A meeting of the **Integration Joint Board Audit Committee**
will be held on **10 December 2018**
at **2.00pm**
in **Boardroom, Carseview, Stirling**
Chair: Councillor Dave Clark, Clackmannanshire Council

Please notify apologies for absence to:

HealthandSocialCarePartnership@clacks.gov.uk

Development Session: **Roles and Responsibilities of Audit Committee**
Facilitated by Kevin O'Kane, Chief Internal Auditor &
Ewan Murray, Chief Finance Officer

AGENDA

1. **Apologies**

2. **Minute of IJB Audit Committee Meeting of 12 September 2018**

3. **Matters Arising**

4. **Governance Update Including Governance Workplan Update**
   Report by Ewan Murray *(For Approval)*

5. **Strategic Risk Register Update**
   Report by Shiona Strachan *(For Approval)*

6. **Internal Audit Draft Information Sharing Protocol**
   Report by Kevin O'Kane, Chief Internal Auditor *(For Noting)*

7. **Accounts Commission Report – Integration Progress**
   Report by Kevin O'Kane, Chief Internal Auditor *(For Noting)*

8. **Strathcarron Hospice: Draft Hospice At Home Inspection Report** *(For Noting)*
   Report by Shiona Strachan, Chief Officer

9. **AOCB**

10. **Date of Next Meeting**
    (To Be Confirmed)

Minute of the Clackmannanshire & Stirling IJB Audit Committee
Wednesday 12 September 2018, 2:30pm
Boardroom, Carseview, Stirling

Present:

Councillor Dave Clark, Clackmannanshire Council (Chair)
Paul Craig, Audit Scotland
Alex Linkston, Chairman, NHS Forth Valley
Councillor Susan McGill, Elected Representative, Stirling representative standing in for Councillor, Graham Houston
Morag Mason, Service User Representative for Stirling
Natalie Masterson, Third Sector Representative, Stirling
Ewan Murray, Chief Finance Officer, Clackmannanshire & Stirling HSCP
Kevin O'Kane, Audit Manager, Corporate Operations, Stirling
Shiona Strachan, Chief Officer, Clackmannanshire & Stirling HSCP
Andrew Wallace, Audit Scotland
Karen Campbell, HSCP Administrator (minute taker)

1. APOLOGIES

Apologies for absence were intimated on behalf of:

Councillor Graham Houston, Elected Representative, Stirling
Fiona Gavine, Non-Executive Board Member, NHS Forth Valley

2. MINUTE OF IJB AUDIT COMMITTEE MEETING OF 24 AUGUST 2018

The minute of the previous meeting was accepted as a true and accurate record. They were proposed by Alex Linkston and seconded by Morag Mason.

3. MATTERS ARISING

None.

4. 2017/18 INTEGRATION JOINT BOARD ANNUAL ACCOUNTS

This paper was presented by Ewan Murray.

He explained that these were the audited final accounts after a number of revisions were made from the unaudited accounts. The consideration of the unaudited accounts were delayed due to the fact that the IJB Audit Committee scheduled for June had to be postponed as it was not quorate.

Alex Linkston commented that he felt that it was a good set of accounts and reflected the position of the Board.

The Audit Committee discussed the accountabilities in terms of budgetary control.

It was acknowledged that the Integration Joint Board is responsible for issuing directions but that there is a mutual responsibility with the health board and the local authorities. It is hoped that progress on delegation will help matters moving forward. It was noted that the financial situation is challenging country wide.

The IJB Audit Committee:

- Considered the 2017/18 Integration Joint Board Annual Accounts.
- Noted the updated management commentary and annual governance statement contained within the accounts.
- Noted the Independent Auditors report contained within the accounts.
- Recommended that the Integration Joint Board approve the Annual Accounts at the 26 September 2018 meeting and that the Chair, Chief Officer and Chief Finance Officer sign the accounts thereafter.

5. 2017/18 ANNUAL AUDIT – INDEPENDENT AUDITORS REPORT

This paper was presented by Paul Craig.

6. PROPOSED 2017/18 ANNUAL AUDIT REPORT

This paper was presented by Paul Craig.

He stated that the Clackmannanshire and Stirling Integration Joint Board Proposed 2017/18 Annual Audit Report will remain 'proposed' until the report is signed off at the Integration Joint Board meeting on 26 September 2018. Paul Craig confirmed that as part of the completion for the audit, Audit Scotland would seek written representations from the Chief Finance Officer on aspects of the annual accounts, including the judgements and estimates made, on the day of signing.

Paul Craig spoke further about the key findings regarding:-

- 2017/18 annual report and accounts
- Financial management and sustainability
- Governance, transparency and value for money

It was noted that more can be done for medium/longer term planning.

Andrew Wallace spoke about appendix 1 – action plan 2017/18. He recommended that the Integration Joint Board put processes in place regarding set aside arrangements for acute hospital services. He acknowledged it is difficult to produce a medium to long term plan. Ewan Murray stated work was ongoing to construct a plan

for the medium term as part of the process alongside developing the Strategic Commisioning Plan for 2019-22 and linked to the imminent publication of the Scottish Governments Medium Term Framework for Health and Social Care. He will also update the Budget Tracker to note if the savings are recurring or not.

Additionally the placing of the advertisement for the public inspection of the accounts will be brought forward in the Annual Accounts planning for future years to ensure compliance with regulations.

Ewan Murray confirmed that a Strategic Needs Assessment paper will go to the Integration Board Meeting on 26 September 2018.

7. INTERNAL AUDIT REVIEW, SELF DIRECTED SUPPORT (STIRLING) – RECOMMENDATIONS AND ACTION PLAN

This paper was presented by Shiona Strachan.

She explained that this internal audit review was commissioned as part of Stirling Council's Internal Audit programme.

Kevin O'Kane stated that he was happy that an improvement plan is in place this early and this reflects the seriousness of some of the recommendations.

A discussion took place surrounding the Self-directed Support Board and who sits on it. Natalie Masterson stated that the third sector interfaces are happy to help regarding Self-Directed support assessments.

Again it was acknowledged the incompatibility of the separate and legacy IT systems. The committee expressed a desire that one social care IT system can be used by the local authorities moving forward.

The IJB Audit Committee:

- Noted the recommendations from the Internal Audit Review (Appendix 1).
- Noted the current action plan in response to the recommendation.

8. AOCB

Councillor Clarke thanked Cllr McGill for attending at short notice to allow the meeting to proceed.

9. DATE OF NEXT MEETING

Ewan Murray advised the new administrator will be in touch shortly to agree the schedule of future meetings.

Clackmannanshire & Stirling
Integration Joint Board

Audit Committee

10 December 2018

This report relates to
Item 4 on the agenda

Governance Workplan

(Paper presented by Ewan C. Murray, Chief Finance Officer)

For Noting

Approved for Submission by	Ewan C. Murray, Chief Finance Officer
Author	Ewan C. Murray, Chief Finance Officer
Date	19 June 2018
List of Background Papers:	
Appendix 1: Governance Workplan	

Title/Subject:	**Governance Workplan**
Meeting:	**Clackmannanshire & Stirling Integration Joint Board: Audit Committee**
Date:	**10 December 2018**
Submitted By:	**Ewan C. Murray, Chief Finance Officer**
Action:	**For Noting**

1. Introduction

1.1 As part of the governance framework for the Integration Joint Board a governance workplan was established which is reported to and monitored by the Audit Committee.

2. Recommendations

The Audit Committee is asked to:

2.1. Note the updated governance workplan appended to this paper.

3. Governance Workplan

3.1. The governance workplan has been updated by the Chief Finance Officer and agreed with the Chief Officer.

3.2. A comprehensive review of the key elements of the governance frameworks has been planned for 2018/19 linked to progress and clarity on operational delegation and management arrangements. As this clarity is not yet fully in place progress on reviewing the frameworks is behind the timescales previously envisaged.

3.3. Further updates, including progress on review of governance frameworks, will be brought to the February 2019 Audit Committee meeting.

4. Resource Implications

4.1. Some of the issues requiring further development, for example support services arrangements, may have resource implications for the Integration Joint Board and/or the constituent authorities. These will be assessed as the specific issues are reviewed.

5. Impact on Integration Joint Board Priorities and Outcomes

5.1. Effective governance systems will aid the Integration Joint Board delivering its identified priorities and outcomes.

6. Legal & Risk Implications

6.1. Effective governance systems will aid the Integration Joint Board in discharging its statutory obligations and effectively managing risk.

7. Exempt reports

7.1. Not exempt.

Appendix I

Clackmannanshire and Stirling Integration Joint Board

Governance Workplan – Update for December 2018 Audit Committee

Action	Senior Responsible Officer	Key Supports	Target Completion Date	Update as at June 2018
Development of an Overarching Local Code of Corporate Governance to demonstrate compliance with the principles set out in the Delivering Good Governance in Local Government Framework including Review of Local Governance Framework Including: • Scheme of Delegation • Financial Regulations • Reserves Policy and Strategy	Chief Finance Officer	Finance and Governance Leads of Constituent Authorities	February 2019	Updates provided to February 2018 Audit Committee. Further update will be presented to Audit Committee on Scheme of Delegation and Financial Regulations linked to required review once future operational management arrangements are agreed. Target date revised from Dec 2018 given delay in finalising operational delegation arrangements for NHS services.
Development and Approval of Support Services Agreement including committee support arrangements	Chief Officer	Chief Executives and Corporate Function Leads from Constituent Authorities	December 2018	Not yet fully complete but significant progress made – workshop held 21 September. Will be completed post further clarification and agreement on future operational delegation / management arrangements.

Appendix I

Review of Structure and Effectiveness of IJB Committee Structure	Chief Finance Officer	Chief Officer, Standards Officers and Governance Support	March 2019	Undertake a review of terms of reference and function of IJB Committee structure and present recommendations for approval.
Delivery of 2018/19 Board Development Programme	Chief Officer	Various dependent on topic of individual session.	March 2019	Development Sessions planned and provided before each Integration Joint Board meeting in 2018/19 plus specific session on Organisational Development and Code of Conduct held.
Review and Update of Register of Interests	Standards Officer	Integration Team	February 2019	In progress. Consideration of Internal Audit recommendations to be incorporated.
Clarification and Agreement by Constituent Authorities of Operational Service Models, Management Structures and Responsibilities and Reporting Lines	Chief Officer	Chief Executives and Governance Leads of Constituent Authorities	March 2019	Updates presented to IJB during 2018.
Review and Agreement of Clinical and Care Governance Framework and underpinning arrangements	Chief Officer	Chief Social Work Officers, Medical Director, Director of Nursing	June 2018	Complete – Approved by IJB June 2018

Appendix I

Review of Approach to Directions and Agreement of Developments Required to Support Strategic Plan Delivery from 2018/19 onwards	Chief Finance Officer	Chief Officer, Finance and Governance Leads of Constituent Authorities	March 2019	Proposed Approach approved by IJB November 2018. Further consideration will be required when revised Scottish Government guidance published as part of Ministerial Review of Integration Progress due to be published early 2019.
Review, Development and Agreement of Approach to Assurance and Best Value Across the Partnership to Improve Governance and Accountability Arrangements	Chief Finance Officer	Chief Officer and Finance Leads	July 2019 (Best Value – linked to Annual Performance Report)	Further development of approach linked to Audit Scotland Guidance and 2019-2022 Strategic Commissioning Plan and locality development required. IJB CFO Section leading some national work in this area.
Induction Programme for New Members (Service User and Carers Reps)	Chief Officer	Standards Officer, Programme Manager	November 2018	Induction Programme is Completed
Review of Risk Management Arrangements including Reporting Requirements	Chief Officer	Chief Finance Officer, Chief Internal Auditor, Risk Management Leads of Constituent Authorities	Ongoing	Risk Register regularly reviewed by Joint Management Team and presented to Audit Committee for Scrutiny. High Risks reported to IJB by exception as part of established performance management frameworks.

