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Aberdeen City Health & Social Care Partnership
A caring partnership

To: Professor Rhona Atkinson, Chairperson; Luan Grugeon; and Councillors Cooke and Duncan.

Town House,
ABERDEEN, 14 November 2017

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

The Members of the **AUDIT AND PERFORMANCE SYSTEMS COMMITTEE** are requested to meet in **Meeting Room 5, Health Village** on **TUESDAY, 21 NOVEMBER 2017 at 10.00 am.**

FRASER BELL
HEAD OF LEGAL AND DEMOCRATIC SERVICES

DECLARATION OF INTERESTS

Members are requested to declare any interests.

DETERMINATION OF EXEMPT BUSINESS

Members are requested to determine that any exempt business be considered with the press and public excluded.

STANDING ITEMS

1 Welcome and Apologies

2 Terms of Reference (for noting) (Pages 3 - 6)

MAIN AGENDA

3 Minute of Previous Meeting - 21 August 2017 (Pages 7 - 10)

4 APS Committee Dates 2018-19 (Pages 11 - 14)

5 Strategic Risk Register (Pages 15 - 42)

6 Board Assurance and Escalation Framework (Pages 43 - 86)

7 Post Integration Review (Pages 87 - 102)

8 Audit Scotland NHS in Scotland 2017 Report (Pages 103 - 154)

PRIVATE SESSION

9 Transformation Update (Pages 155 - 174)

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Website Address: http://www.aberdeencityhscp.scot/

Should you require any further information about this agenda, please contact Iain Robertson, tel 01224 522869 or email iairobertson@aberdeencity.gov.uk

ABERDEEN CITY INTEGRATION JOINT BOARD
AUDIT & PERFORMANCE SYSTEMS COMMITTEE
TERMS OF REFERENCE

1	**Introduction**
1.1	The Audit & Performance Systems Committee is identified as a Committee of the Integration Joint Board (IJB). The approved Terms of Reference and information on the composition and frequency of the Committee will be considered as an integral part of the Standing Orders.
1.2	The Committee will be known as the Audit & Performance Systems Committee (APS) of the IJB and will be a Standing Committee of the Board,
2	**Constitution**
2.1	The IJB shall appoint the Committee. The Committee will consist of not less than 4 members of the IJB, excluding Professional Advisors. The Committee will include at least two voting members, one from Health and one from the Council.
3	**Chair**
3.1	The Committee will be chaired by a non-office bearing voting member of the IJB and will rotate between NHS and ACC.
4	**Quorum**
4.1	Three Members of the Committee will constitute a quorum.
5	**Attendance at meetings**
5.1	The Board Chair, Chief Officer, Chief Finance Officer Chief Internal Auditor and other Professional Advisors and senior officers as required as a matter of course, external audit or other persons shall attend meetings at the invitation of the Committee.
5.2	The Chief Internal Auditor should normally attend meetings and the external auditor will attend at least one meeting per annum.
5.3	The Committee may co-opt additional advisors as required.
6	**Meeting Frequency**
6.1	The Committee will meet at least 4 times each financial year. There should be at least one meeting a year, or part therefore, where the Committee meets the external and Chief Internal Auditor without other seniors officers present. A further 2 developmental sessions will be planned over the course of the year to support the development of members.
7	**Authority**
7.1	The Committee is authorised to instruct further investigation on any matters which fall

	within its Terms of Reference.
8	**Duties**
8.1	The Committee will review the overall Internal Control arrangements of the Board and make recommendations to the Board regarding signing of the Governance Statement, having received assurance from all relevant Committees.
	Specifically it will be responsible for the following duties:
	1. The preparation and implementation of the strategy for Performance Review and monitoring the performance of the Partnership towards achieving its policy objectives and priorities in relation to all functions of the IJB;
	2. Ensuring that the Chief Officer establishes and implements satisfactory arrangements for reviewing and appraising service performance against the national health and wellbeing outcomes, the associated core suite of indicators and other local objectives and outcomes and for reporting this appropriately to the Committee and Board.. The performance systems scrutiny role of the Committee is underpinned by an Assurance Framework which itself is based on the Board's understanding of the nature of risk to its desired priorities and outcomes and its appetite for risk-taking. This role will be reviewed and revised within the context of the Board and Committee reviewing these Terms of Reference and the Assurance Framework to ensure effective oversight and governance of the partnership's activities..
	3. Acting as a focus for value for money and service quality initiatives;
	4. To review and approve the annual audit plan on behalf of the IJB, receiving reports, overseeing and reviewing actions taken on audit recommendations and reporting to the Board;
	5. Monitoring the annual work programme of Internal Audit, including ensuring IJB oversight of the clinical and care audit function and programme to ensure this is carried out strategically;
	6. To consider matters arising from Internal and External Audit reports;
	7. Review on a regular basis actions planned by management to remedy weaknesses or other criticisms made by Internal or External Audit
	8. To support the IJB in ensuring that the strategic integrated assurance and performance framework is working effectively, and that escalation of notice and action is consistent with the risk tolerance set by the Board.
	9. To support the IJB in delivering and expecting cooperation in seeking assurance that hosted services run by partners are working effectively in order

