89.1% of Adults (compared to 88.4% Scotland: 92.3% GG&C).</p>	<p>Current Investment - £10.7m</p> <p>Financial Efficiency - none expected for 2018/19.</p>
<ul style="list-style-type: none"> Develop a Health Board wide premises strategy in relation to PDS services, including consolidation and possible reduction and relocation of oral health services in relation to the PDS 	OHSP03/ Service Transformation	Green	<p>Review document in draft format for checking by CDPH/GM.</p> <p>Engagement sessions completed across all PDS sites.</p> <p>Rationale and progress presented to Glasgow University Liaison group and NES.</p> <p>Discussed at GDP Sub-Committee Meeting/Area Dental Committee meeting.</p>	<p>Current Investment - tbc</p> <p>Financial Efficiency - none expected for 2018/19.</p>
Corporate Services				
<ul style="list-style-type: none"> Develop an ICT Plan 	CSP01/ Policy Development	Amber	<p>Initial delay in roll out of shared desktop now progressing, ICT Plan development underway to identify priority for next steps.</p>	<p>Current Investment – ICT resources</p> <p>Financial Efficiency – none expected</p>
<ul style="list-style-type: none"> Develop a Property / Accommodation Strategy 	CSP02/ Policy Development	Green	<p>Strategy complete and approved through IJB.</p>	<p>Current Investment – property budgets remain with partner agencies.</p> <p>Financial Efficiency - none expected for 2018/19.</p>
<ul style="list-style-type: none"> Develop a Health & Care Centre within the west locality 	CSP03/ Service Transformation	Amber	<p>Detailed scoping underway for requirements for a new health centre - engagement with GPs and wider stakeholders. Focus to shift to how services will be delivered in a future model through integration and consideration of future plans. Joint planning meetings in place to</p>	<p>Current Investment – capital funding to be secured</p> <p>Financial Efficiency – none expected.</p>

			progress agenda to Feasibility Study stage once detailed scope complete.	
<ul style="list-style-type: none"> Scope the potential to accommodate children's SW Services within the KHCC 	CSP04/ Service Improvement	Green	Insufficient capacity within KHCC to accommodate the needs of Children's Services – plans developed for refurbished Southbank to include requirements of Children's Services, work underway to progress through Council Property & Assets.	Current Investment – capital funding as part of Council Accommodation programme Financial Efficiency – none expected.