Clackmannanshire & Stirling
Integration Joint Board

Audit Committee

10 December 2018

This report relates to
Item 5 on the agenda

Strategic Risk Register

(Paper presented by Shiona Strachan, Chief Officer)

For Approval

Approved for Submission by	Shiona Strachan, Chief Officer
Author(s)	Ewan C. Murray, Chief Finance Officer Shiona Strachan, Chief Officer
Date	3 December 2018
List of Background Papers: Clackmannanshire and Stirling Integration Joint Board Risk Strategy	
Appendices: Appendix 1 – Strategic Risk Register	

Title/Subject:	**Strategic Risk Register**
Meeting:	**Clackmannanshire & Stirling Integration Joint Board: Audit Committee**
Date:	**10 December 2018**
Submitted By:	**Ewan C. Murray, Chief Finance Officer**
Action:	**For Approval**

1. Introduction

1.1 This report provides the Audit Committee with the current Strategic Risk Register.

2. Executive Summary

2.1. The Strategic Risk Register was considered in full by the Integration Joint Board in April 2017 and is now considered on an exception basis as part of agreed Performance Reporting frameworks.

2.2. Scrutiny and monitoring of the full Strategic Risk Register forms part of the Audit Committees agreed terms of reference.

3. Recommendations

The Audit Committee is asked to:

3.1. Approve the updated register with regard to progress of relevant actions, and the alignment to key strategic processes.

3.2. To note the ongoing development of the risk register and reporting arrangements

4. Background and Considerations

4.1. The Strategic Risk Register was considered in full by the Integration Joint Board in April 2017.

4.2. Since that point the Integration Joint Board receive updates on high risks on an exception based as part of ongoing Performance Management arrangements.

4.3. Taking into account feedback from users of the Risk Register and appropriate professional advice the format and structure of the Strategic Risk Register was been reviewed to enhance readability and scrutiny.

4.4. The Strategic Risk Register was further reviewed by the Joint Management Team in April, June and November 2018. As part of the latest update a

specific risk in relation to the UK's decision to leave the EU has been added (HSC013).

4.5. As part of agreeing support services arrangements lead support for risk managements arrangements and professional support requires to be agreed as detailed in the governance workplan.

4.6. A further update will be brought to the February 2019 Audit Committee.

5. Conclusions

5.1. The Strategic Risk Register (Appendix1) outlines the key risks to achieving the Integration Joint Board's Strategic Plan, and processes in place to mitigate those risks. It provides the Board with assurance that significant risks have been identified and are being managed and/or mitigated appropriately.

5.2. The Strategic Risk Register is a dynamic document and will continue to evolve as partnership arrangements develop.

6. Resource Implications

6.1. This report has no direct resource implications for the Integration Joint Board other than those specifically detailed in the risk register.

7. Impact on Integration Joint Board Priorities and Outcomes

7.1. Effective and efficient risk management arrangements support the Integration Joint Board to make best use of scarce public resources in pursuance of its priorities and outcomes.

8. Legal & Risk Implications

8.1. The Strategic Risk Register forms part of the Integration Joint Boards governance and risk arrangements and as such is kept under regular review

9. Equality and Human Rights Impact Assessment

9.1. N/A.

10. Exempt reports

10.1. Not exempt.

APPENDIX 1

CLACKMANNANSHIRE & STIRLING HEALTH & SOCIAL CARE PARTNERSHIP: STRATEGIC RISK REGISTER AT 15 June 2018

Ref	Risk	Strategic Fit	Likelihood	Impact	Risk Score	Risk Reduction Action	Risk Owner(s)	Notes
HSCP 001	**Financial Resilience** (This risk relates to financial and operational stability, and commissioning. It includes the sustainable capacity across all sectors, and co-location and/or sharing of teams and assets).	**1.** National Core Outcome 'Resources are Used Effectively & Efficiently' **2.** Local Outcome 'Decision Making'	Current (4) Target (3)	Current (5) Target (4)	Current (20) High Target (12) Medium	**1.** Establish efficiency and redesign monitoring arrangements including development and updating of pan-partnership savings tracker. **2.** Review and continual assessment of deliverability of efficiency and redesign programmes and alignment to Strategic Plan. **3.** Develop medium term financial strategy to complement and support delivery planning to implement Strategic Plan. **4.** Develop and implement process for agreement and payment of contract rates including uplifts. **5.** Identify and mitigate as far a possible the financial risk associated legislative changes including the Carers Act and Free Personal Care for <65s **6.** Develop planning and shared accountability arrangements for Unscheduled Care and the 'set aside' budget for large hospital services based on self assessment presented to June 18 IJB. . **7.** Review of financial regulations and reserves policy and strategy as part of prudent financial planning and management arrangements. **8.** Review and agree relationship with Alcohol and Drugs partnership including financial plan and impact on outcomes. **9.** Further consider evaluation of impact and outcomes from investment of Partnership Funding	Chief Finance Officer	There is a need to further at the implications of the stepped delegation of operational responsibilities to Chief Officer in 18/19 based on updates to IJB in June 18. Key financial risks updated annually as part of budget setting cycle.

CLACKMANNANSHIRE & STIRLING HEALTH & SOCIAL CARE PARTNERSHIP: STRATEGIC RISK REGISTER AT 15 June 2018

Ref	Risk	Strategic Fit	Likelihood	Impact	Risk Score	Risk Reduction Action	Risk Owner(s)	Notes
						Streams linked to Prioritisation Frameworks Work with Caledonian University. **10**. Horizon Scanning arrangements across the Partnerships e.g. through monthly finance officers meetings to highlight potential emerging risks and/or changes in policy or legislation with financial implications e.g. Pay Awards, Free Personal Care for < 65's **11**. Financial Reporting to Integration Joint Board, Strategic Planning Group and Joint Management Team including development, where possible, of locality level reporting. **12**. Ongoing monitoring of demand trends and relationship between investment and key performance indicators including Delays to Discharge 13. Development of Scrutiny Role of IJB Finance Committee		
HSC 002	**Leadership, Decision Making and Scrutiny** (including effectiveness of governance arrangements and potential for adverse audits and inspections).	**1.** National Core Outcome 'Resources are Used Effectively & Efficiently' **2.** Local Outcome 'Decision Making'	Current (3) Target (2)	Current (4) Target (4)	Current (12) Medium Target (8) Low	**1.** There is a joint leadership structure which reflects partnership arrangements. **2.** Develop planning and operational structures **3.** Develop role and Function of Strategic Planning Group and Strategic Plan Working Group implementing Partnership Planning Approach agreed by IJB in March 2018 **4.** Review of Governance Frameworks and Scheme of Delegation.	Chief Officer	Annual external audit report 17/18 did not identify any instances of non-compliance with the Code in relation to the Annual Governance Statement. Risk-based Internal Audit Plan included review of governance processes. This found that, generally corporate governance

CLACKMANNANSHIRE & STIRLING HEALTH & SOCIAL CARE PARTNERSHIP: STRATEGIC RISK REGISTER AT 15 June 2018

Ref	Risk	Strategic Fit	Likelihood	Impact	Risk Score	Risk Reduction Action	Risk Owner(s)	Notes
						5. Integration Joint Board development programme **6.** Establishment of Delivery Plan (April 2017) incorporating Transformational Change Programme **7.** Continuing Work in association with Glasgow Caledonian University on development and application of Priority Setting Frameworks.		arrangements are appropriate and are operating effectively. No critical or high risk findings. Governance Action Plan being monitored by the Audit Committee with substantial review of governance frameworks planned for during 18/19.
HSC 003	**Sustainability of Partnership** (The unique three way Health &Social Care Partnership fails to further develop due to differing priorities and requirements).	**1.** National Core Outcome 'Resources are Used Effectively & Efficiently'.	Current (2) Target (1)	Current (5) Target (5)	Current (10) Medium Target (5) Low	**1.** Establish, implement and periodically review Governance Framework. **2.** Regular meetings between Chief Executives and Leaders of Councils established to ensure flow of communication. **3.** Regular Meetings of Leadership Group **4.** Pre Agenda and use of briefings / seminars where appropriate (e.g. budget seminars) **5**. Review of Governance and committee arrangements including establishment of Finance Committee **6**. Board Organisational Development Programme. 7. Appointment of Interim Chief Officer and agreement on process for permanent appointment.	Chief Officer	
HSC 004	**Performance Framework** (This relates to the responsibility of the Health and Social Care Partnership	**1.** National Core Outcome 'Resources are Used Effectively & Efficiently'	Current (2) Target	Current (4) Target	Current (8) Low Target	**1.** Provide clarity of key priorities within Strategic Plan to ensure focus for the Integration Joint Board in performance assessment.	Performance and Measurement Work stream	

CLACKMANNANSHIRE & STIRLING HEALTH & SOCIAL CARE PARTNERSHIP: STRATEGIC RISK REGISTER AT 15 June 2018

Ref	Risk	Strategic Fit	Likelihood	Impact	Risk Score	Risk Reduction Action	Risk Owner(s)	Notes
	to provide an overview of performance in planning and carrying out the integrated functions in an open and accountable way).	**2.** Local Outcome 'Decision Making'.	(1)	(4)	(4) Low	**2.** Minimise duplication and bureaucracy to ensure performance management and reporting meaningful and realistic. **3.** Measuring Performance Under Integration agree and monitor targets / trajectories. **4**. Further develop approach to Annual Performance Report including future development of planning and reporting at locality level and benchmarking with 'peer' Health and Social Care Partnerships. **5.** Internal Audit Review of Performance Management Arrangements 6. Focused presentation on unscheduled care performance in response to recent whole system pressures (Nov 18)	Lead / Chief Officer / Chief Finance Officer	
HSC 005	**Culture/HR/Workforce Planning** (This risk relates broadly to the work of Human Resource management across all partners to Workforce Planning for the 'in scope' workforce. It includes developing culture, behaviours and values, as well as sustainable change skills and capabilities).	**1.** National Core Outcome 'Engaged Workforce', and 'Resources are Used Effectively & Efficiently' **2.** Local Outcome 'Decision Making' **3.** HSCP priority 'Develop Single Care Pathways', and 'Support more Co-location of Staff from across Professions and Organisations'	Current (2) Target (1)	Current (4) Target (4)	Current (8) Low Target (4) Low	**1.** Develop multi-disciplinary care pathways and teams. **2.** Develop workforce strategy and plan. **3.** Communicate regularly with staff. **4.** Organisational Development working with staff to support culture change. **5**. Collaborative Leadership in Practice (CLiP) programme for Joint Management Team **6.** Models of Neighbourhood Care in Rural West Stirlingshire 7. Pre IJB Briefings with staff side reps.	Workforce Work stream Lead & Joint Management Team	Key strategic plans in place, Workforce Strategy (Jan 2016), and Participation & Engagement Strategy (Feb 2016).
HSC	**Experience of service**	**1.** National Core	Current	Current	Current	**1.** Implement Participation and	Chief Officer	An Equality Outcomes