	to allow Aberdeen City IJB to sign off on its accountabilities for its resident population.
	10. Review risk management arrangements, receive annual Risk Management updates and reports and annually review with the full Board the IJB's risk appetite document .
	11. Ensure existence of and compliance with an appropriate Risk Management Strategy.
	12. Reporting to the IJB on the resources required to carry out Performance Reviews and related processes;
	13. To consider and approve annual financial accounts and related matters
	14. Ensuring that the Senior Management Team, including Heads of Service, Professional Leads and Principal Managers maintain effective controls within their services which comply with financial procedures and regulations;
	15. Reviewing the implementation of the Strategic Plan;
	16. To be responsible for setting its own work programme which will include the right to undertake reviews following input from the IJB and any other IJB Committees;
	17. The Committee may at its discretion set up short term working groups for review work. Membership of the working group will be open to anyone whom the Committee considers will assist in the task assigned. The working groups will not be decision making bodies or formal committees but will make recommendations to the Audit Committee;
	18. Promoting the highest standards of conduct by Board Members; and
	19. Monitoring and keeping under review the Codes of Conduct maintained by the IJB.
	20. Will have oversight of Information Governance arrangements and staffing arrangements as part of the Performance and Audit process.
	21. Ensuring effective IJB oversight of the scrutiny of Serious Incidents in health and social care, including monitoring and reporting systems, timely action, training and improvement activities.
	22. To be aware of, and act on, Audit Scotland, national and UK audit findings and inspections/regulatory advice, and to confirm that all compliance has been responded to in timely fashion.
9	**Review**
9.1	The Terms of Reference will be reviewed every six months to ensure their ongoing appropriateness in dealing with the business of the IJB.
9.2	As a matter of good practice, the Committee should expose itself to periodic review utilising best practice guidelines and external facilitation as required.

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AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

Minute of Meeting

21 August 2017
Health Village, Aberdeen

Present: Professor Mike Greaves (NHS Grampian (NHSG)) Chairperson; Rhona Atkinson (NHSG); and Councillors Cooke and Duncan.

Also in attendance: Judith Proctor (Chief Officer, Aberdeen City Health and Social Care Partnership (ACHSCP)), Alex Stephen (Chief Finance Officer, ACHSCP), Tom Cowan (Head of Operations, ACHSCP), Gail Woodcock (Lead Transformation Manager, ACHSCP), Sarah Gibbon (Executive Assistant, ACHSCP), David Hughes (Internal Audit), Andy Shaw (External Audit), Ricky McLaughlin (PricewaterhouseCoopers (PwC)) and Iain Robertson (Clerk, Aberdeen City Council (ACC)).

DECLARATIONS OF INTEREST

1. Members were requested to intimate any declarations of interest.

The Committee resolved:-
To note that no declarations of interest were intimated at this time for items on today's agenda.

DETERMINATION OF EXEMPT BUSINESS

2. The Chair proposed that item 7 (NHS Grampian Internal Audit Report) on today's agenda be considered with the press and public excluded.

The Committee resolved:-
In terms of Section 50(A)(4) of the Local Government (Scotland) Act 1973, to exclude the press and public from the meeting during consideration of the aforementioned items of business so as to avoid disclosure of exempt information of the classes described in paragraph 6 (NHS Grampian Internal Audit Report) of Schedule 7(A) of the Act.

MINUTE OF PREVIOUS MEETING – 20 June 2017

3. The Committee had before it the minute of the previous meeting of 20 June 2017.

With reference to item 6(ii), the Chief Finance Officer confirmed that he had met with Councillor Cooke to discuss the Board Assurance and Escalation Framework (BAEF) and advised that the Good Governance Institute were currently reviewing the BAEF and it would be resubmitted to the Committee in due course; and

With reference to item 7(v), the Clerk explained that he would liaise with colleagues from NHS Grampian to streamline the relevant audit committees and advised that an indicative IJB schedule would be presented to the IJB before the end of the calendar year. The Chief Officer added that the Partnership would also support re-convening a group consisting of the chairpersons of the Audit and Performance Systems Committee; the Council's Audit, Risk and Scrutiny Committee and NHS Grampian's Audit Committee to discuss how committee scheduling could be organised to support the audit function.