APPENDIX 1

CLACKMANNANSHIRE & STIRLING HEALTH & SOCIAL CARE PARTNERSHIP: STRATEGIC RISK REGISTER AT 15 June 2018

Ref	Risk	Strategic Fit	Likelihood	Impact	Risk Score	Risk Reduction Action	Risk Owner(s)	Notes
006	**users/patients/unpaid carers** (This risk is about failure to engage adequately and fully with stakeholders, in particular those harder to reach groups of service users and their unpaid carers. It includes feedback and learning from complaints. Key challenges in this area are around measuring and evidencing change).	Outcome 'Carers are supported', and 'Positive Experiences' and Local Outcome 'Experience'' **2.** Local Outcome 'Community Focused Supports' **3.** HSCP priority ' Further develop anticipatory and planned care services', 'Develop 7 day access to appropriate services', and 'Take further steps to reduce the number of unplanned admissions to hospital and acute services'	(4) Target (2)	(4) Target (3)	(16) High Target (6) Low	Engagement Strategy. **2.** Planning for implementation of Carers Act. **3.** Collegiate working across Forth Valley in relation to Ministerial Steering Group (MSG) indicators. **4**. Strategic Commissioning Plan and Budget Consultation process		and Mainstreaming Report has been considered by the Integration Joint Board in April 2016 and published. Equality and Human Rights Impact Assessment will be completed where required. The IJB report template includes sections on Consultation and Equalities Assessment, which ensures that the Board are aware of the extent of consultation undertaken when decisions are being taken.
HSC 007	**Information Management and Governance** (This risk relates to Information Management and Governance, and the risk of increased demand for relevant areas of provision covering Health & social Care combined. It includes the lack of resources which are fit for purpose, capacity and capability of staff, as well as records and data management processes. It	**1.** National Core Outcome 'Resources are Used Effectively & Efficiently' **2.** Local Outcome 'Decision Making' HSCP priority 'Provide more single points of entry to services', **3.** 'Develop 7 day access to appropriate services, ' **4.** 'Further develop systems to enable front line staff to access and	Current (4) Target (3)	Current (4) Target (4)	Current (16) High Target (12) Medium	**1.** Refresh data sharing governance arrangements. **2.** Consideration of development of information sharing portal. **3.** Development of Cross ICT system working capabilities across constituent authorities. 4. GDPR arrangements. 5. Testing ICT arrangements for Bellfield Centre	Chair of Data Sharing Partnership	This risk relates to Information Management and Governance. Including the difference between anonymised information, identifiable information, and performance information.

CLACKMANNANSHIRE & STIRLING HEALTH & SOCIAL CARE PARTNERSHIP: STRATEGIC RISK REGISTER AT 15 June 2018

Ref	Risk	Strategic Fit	Likelihood	Impact	Risk Score	Risk Reduction Action	Risk Owner(s)	Notes
	also covers Information and Communication Technology systems, infrastructure, data protection and data sharing).	share information', and 'Support more co-location of staff from across professions and organisations.'						
HSC 008	**Information sharing process and practice** (This relates to the risk of a lack of a structured common information provision across council social work areas and NHS, which is monitored, evaluated and managed operationally within integrated functions of the Clackmannanshire and Stirling Health and Social Care Partnership).	**1.** National Core Outcome 'Resources are Used Effectively & Efficiently' **2.** Local Outcome 'Decision Making' **3.** HSCP priority ' Further develop systems to enable front line staff to access and share information'	Current (4) Target (3)	Current (4) Target (4)	Current (16) High Target (12) Medium	**1.** Building sufficient capacity and capabilities to carry out analytical functions for partnership in the long term including use of LIST Analysts **2.** Appropriate Information Sharing Agreements are in place and reviewed timeously. **3.** Develop use of SOURCE system to inform planning and benchmarking.	Chair of Data Sharing Partnership	This risk relates to Information Management and Governance. Including the difference between anonymised information, identifiable information, and performance information.
HSC 009	**Effective Links with other Partnerships** (This risk relates to partnership planning and effective links with other partnerships. Such as Community Planning, Third and Voluntary Sectors, Criminal Justice, Housing, Falkirk Health and Social Care Partnership, Emergency Planning and Resilience	**1.** National Outcome 'Resources are Used Effectively and Efficiently, and ' People are safe' **2.** Health and Social Care Partnership priority 'Develop single care pathways, and ' Provide more single points of entry to services'	Current (3) Target (2)	Current (3) Target (3)	Current (9) Medium Target (6) Low	**1.** Develop statutory links with Community Planning Partnerships in Clackmannanshire and Stirling. **2.** Develop links with Public Protection Fora. **3.** Clarification of Relationship and Accountabilities with Alcohol and Drug Partnerships at Forth Valley and Partnership levels. **4**. Develop relationships, linked to approach to Annual Performance Report, with 'peer' Health and	Chief Officer, Chief Finance Officer and Programme Manager	Links are currently established with partners, including: a) Criminal Justice Authority (and successors) and Community Planning Partnership (note: these are Statutory links) b) Alcohol and Drugs Partnership (ADP)

CLACKMANNANSHIRE & STIRLING HEALTH & SOCIAL CARE PARTNERSHIP: STRATEGIC RISK REGISTER AT 15 June 2018

Ref	Risk	Strategic Fit	Likelihood	Impact	Risk Score	Risk Reduction Action	Risk Owner(s)	Notes
	Partnership).					Social Care Partnerships **5.** Maintain effective working relationships with Third Sector Interface organisations and Providers through mechanisms such as Providers Fora.		and Public Protection fora c) Third and Independent Sectors – representation as appropriate at Integration Joint Board and Strategic Planning Group d) Housing Contribution Group e) Other Integration Authorities – via the Chief Officer, Chief Finance Officer and Integration Managers Networks
HSC 010	**Harm to Vulnerable People, Public Protection and Clinical & Care Governance** (This risk relates to the risk to self, to others, and from others. Public Protection and involves the strategic work of the Adult Protection Lead Officer, Child Protection Lead Officer, Mental Health Officers, Independent Chair of the Adult and Child Protection Committees, as well as processes such as PVG checking, and training procedures).	**1.** National Outcome 'Resources are Used Effectively and Efficiently', ' People are safe', 'Positive Experience', **2.** 'Quality of life' Local Outcome 'Self-Management' 'Community Focused Supports', 'safety', Experience' **3.** HSCP priority 'Develop single care pathways', ' Take further steps to reduce the number of unplanned admissions to hospital and acute	Current (2) Target (1)	Current (4) Target (4)	Current (8) Low Target (4) Low	**1.** Integration Joint Board has assurance that services operate and are delivered in a consistent and safe way. 2. Reviewed Clinical and Care Governance Framework (June 18 IJB) **2.** Services work together to strive to meet Delayed Discharge targets. **3.** Development of Health and Care Village in Stirling and agreement around model of care. **4.** Primary Care Out Of Hours Service Review. **5.** Review End Of Life Care pathways to ensure the right care is provided at the right time. **6.** Establishment of Quarterly	Chief Social Work Officers / NHS Forth Valley Medical Director	

CLACKMANNANSHIRE & STIRLING HEALTH & SOCIAL CARE PARTNERSHIP: STRATEGIC RISK REGISTER AT 15 June 2018

Ref	Risk	Strategic Fit	Likelihood	Impact	Risk Score	Risk Reduction Action	Risk Owner(s)	Notes
		services', 'Deliver Stirling Health and Care Village', 'Further develop anticipatory and planned care services''				Clinical and Care Governance Meetings. 7. Review of Intermediate Care Services 8. Linkage with Performance Frameworks		
HSC 011	**Sustainability and safety of adult placement in external care home and care at home sectors** Both Local Authorities utilise externally commissioned care home placements for adults, particularly older adults. External care homes are commissioned and inspected nevertheless risks arise from the sustainability of care homes as business models; having enough scrutiny at an earlier stage of any risks or concerns within a care home; reviews of adult placements by Local Authorities should take place at a minimum of once a year, this is a statutory requirement. Capacity to review is under significant pressure and an escalation method of concern needs put in place. Approach replicated, as appropriate for Care at Home providers.	1. National Outcomes 'People are Safe' 'Positive Experience' 2. Quality of Life	Current (3) Target (2)	Current (4) Target (2)	Current (12) Medium Target (4) Low	1. Provider forums are in place as is a commissioning and monitoring framework. 2. There is clear regulation and inspection. 3. The thresholds matrix for homes around adult support and protection has been implemented and is being monitored. 4. A process for reviews and a clear escalation model is being developed. This will be reported to the Clinical and Care Governance Group on a 6 monthly basis.	Relevant Service/ Locality Managers / Adult Support and Protection Coordinator	

CLACKMANNANSHIRE & STIRLING HEALTH & SOCIAL CARE PARTNERSHIP: STRATEGIC RISK REGISTER AT 15 June 2018

Ref	Risk	Strategic Fit	Likelihood	Impact	Risk Score	Risk Reduction Action	Risk Owner(s)	Notes
HSC 012	**Adult community nursing workforce demographic / resilience of service.** This risk relates to the sustainability of community nursing workforce as more than 30% will retire within next 5 years.	**Health and Social Care Outcomes** • **People can live well at home for as long as possible** • **People are safe and live well for longer** • **People are happy with the care they get**	Current (3) Target (2)	Current (4) Target (3)	(12) Medium Target (6) Low	1 Proactively implement Transforming community Nursing programme 2 Review Clinical and Care Governance Framework. **3** Review models of community working and optimise opportunities of integration. **4** Review End Of Life Care pathways to ensure the right care is provided at the right time. 5. proactive recruitment including opportunities for new roles, such as the building on the national funding for newly qualified nurses for practice nurse training to extend their experience to community work. 6. explore opportunities with staff to optimise retention. Flexible working, training, education. 7. consider organisational change opportunities to build workforce capacity.	Director of Nursing, Service Managers and Head of Community nursing.	

APPENDIX 1

CLACKMANNANSHIRE & STIRLING HEALTH & SOCIAL CARE PARTNERSHIP: STRATEGIC RISK REGISTER AT 15 June 2018

Ref	Risk	Strategic Fit	Likelihood	Impact	Risk Score	Risk Reduction Action	Risk Owner(s)	Notes
HSC 013	**Potential Impact of the UK Decision to Leave the EU (commonly referred to as Brexit)**	**1.** National Outcome 'Resources are Used Effectively and Efficiently, and ' People are safe'	Current (3) Target (2)	Current (4) Target (3)	12 (Medium) 6 (Low)	1. Work with constituent authorities to understand assessed risk in relation to commissioned services. 2. Use above to develop and partnership Brexit risk mitigation plan with specific regard to key areas such as supply chains (including drugs) and workforce. 3. Perioidically review plans in light of transistional arrangements and emergent issues.	Chief Officer	Existing constituent plans sought for consideration.

Explanation of Scoring:

Likelihood and Impact are Scored on a 1-5 Rating. The scores are then multiplied to give and overall risk score. Risk scores over 15 are rated High/Red. Risk Scores from 9 to 15 are rated Medium / Amber and risk scores up to 8 are rated Low/ Green.

Clackmannanshire & Stirling
Integration Joint Board

Audit Committee

10 December 2018

This report relates to
Item 6 on the agenda

Internal Audit Output Sharing Protocol

(Paper presented by Kevin O'Kane)

For Noting

Approved for Submission by	Ewan C. Murray, Chief Finance Officer
Author	Kevin O'Kane, Chief Internal Auditor
Date	10 December 2018
List of Background Papers: None	
Appendices: **Appendix 1** – Internal Audit Output Sharing Protocol between Clackmannanshire Council, NHS Forth Valley, Stirling Council and the Integration Joint Board	

Title/Subject:	**Internal Audit Output Sharing Protocol between Clackmannanshire Council, NHS Forth Valley, Stirling Council and the Integration Joint Board**
Meeting:	**Clackmannanshire & Stirling Integration Joint Board: Audit Committee**
Date:	**10 December 2018**
Submitted By:	**Kevin O'Kane, Chief Internal Auditor**
Action:	**For Noting**

1. Introduction

1.1 The Chief Internal Auditor to the Integration Joint Board has developed a draft Internal Audit Output Sharing Protocol (hereafter referred to as the 'Protocol') to govern, and set out specific arrangements that will apply to, the sharing of internal audit outputs between Clackmannanshire Council, NHS Forth Valley, Stirling Council and the Integration Joint Board.

1.2 A copy of the draft Protocol is attached at Appendix 1 for consideration by the Audit Committee.

2. Recommendations

The Audit Committee is asked to:

2.1. note the draft Internal Audit Output Sharing Protocol between Clackmannanshire Council, NHS Forth Valley, Stirling Council and the Integration Joint Board.

2.2. make any comments that it considers relevant to the content of the draft Internal Audit Output Sharing Protocol, and that should be considered before the draft Protocol is submitted for agreement and signing by relevant senior officers of the Integration Joint Board and the constituent authorities.

3. Considerations

3.1. The draft Internal Audit Output Sharing Protocol was developed at the request of the Chief Finance Officer to the Integration Joint Board. The chief audit executives of each of the constituent authorities were consulted on the content of the draft document.

3.2. The Scottish Government Integrated Resources Advisory Group (IRAG) published a Finance Guidance document in May 2015, providing guidance and advice on financial matters for health boards and local authorities in relation to the integration of health and social care. Section 2.4 of that document provides relevant guidance for the internal audit service to the Integration Joint Board.

3.3. Paragraph 2.4.1 of the IRAG Finance Guidance notes that the Integration Joint Board is responsible for establishing adequate and proportionate internal audit arrangements to review the adequacy of arrangements for risk management, governance and control of the resources delegated by the partner bodies.

3.4. Paragraph 2.4.7 recommends that the internal audit service should be provided by one of the internal audit teams from the health board or local authority. For the Clackmannanshire & Stirling Integration Joint Board, resources are provided jointly for the internal audit service by the partner bodies, with the Chief Internal Auditor role rotating between their chief audit executives on a 3-yearly basis.

3.5. Paragraph 2.4.2 notes that the operational delivery of services within the heath board and local authority (on behalf of the Integration Joint Board) will be covered by their respective internal audit arrangements. This recognises a limitation on the scope and reporting of the internal audit team(s) who, at the same time, also provide internal audit services to the Integration Joint Board.

3.6. Paragraph 2.4.4 recommends that the chief audit executives of each partner body share information and co-ordinate their activities with each other, and with other providers of assurance and consulting services, in order to:

- ensure the risk based audit plans for the Integration Joint Board, local authority and health board are co-ordinated; and
- ensure proper coverage, avoid duplication of efforts and determine areas of reliance from the work of each team.

3.7. The draft Protocol developed is, therefore, intended to govern and facilitate the sharing of relevant internal audit outputs, as required by the IRAG Finance Guidance, whereby:

- outputs prepared specifically for the Integration Joint Board will be shared with the chief audit executive of each of the partner bodies; and
- outputs prepared specifically for a partner body, and which meet specific criteria set out in the Protocol, will be shared with the Chief Internal Auditor of the Integration Joint Board.

3.8. The Protocol also provides that further internal audit outputs may be shared subject to approval by a relevant Director (or equivalent) and the chief audit executive of the body for whom the output has been prepared.

3.9. The detailed purposes of sharing outputs within the scope of the Protocol, and the specific outputs intended to be shared, are set out at Section 3 and Section 6 respectively in the Protocol.

4. Conclusions

4.1. The Internal Audit Output Sharing Protocol will provide a mechanism that governs the sharing of internal audit outputs between Clackmannanshire Council, NHS Forth Valley, Stirling Council and the Integration Joint Board. It will, therefore, strengthen the governance and delivery of the internal audit service provided to the Integration Joint Board.

5. Resource Implications

5.1. There are no resource implications directly associated with [noting/approving] the Internal Audit Output Sharing Protocol.

6. Impact on Integration Joint Board Priorities and Outcomes

6.1. This report, and the provision of an Internal Audit service in general, helps the Integration Joint Board and the Partnership in their delivery against National Health & Wellbeing Outcome 9: Resources are used effectively and efficiently - to deliver Best Value and ensure scarce resources are used effectively and efficiently in the provision of health and social care services.

7. Legal & Risk Implications

7.1. There are no legal implications directly associated with noting / approving the Internal Audit Output Sharing Protocol.

7.2. Noting / approving the Internal Audit Output Sharing Protocol will help address risk HSC002 in the Strategic Risk Register: Leadership, Decision Making and Scrutiny (including effectiveness of governance arrangements and potential for adverse audits and inspections).

8. Consultation

8.1. None.

9. Equality and Human Rights Impact Assessment

9.1. N/A.

10. Exempt reports

10.1. Not exempt.

Appendix 1

Clackmannanshire & Stirling Integration Joint Board

Internal Audit Output Sharing Protocol between Clackmannanshire Council, NHS Forth Valley, Stirling Council and the Integration Joint Board

Introduction

1. Internal Audit for the Clackmannanshire & Stirling Integration Joint Board is provided jointly by the internal audit functions of the three partner bodies: in practice, this is delivered as an annual resource contribution from each of those functions, with the Chief Internal Auditor appointment rotating between the three on a 3-yearly basis. This arrangement was approved by the Integration Joint Board on 24 February 2016.

2. This protocol is intended to facilitate the sharing of relevant internal audit outputs as follows:

    - outputs prepared specifically for the Integration Joint Board will be shared with the chief audit executive of each of the partner bodies; and,
    - outputs prepared specifically for a partner body, and which meet any of the criteria set out at paragraph 6 of this document, will be shared with the Chief Internal Auditor of the Integration Joint Board.

3. The purposes of sharing outputs within the scope of this protocol are:

    - to inform the risk-based internal audit plans for the Integration Joint Board
    - to enable the Audit Committee of the Integration Joint Board to identify planned internal audit reviews of commissioned services within the partner bodies, and to be provided with assurance on progress against agreed management actions.
    - to inform the Chief Internal Auditor's annual report (including assurance opinion) to the Integration Joint Board
    - to support effective scrutiny by the audit committee (or equivalent) of the Integration Joint Board and each of the partner bodies
    - to support effective 'following the public pound' arrangements within all bodies covered by this protocol
    - to facilitate joint and/or co-ordinated working across the partner bodies where this is merited, and to minimise duplication of effort
    - to comply, so far as is appropriate and while safeguarding confidentiality, with principles of openness and transparency
    - to meet expectations set out in health and social care integration guidance issued by the Scottish Government

4. The term 'chief audit executive' describes a person in a senior position responsible for effectively managing the internal audit activity: the specific job title of the chief audit executive may vary across the partner bodies. Currently, the title of the Integration Joint Board's chief audit executive is Chief Internal Auditor.

5. Where an output has been shared under this protocol, the chief audit executive who receives the output will determine whether and in what form it is presented to relevant senior management and/or the audit committee of the body that has received it.

6. The outputs to be covered by this protocol will include, as a minimum:
    - the annual and, where they exist, strategic, internal audit plans for the Integration Joint Board
    - the approved annual internal audit plan for NHS Forth Valley
    - the published annual internal audit plans of Clackmannanshire Council and Stirling Council
    - the Chief Internal Auditor's annual report to the Integration Joint Board
    - the published internal audit reports to the Integration Joint Board
    - the published internal audit reports of Clackmannanshire Council and Stirling Council, where the subject of these is a service commissioned by the Integration Joint Board;
    - summaries of the final internal audit reports for NHS Forth Valley, or of relevant issues from within those reports, where the subject of these is a service commissioned by the Integration Joint Board
    - the published internal audit reports of Clackmannanshire Council and Stirling Council, where the subject of these is a support service commissioned by the Integration Joint Board;
    - summaries of relevant issues from within final internal audit reports for NHS Forth Valley where the subject of these is a support service relevant to services commissioned by the Integration Joint Board
7. The term "published" above means that the output has been made available on the public website of the body for which the report has been prepared. The reports themselves may take a range of forms (for example, full report, summary report, extract from progress report). Note that, at the present time, internal audit reports for NHS Forth Valley are not normally made public.
8. Any further outputs may be shared where this is approved by both a relevant Director (or equivalent) and the chief audit executive of the body for whom the output has been prepared.

Clackmannanshire & Stirling
Integration Joint Board

Audit Committee

10 December 2018

This report relates to
Item 7 on the agenda

Accounts Commission Report: Health and Social Care Integration: Update on Progress

(Paper presented by Kevin O'Kane)

For Noting

Approved for Submission by	Ewan C. Murray, Chief Finance Officer
Author	Kevin O'Kane, Chief Internal Auditor
Date	10 December 2018
List of Background Papers: Health and Social Care Integration - Accounts Commission and Auditor General (December 2015) Integration Joint Board Audit Committee 24 August 2018: Agenda Item 9 - Audit Scotland: Health and Social Care Integration: Project Scope	
Appendices: Appendix 1 – Health and Social Care Integration: Update on Progress - Accounts Commission and Auditor General (November 2018)	

Title/Subject:	**Accounts Commission Report: Health and Social Care Integration: Update on Progress**
Meeting:	**Clackmannanshire & Stirling Integration Joint Board: Audit Committee**
Date:	**10 December 2018**
Submitted By:	**Kevin O'Kane, Chief Internal Auditor**
Action:	**For Noting**

1. Introduction

1.1 The Accounts Commission and Auditor General for Scotland jointly published their report: 'Health and Social Care Integration: Update on Progress' on 15 November 2018. The report was prepared by Audit Scotland and a copy is attached at Appendix 1.

1.2 This is a national report setting out key messages and recommended actions that are relevant to all Councils and Integration Joint Boards across Scotland, and are not directed solely at the Clackmannanshire and Stirling Integration Joint Board.

1.3 The Chief Internal Auditor is drawing this report to the attention of the Audit Committee in accordance with good governance practice. Integration Joint Board officers are currently preparing a specific response and action plan to address the relevant recommended actions in the national report, and will bring those forward to the Committee for consideration in February 2019.

2. Executive Summary

2.1. On 3 December 2015, the Accounts Commission and Auditor General for Scotland jointly published a national report titled 'Health and Social Care Integration'. This followed an early review carried out on their behalf by Audit Scotland, of the integration of health and social care services across Scotland under the Public Bodies (Joint Working) (Scotland) Act 2014.

2.2. In March 2018, Audit Scotland published the scope of a second review it would carry out on behalf of the Accounts Commission and Auditor General for Scotland. The Chief Officer presented a paper to the Integration Joint Board Audit Committee on 24 August 2018, providing a copy of the project scope, and noted that the report and findings of that review would be published in November 2018.

2.3. The 'Health and Social Care Integration: Update on Progress' report was jointly published by the Accounts Commission and Auditor General for Scotland on 15 November 2018.

2.4. The report highlights that integration authorities oversee almost £9 billion of health and social care resources, of which over 70% (£5.9 billion) comes from NHS boards and the remainder from councils (£2.4 billion), money which they previously managed directly. In 2017/18, integration joint boards reported an overall underspend of £39.3 million (0.4% of their total income allocation for the year). However, this masks a much more complex picture of their finances, and many struggled to achieve financial balance at the year-end due to rising demand for services, financial pressures and their quality of financial planning.

2.5. The report notes that significant changes are required in a number of areas to support effective health and social care integration and service delivery. These include:

- strategic and financial planning;
- governance;
- leadership and strategic capacity;
- data and information sharing; and
- engagement at national and local level between politicians, communities and staff.

2.6. Pages 6 and 7 of the report set out 16 recommendations in total for the Scottish Government, COSLA and public bodies to consider and undertake; 9 of those are recommendations for integration authorities, councils and NHS Boards to take forward collaboratively. Those recommendations relate to five key areas, and more details are out at paragraphs 5.3 and 6.1 of this report.

2.7. Appendix 3 of the report (pages 43 to 46) summarises progress made by the Scottish Government, COSLA and public bodies against the recommendations in the previous Accounts Commission and Auditor General for Scotland report 'Health and Social Care Integration', published in December 2015.

2.8. Appendix 4 of the report (page 47) sets out details of the financial position for 2017/18 of all integration joint boards across Scotland, including underspends, overspends, their year-end position and any additional funding allocations required from constituent partners.

3. Recommendations

The Audit Committee is asked to:

3.1. note the contents of the Accounts Commission and the Auditor General for Scotland national report titled 'Health and Social Care Integration: Update on Progress', attached at Appendix 1, and in particular the key messages and recommendations at sections 5 and 6 of this covering report;

3.2. note that Integration Joint Board officers are preparing a specific response and action plan to address the relevant recommendations in the national report,

and will bring those forward to the Committee for consideration in February 2019; and

3.3. to make any comments or recommendations the Committee considers may be necessary or appropriate for the Integration Joint Board to undertake in order to meet the best practice set out in the report by the Accounts Commission and Auditor General for Scotland.

4. Background

4.1. The Accounts Commission is the public spending watchdog for local government. It holds councils, joint boards and committees in Scotland to account and helps them to improve. It operates impartially and independently of councils and of the Scottish Government, and meets and reports in public. Audit Scotland is a statutory body set up in April 2000, under the Public Finance and Accountability (Scotland) Act, 2000. It provides services to the Auditor General for Scotland and the Accounts Commission for Scotland.

5. Purpose and Key Messages

5.1. The purpose of the report is to examine the impact public bodies are having as they integrate health and social care services. It does not focus in detail on local processes or arrangements, but it does complement strategic inspections carried out by the Care Inspectorate and Healthcare Improvement Scotland.

5.2. The Accounts Commission and Auditor General for Scotland set out the following key messages in the report:

- integration authorities have started to introduce more collaborative ways of delivering services, and to improve in several areas, including reducing unplanned hospital activity, delayed discharges and people at the 'end of life' spending more time at home or in a homely setting, than hospital. These improvements show that integration can work within the current legislative framework, but integration authorities 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. This fundamental issue will limit the ability of integration authorities to improve the health and social care system. Financial pressures in health and care make it difficult for integration authorities, which were designed to control some budgets and services provided by acute hospitals, to achieve meaningful change. This key part of the legislation has not been enacted in most areas;
- 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 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; and,

- 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.

5.3. The report sets out five key areas that need to be addressed if health and social care services integration is to make a meaningful difference in Scotland, with recommendations for councils, NHS boards and Integration Authorities to consider and undertake in each area. These are set out in more detail at paragraph 6.1 below, and cover:

- agreed governance and accountability arrangements;
- meaningful and sustained engagement;
- ability and willingness to share information;
- integrated finances and financial planning; and,
- effective strategic planning for improvement.

5.4. In terms of integration joint board (IJB) finances for 2017/18 financial year, the report highlights that:

- 14 IJBs had a financial surplus between £0.2 million and £12.3 million for various reasons including: achieving savings early; contingencies not required; slippages in spending plans and projects; and staff vacancies;
- 15 IJBs ended the year with at financial 'break-even', and one IJB had a deficit of £2.6 million;
- 28 IJBs needed additional, unplanned funding allocations from at least one of their partners to achieve 'break-even' at the year-end. NHS boards contributed to £33.3 million, and councils £19.1 million to this;
- 8 IJBs drew a total of £9.1 million from reserves to help achieve 'break-even'; 4 also required additional funding from at least one of their partners to achieve this, as noted above;
- 14 IJBs added to their reserves, amounting to £41.9 million, but the level of reserves held varied across IJB's, and not all integration schemes allow the IJB to hold reserves, which totalled £125.5 million or 1.5% of total income; and
- reserves were not always planned and, in some areas, arose for reasons including late allocations of money; unspent strategic funding; vacancies; or year-end timing differences. 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.

5.5. The report notes that, for the Clackmannanshire & Stirling Integration Joint Board, the 2017/18 year-end position was 'break-even', after use of reserves of £1.1 million and additional contributions from the Council and NHS of £0.6 million each. Reserves were £2.4 million, or 1.3% of total income.

6. Recommendations

6.1 The report recommends that integration authorities, councils and NHS boards should consider and undertake the following, in each area:

Effective strategic planning for improvement

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

Integrated finances and financial planning

- 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; and
- view 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

- 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

- share learning from successful integration approaches across Scotland;
- address data and information sharing issues, recognising that in some cases national solutions may be needed; and
- 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

- 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.

7. Conclusions

7.1. The report by the Accounts Commission and the Auditor General for Scotland highlights key messages and makes a number of recommendations that are relevant to the Clackmannanshire & Stirling Integration Joint Board. These have been summarised at Section 6 of this report, and Integration Joint Board officers are preparing a specific response and action plan to address the relevant recommendations: they will bring those forward to the Committee for consideration in February 2019.

8. Resource Implications

8.1. There are no resource implications directly associated with drawing attention to the Accounts Commission and the Auditor General for Scotland's report.

9. Impact on Integration Joint Board Priorities and Outcomes

9.1. This report, and the provision of an Internal Audit service in general, helps the Integration Joint Board and the Partnership in their delivery against National Health & Wellbeing Outcome 9: Resources are used effectively and efficiently - to deliver Best Value and ensure scarce resources are used effectively and efficiently in the provision of health and social care services.

10. Legal & Risk Implications

10.1. There are no legal implications directly associated with drawing attention to the Accounts Commission and the Auditor General for Scotland's report.

10.2. Consideration of the Accounts Commission's report, and actions in response to the recommendations contained within, will help address risk HSC002 in the Strategic Risk Register: Leadership, Decision Making and Scrutiny (including effectiveness of governance arrangements and potential for adverse audits and inspections).

11. Consultation

11.1. None.

12. Equality and Human Rights Impact Assessment

12.1. N/A.

13. Exempt reports

13.1. Not exempt.

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.

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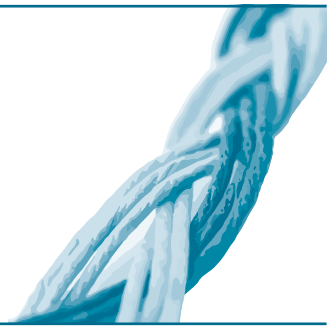


Links

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.

Audit team

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

Key facts

Savings Integration Authorities needed to achieve in 2017/18

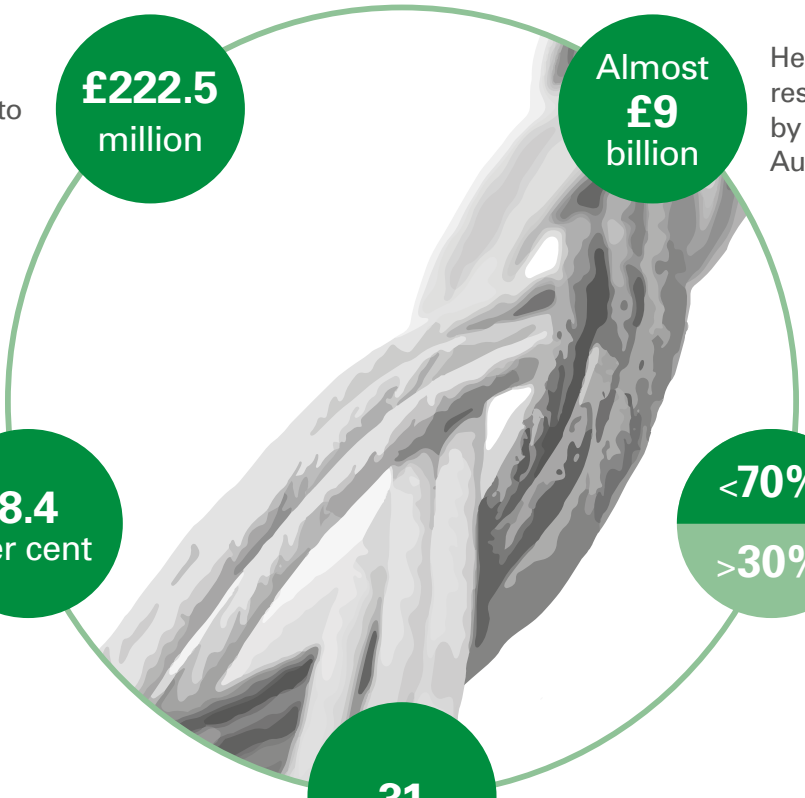
£222.5 million

Almost **£9 billion**

Health and social care resources directed by Integration Authorities

Increase in required savings from 2016/17

8.4 per cent



<70%

>30%

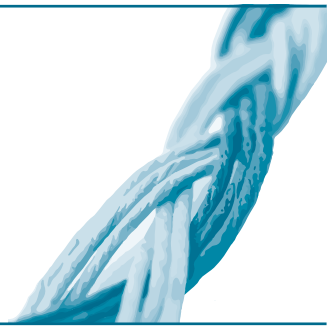
Integration Authority funding comes from the NHS

Funding comes from local authorities

31

Integration Authorities established through partnerships between the 14 NHS boards and 32 councils in Scotland

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:

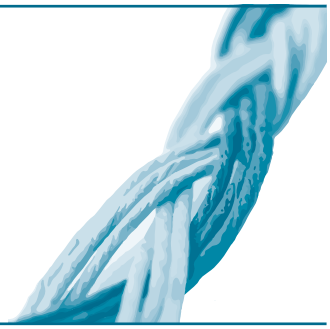
- share learning from successful integration approaches across Scotland
- address data and information sharing issues, recognising that in some cases national solutions may be needed
- review and improve the data and intelligence needed to inform integration and to demonstrate improved outcomes in the 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.

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

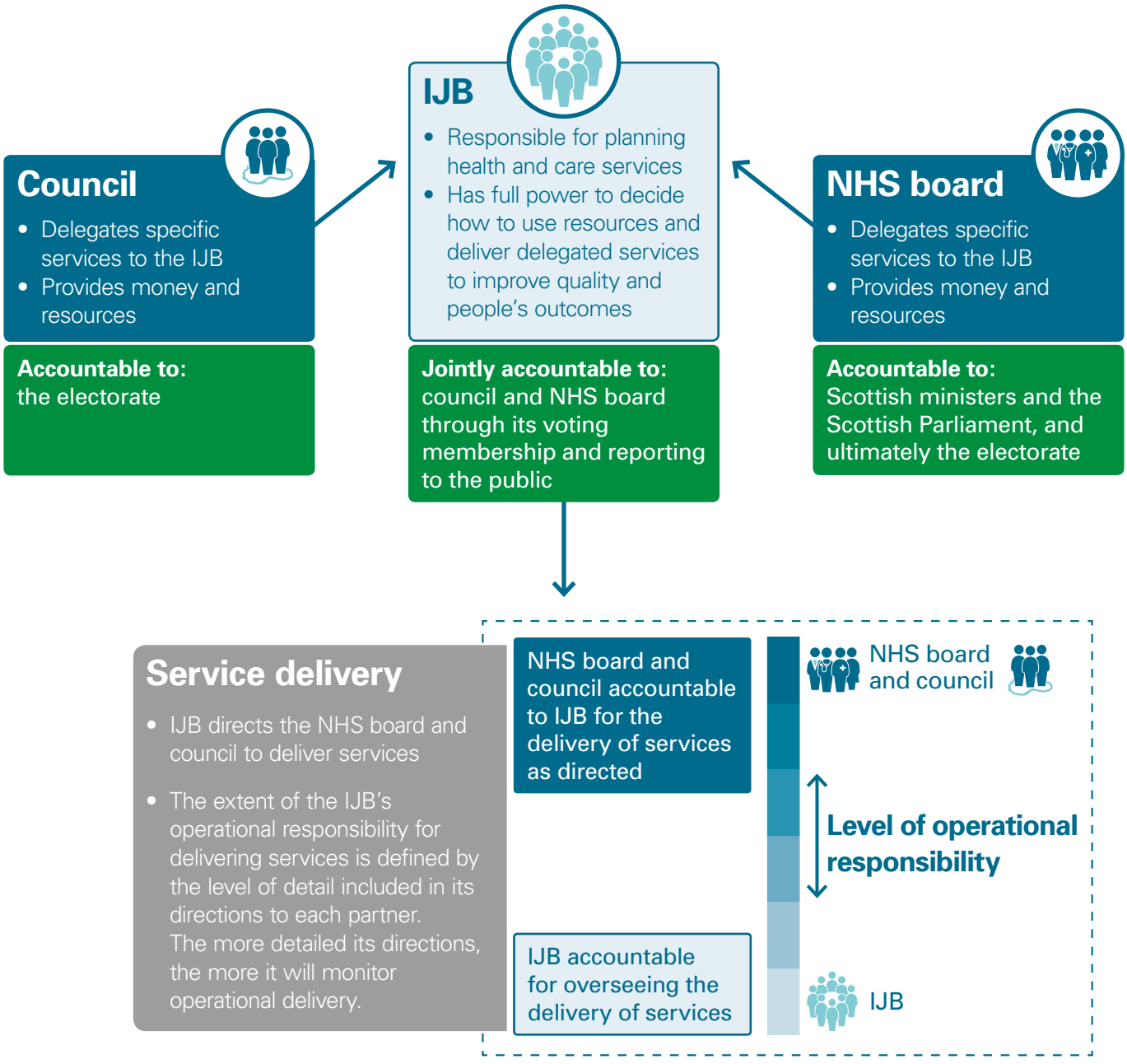
the reforms affect everyone who receives, delivers and plans health and social care services in Scotland

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

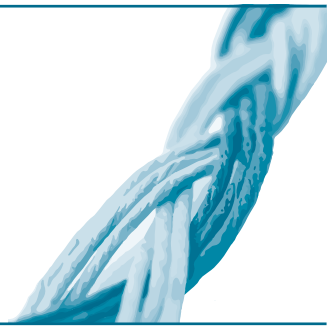
There are 30 Integration Joint Boards across Scotland.



Source: Audit 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:

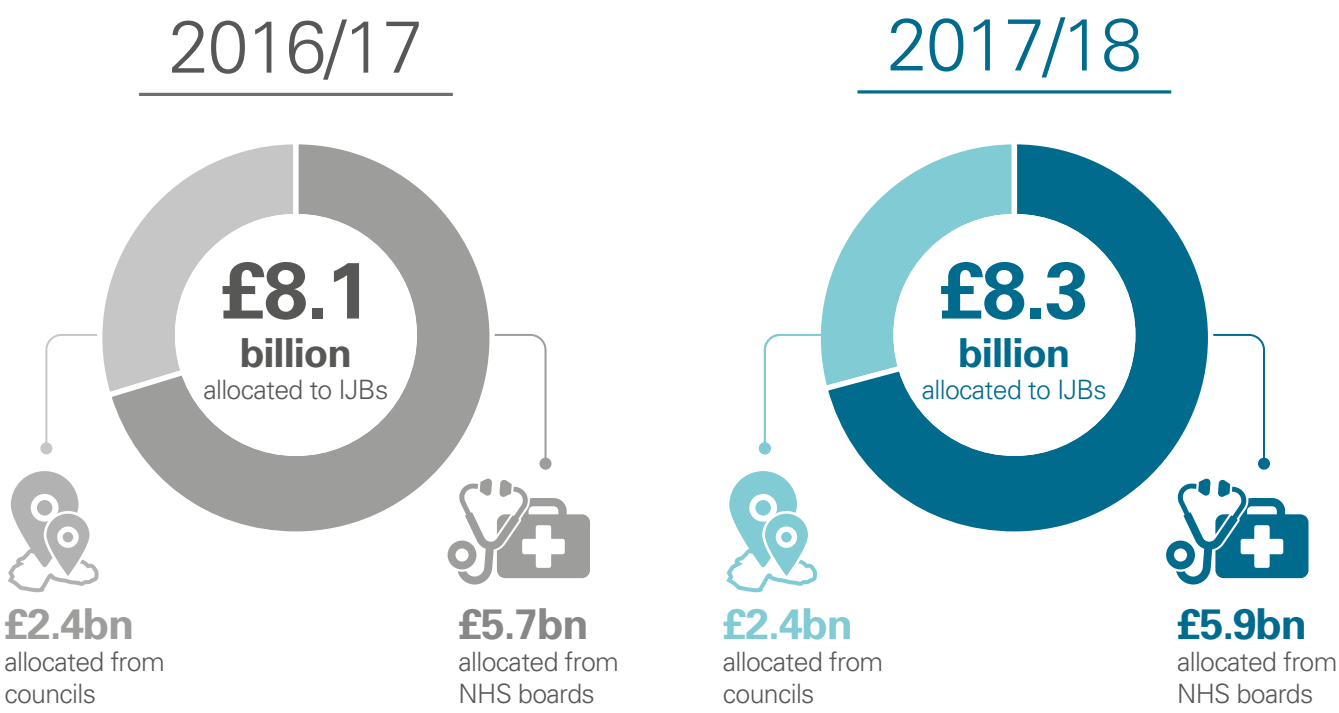
- as a working balance to help prevent the impact of uneven cash flows
- as a contingency to cushion the impact of unexpected events or emergencies
- held to fund known or predicted future requirements – often referred to as 'earmarked reserves'.[3]

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:

- 17 needed additional money from NHS boards amounting to £33.3 million
- 11 needed additional money from councils amounting to £19.1 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.

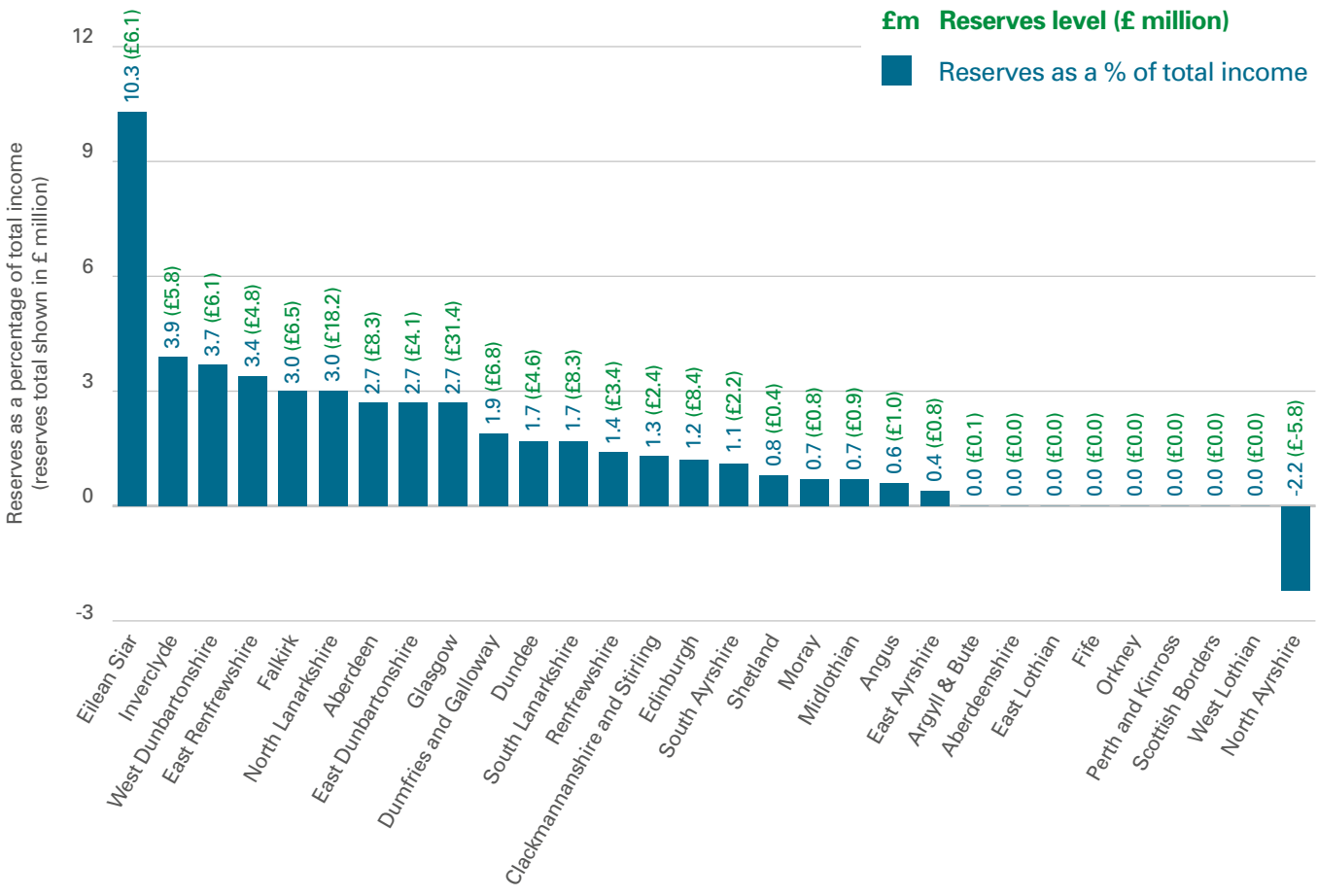
Reserves

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.



Source: Integration Authority annual accounts, 2017/18

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:

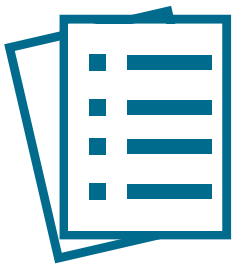
- **Outcome:** We are healthy and active
- **Indicators:** Healthy life expectancy, mental wellbeing, healthy weight, health risk behaviours, physical activity, journeys by active travel, quality of care experience, work-related ill health, premature mortality
- **Sustainable development goals:** gender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

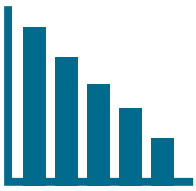
Cont.

Exhibit 4 (continued)



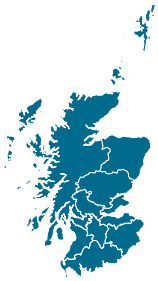
12 principles within the Act

- 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

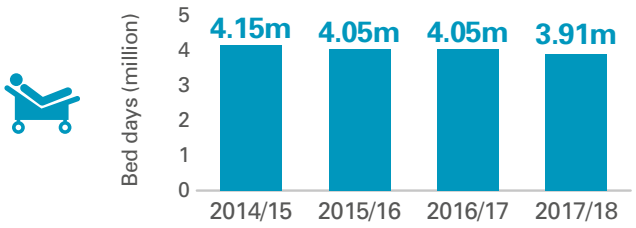
Source: Audit Scotland

Exhibit 5

National performance against six priority areas

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

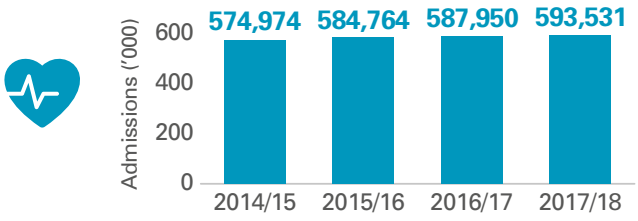
1. Acute unplanned bed days



Integration aims to reduce unplanned hospital activity

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

2. Emergency admissions

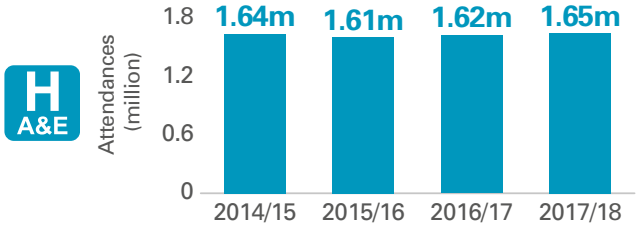


Integration aims to ensure that people's health and care needs are anticipated and planned appropriately, reducing unplanned hospital activity

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

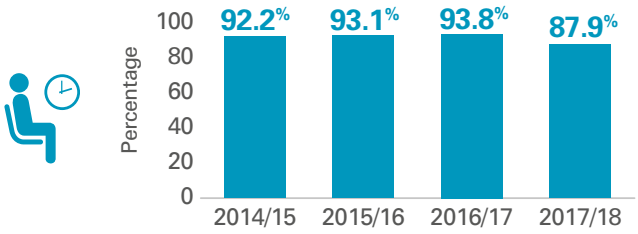


A&E attendances can be an indication of the degree to which community services are helping people receive care in the right place at the right time.

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

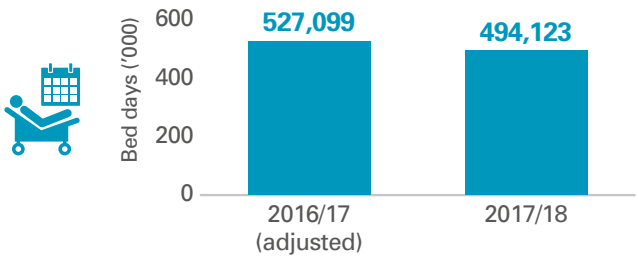
3b. Achievement of the four-hour A&E waiting time target



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+)

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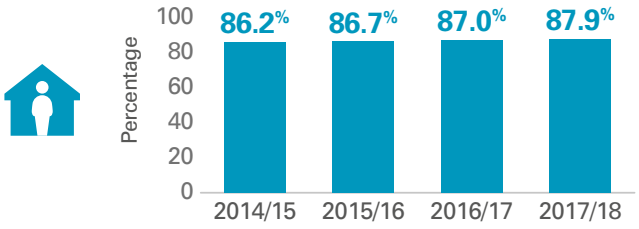
Exhibit 5 (continued)

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

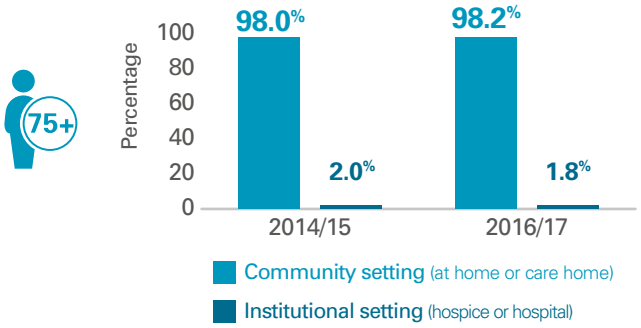


Integration aims to support people with health and care needs in their own home or in a community setting, especially at the end of life.

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
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 specialty of geriatric long stay is excluded.
2. 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.
3. Unscheduled bed days relate to all occupied bed days within a continuous hospital stay following an emergency or urgent admission.
4. The Scotland total presented is the sum of all those resident in IA areas and excludes non-Scottish residents.
5. 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.
6. Based on data submitted to ISD in August 2018.

Indicator 2
1. ISD published data as at September 2018.

Indicator 3a
1. ISD published data as at August 2018.

Indicator 3b
1. ISD published data as at June 2018.
2. Performance for the month ending March for each year.

Indicator 4
1. ISD published data as at September 2018.
2. 2016/17 figures adjusted to reflect revised definitions across the whole year.

Indicator 5
1. ISD published data as at October 2018.

Indicator 6
1. 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.
2. Figures provided by ISD.

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

Source: Information Services Division (ISD) and Scottish Government

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.

Cont.

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.

Cont.

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).

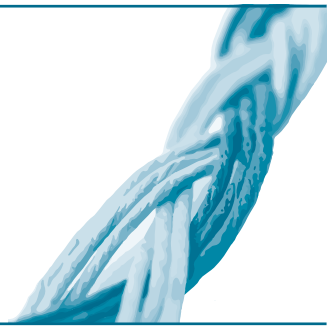
Angus

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.

Source: Audit Scotland review of Integration Authorities' Performance Reports, 2018

Part 2

Making integration a success

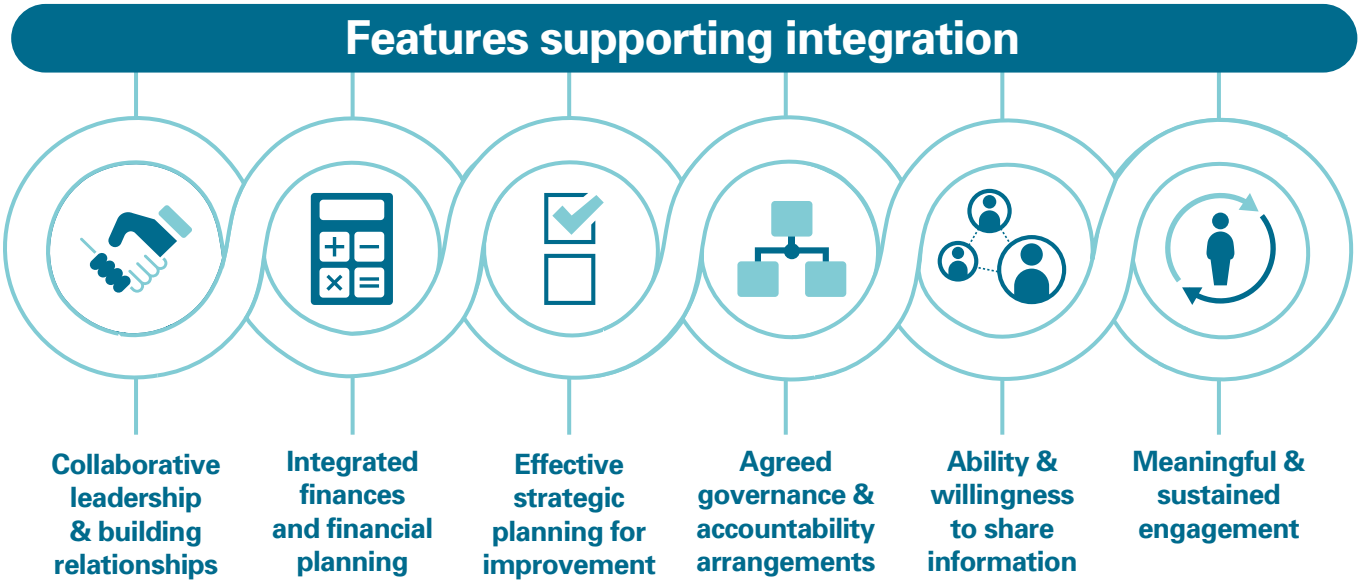


29. IAs are addressing some significant, long-standing, complex and inter-connected issues in health and social care. Our work has identified six key areas that, if addressed, should lead to broader improvements and help IAs to take positive steps toward making a systematic impact on health and care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

Source: Audit Scotland, 2018; from various publications by The Kings Fund; Our Voice; Scottish Government; Health and Sport Committee and the Scottish Social Services Council.

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 responsibly 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.

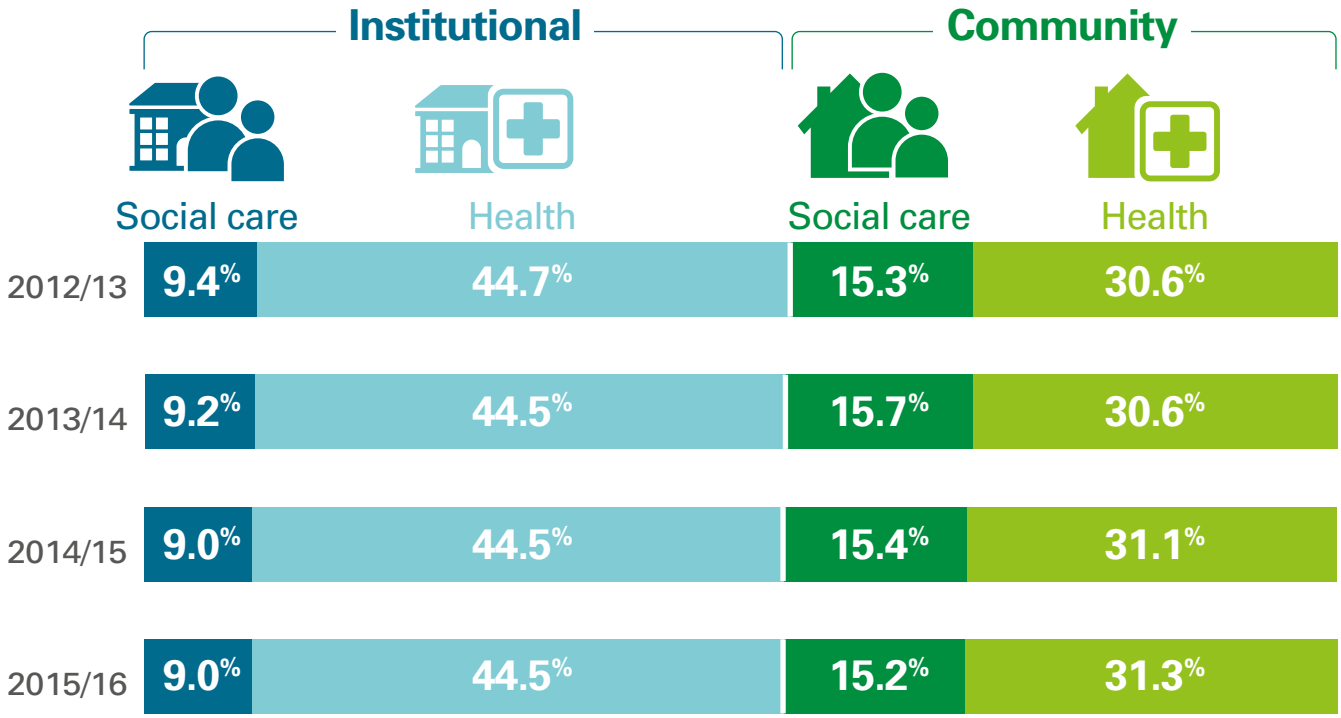
53. Attempts at integrating health and social care go back several years and it is not possible to identify the full cost of the reforms. This, in part, is due to the scale of the reforms and the interconnectedness with the rest of the health and social care system.

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.

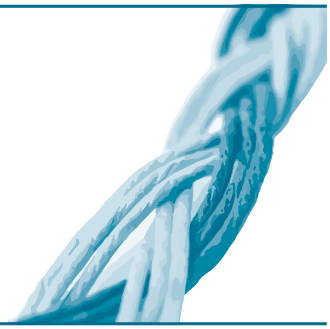
In addition to this involvement, the IJB has also embarked upon a review of its grants to the third-sector. This has been done in full collaboration and partnership with the third-sector. Through the SPG, a steering group was appointed, again with the involvement of LCHIF. This involvement contributed 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.	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.
• 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.	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.
• 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.	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.

Cont.

Recommendations	Progress
Integration Authorities should:	
• provide clear and strategic leadership to take forward the integration agenda; this includes: – 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.	We found that a lack of collaborative leadership and cultural differences are proving to be significant barriers to change in some areas.
• 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: – 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.	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. 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.
• ensure that a constructive working relationship exists between IJB members and the chief officer and finance officer and the public. This includes: – 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.	IAs have helped to improve engagement with the public and providers in the local area in some instances but there is more to do.
• be rigorous and transparent about how decisions are taken and listening and acting on the outcome of constructive scrutiny, including: – 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.	We found that decision-making is not localised or transparent in some areas and risk management arrangements are not well developed.

Cont.

Recommendations	Progress
• develop strategic plans that do more than set out the local context for the reforms; this includes: – 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.	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.
• 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: – 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.	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. Financial planning is not integrated, or long term and financial pressures make meaningful change hard to achieve. Arrangements for understanding and measuring Best Value arrangements are not well developed.
• 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.	We found there has been limited change in how resources are being used across the system at this stage – see above.

Cont.

Recommendations	Progress
Integration Authorities should work with councils and NHS boards to:	
• 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.	We found a lack of agreement over governance and a lack of understanding about integration remain significant barriers in some areas. 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.
• 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.	Auditors report that members of IA leadership have differing views about governance, especially clinical governance, and roles and responsibilities.
• 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.	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. 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.
• 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.	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.
• put in place data-sharing agreements to allow them to access the new data provided by ISD Scotland.	IAs and ISD are have difficulties in agreeing data-sharing protocols for using national databases.

Appendix 4

Financial performance 2017/18

IJB	**Position** (pre-additional allocations) **Overspend/** (underspend)	**Additional allocation/ (reduction)** **Council**	**NHS board**	**Use of reserves**	**Year-end position Deficit/ (Surplus)**
	(£million)	(£million)	(£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	2.2	0.6	0.6	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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Clackmannanshire & Stirling
Integration Joint Board

Audit Committee

10 December 2018

This report relates to
Item 8 on the agenda

Strathcarron Hospice: Hospice at Home Inspection Report

(Paper presented by Shiona Strachan, Chief Officer)

For Noting

Approved for Submission by	Shiona Strachan, Chief Officer
Author	Ewan C. Murray, Chief Finance Officer
Date	3 December 2018
List of Background Papers:	
Appendix 1: Inspection Report	

Title/Subject:	**Hospice at Home: Inspection Report**
Meeting:	**Clackmannanshire & Stirling Integration Joint Board: Audit Committee**
Date:	**10 December 2018**
Submitted By:	**Ewan C. Murray, Chief Finance Officer**
Action:	**For Noting**

1. Introduction

1.1 The Hospice at Home service was inspected by the Care Inspectorate in July 2018. This purpose of this report is to provide assurance on the services commissioned by the Integration Joint Board.

2. Recommendations

The Audit Committee is asked to:

2.1. Note the inspection report and gradings therein.

3. Inspection Report

3.1. The Care Inspectorate undertook an unannounced inspection of the Hospice at Home Service in July 2018.

3.2. The inspection report graded the services as:

Quality of care and support 6 - Excellent
Quality of staffing not assessed
Quality of management and leadership 6 – Excellent

3.3. The Audit Committee are also asked to note the postive client feedback on the service contained in the report.

4. Resource Implications

4.1. None arising.

5. Impact on Integration Joint Board Priorities and Outcomes

5.1. Supporting people to remain in their own homes for as long as possible is a Partnership priority.

6. Legal & Risk Implications

6.1. Inspection reports form part of effective assurance systems in relation to the services commissioned by the Integration Joint Board.

7. Exempt reports

7.1. Not exempt.

Hospice at Home
Support Service

Strathcarron Hospice
Randolph Hill
Fankerton
Denny
FK6 5HJ

Telephone: 01324 826222

Type of inspection:
Unannounced

Completed on:
19 July 2018

Service provided by:
Strathcarron Hospice a company limited by guarantee

Service provider number:
SP2003002729

Service no:
CS2014323454

About the service

The Hospice at Home service is based within Strathcarron Hospice, a charitable organisation located on the outskirts of Denny. Hospice at Home provides personal, practical and emotional support to residents of Forth Valley, Cumbernauld and Kilsyth (North Lanarkshire).

The service is available in the last two weeks of life and its stated aim is to "provide personal care to those who choose to die at home, to listen to what's important to them and their family/carers, to provide support with decisions about end of life care, and to support families in their caring role."

The service is available seven days a week and the Hospice at Home team work with District Nurses, Social Services and others to provide care and support at a crucial time in people's lives.

This service registered with the Care Inspectorate on 19 August 2014.

What people told us

Prior to the inspection, care service questionnaires (CSQ's) were issued to people using the service, their relatives and members of staff. We also spoke to relatives, staff and allied professionals during the inspection. The feedback we received was overwhelmingly positive with regards to all aspects of the Hospice at Home service.

We saw that the service played a valuable role during end of life. Patients' relatives told us that their loved ones felt listened to and supported and that their wishes mattered. They also told us how much they themselves valued their relationship with the staff team. We heard that staff were kind, compassionate and respectful and delivered care and practical support with patience and sensitivity. The team were able to build trusting relationships with those they cared for and their families/carers and had the knowledge and understanding to know what support was required at different stages. People spoke positively about the quality of care and support they received, they told us it was second to none, that they were given choice and that their wishes and aspirations regarding their treatment and delivery of care was always respected.

Comments included:

"They always know what to do and their confidence makes you trust them."
"They go the extra mile."
"You can tell the staff are well-trained, they always knew how to respond, even when I was angry, upset and distressed."
"They were always there for us, not just our loved one but also the family."
"I didn't ever have to ask, they thought ahead for what we might need."
"We will always be grateful for everything they did to help us through these last days and the compassion, time and support given during an extremely difficult time."
"Staff are well-trained, they are full of compassion and provide excellent care."
"The staff are brilliant."
"The service is unique."

Members of the staff team spoke with pride and passion about their work and demonstrated knowledge and values consistent with the service's aims and objectives. We saw that staff supported each other and that there was a strong team spirit.

Staff told us;

"From the beginning of my employment I have been trained and supported to perform my duties to the best of my ability."
"I feel very privileged to work in this role"
"I can access as much training and support as I need."
"I would not want to do anything else, I love my job."
"I love working here."
"The training and support is exceptional. Everyone pulls together and works together."
"The manager is amazing, we are always being encouraged to talk about what we do, we are given the chance to lead and mentor new staff coming in, we are part of a big team."
"It's the most amazing job I could ever ask for, I feel so proud to say I work here, there is so much job satisfaction, we have so much support and opportunities to talk about scenarios of any kind, and how we feel."
"It is entirely different working here to other places, it is a privilege working here because you actually get the chance to care for people properly."
"There are always enough staff to ensure people receive quality care, we are able to talk and spend time with people."

Self assessment

We did not request a self assessment this year but looked at the services own development and improvement plan as part of the inspection.

From this inspection we graded this service as:

Quality of care and support	6 - Excellent
Quality of staffing	not assessed
Quality of management and leadership	6 - Excellent

Quality of care and support

Findings from the inspection

The values and aims of Hospice at Home were visible and demonstrated at all levels of the service. There was a clear emphasis on respect and ensuring dignity for patients in their last days. Patients and their relatives/carers received outstanding care from staff that were well-trained, compassionate and understanding and who had distinctive skills in supporting people with end of life care. People told us they were confident in the knowledge and expertise of the team. We saw that care and support was provided in a range of flexible ways and tailored towards individual choice and need. The service took time to get to know patient's needs, ensured it had all the necessary information to support and fulfil patient's wishes and was able to effectively manage any risks in relation to them being supported at home. individuals rights were embedded in the care provided with a strong emphasis on dignity, respect, inclusion and compassion.

We saw that Hospice at Home provided a specialised, flexible and responsive service. It responded promptly at times of crisis not only in terms of the care provided to patients but also in ensuring that families were informed, skilled and equipped to care for their loved ones, whilst recognising the importance of choice. There were strong links with the local community and people received co-ordinated person-centred care through outstanding

partnership working with patients, their families and other professionals, thus ensuring consistently high quality support and joined-up care. The service worked with patients to identify what was important to them and ensured that patients and their families were included and involved in key decisions about their care. Due to effective communication and appropriate sharing of information, people's care and treatment was consistent, flexible and properly informed to meet their needs. Staff had an enabling attitude and were able to vary the time spent with patients in order that the care and support provided, matched patients and families need at that particular time.

Patients and their families were provided with the emotional and bereavement support they needed, both during and after end of life care. Bereavement visits/telephone calls were carried out on the day, or the day after bereavement to allow families/carers the opportunity to talk or ask questions, following which the Hospice Bereavement service kept in touch, offering counselling and tailored support in line with people's wishes.

Requirements

Number of requirements: 0

Recommendations

Number of recommendations: 0

Grade: 6 - excellent

Quality of staffing

This quality theme was not assessed.

Quality of management and leadership

Findings from the inspection

We were very impressed with the quality of management and leadership and saw that there was a strong focus on continuous improvement. This was visible at all levels and inspired staff to provide a quality service. The manager demonstrated an excellent understanding and knowledge of end of life care at home as well as the range of services and resources available. The manager encouraged a culture of trust, respect, openness, transparency and ownership at all levels. This was reiterated when speaking to staff and it was clear that there was a shared commitment to delivering the highest quality end of life care to people in their own homes. Staff told us that they received emotional support and guidance, that they felt valued and were encouraged to share their ideas and participate in developing the service. They worked as a team and looked after each other, coming together regularly to discuss the emotional aspects of their work. The manager gave up-to-date and detailed handovers at the start of each shift. This information was person-centred and included an update on family members and their concerns or needs. The manager was also available to give advice during visits and for debriefs at the end of shifts. The manager worked hard to support and build resilience within the team, acknowledging that there was a strong link between the ethos of the service, a skilled and supported staff team and the outcomes for people using the service.

All staff had undergone robust pre-employment and recruitment checks with their suitability for the role assessed prior to being appointed. Staff also received on-going training to ensure they were continually updating their knowledge and skills and were providing best practice in end of life care. This ensured that patients received evidence based care from experienced staff with the skills and competencies to provide effective and high quality support. As part of the services quality assurance process the manager used a range of methods to seek feedback from those using the service, their relatives, staff and other professionals. We saw that there were consistent themes from the information gathered and what people told us. These included; excellent care and support for patients and their families, kind, skilled and professional staff and excellent management and leadership. This feedback helped monitor and improve the quality of people's care and evidenced a history of sustained improvement and outstanding practice over a period of time.

Requirements

Number of requirements: 0

Recommendations

Number of recommendations: 0

Grade: 6 - excellent

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

There are no outstanding recommendations.

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	
16 Aug 2017	Unannounced	Care and support Environment Staffing Management and leadership	6 - Excellent Not assessed 6 - Excellent Not assessed
25 Jul 2016	Unannounced	Care and support Environment Staffing Management and leadership	6 - Excellent Not assessed Not assessed 6 - Excellent
21 Jul 2015	Unannounced	Care and support Environment Staffing Management and leadership	5 - Very good Not assessed 5 - Very good 5 - Very good

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