The Committee resolved:-
(i) to approve the minute as a correct record; and
(ii) otherwise note the information provided.

FINAL EXTERNAL AUDIT ANNUAL REPORT

4. The Committee had before it a report by the Chief Finance Officer which presented the Committee with the external audit report for discussion and noting.

The report recommended:-
That the Committee note the content of the Annual Audit Report to members and the Controller of Audit report.

Andy Shaw (External Audit) advised that the annual report was a public document addressed to both the IJB and the Controller of Audit. Mr Shaw summarised the IJB's financial results and noted the financial pressures faced by its partner organisations. Thereafter he outlined the audit conclusions and confirmed that the accounts complied with both CIPFA accounting standards and the four audit dimensions for the local government sector which were Financial Sustainability; Financial Management; Governance and Transparency; and Value for Money.

Mr Shaw noted that a letter had been drafted confirming the independence of the external auditors; and referred members to External Audit's only recommendation which asked the IJB to consider putting in place a document management system with version control. He noted that this recommendation had been accepted by management with an indicative implementation date of 31 March 2018.

The Committee resolved:-
(i) to note the content of the Annual Audit Report to members and the Controller of Audit report; and
(ii) to note that External Audit's recommendation for the IJB to put in place a document management system with version control had been accepted by management with an indicative date for implementation of 31 March 2018.

ANNUAL ACCOUNTS (AUDITED) 2016-17

5. The Committee had before it a report by the Chief Finance Officer which presented the Committee with the audited final accounts for 2016/17.

The report recommended:-
That the Committee -
a) Consider and agree the Integration Joint Board's Audited Accounts for 2016/17, as attached at appendix A;
b) Instruct officers to submit the approved audited accounts to NHS Grampian and Aberdeen City Council; and
c) Instruct the Chief Finance Officer to sign the representation letter, as attached at appendix B.

The Chief Finance Officer explained that terms of reference delegated authority to the APS Committee to approve the IJB annual accounts which members would be requested to do at today's meeting. He highlighted that the accounts were largely unchanged from the unaudited accounts presented to the Committee on 20 June 2017, but he appended a slight revision to p38 of the accounts which had been inadvertently altered during the version control process.

Thereafter members were advised on the definition and purpose of the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS).

The Committee resolved:-
(i) to agree the Integration Joint Board's Audited Accounts for 2016/17, as attached at appendix A;
(ii) to instruct officers to submit the approved audited accounts to NHS Grampian and Aberdeen City Council;
(iii) to instruct the Chief Finance Officer to sign the representation letter, as attached at appendix B; and
(iv) to circulate the approved annual accounts to IJB members for information.

TRANSFORMATION PROGRAMME UPDATE

6. The Committee had before it a report by Gail Woodcock (Lead Transformation Manager, ACHSCP) which provided an update on the progress of the Transformation Programme.

The report recommended:-
That the Committee –
a) Note the ongoing process and progress in developing and delivering the transformational programme; and
b) Note the change requirement in relation to the provision of funding for Thinc social transport during 2017/18.

Gail Woodcock (Lead Transformation Manager, ACHSCP) advised that the report provided an update on the IJB's six priority areas for strategic investment and outlined the governance arrangements which supported the management of the

Transformation Programme. She explained that levels of expenditure; opportunities; risks; and mitigations had been set out for each priority area and noted that a number of projects had been delayed due to recruitment and capacity issues but advised that the recruitment of four programme managers would help to expedite this process. Ms Woodcock confirmed that THInc funding had been agreed by the IJB at its meeting on 15 August 2017.

Thereafter there were questions and comments on recruitment and capacity risks; the level of duplication within the governance structure, with particular reference to the roles and remits of the Strategic Planning Group and the Executive Programme Board; and the process for assessing the RAG status for the six priority areas for strategic investment;

The Committee resolved:-

(i) to note the ongoing process and progress in developing and delivering the transformational programme; and

(ii) to request additional detail within the next Transformation Programme Update on the process for assessing the RAG status for the six priority areas for strategic investment to provide clarification and assurance to the Committee.

In accordance with the decision recorded under article 2 of this minute, the following items were considered with the press and public excluded.

NHS GRAMPIAN INTERNAL AUDIT REPORT

7. The Committee had before it a report by the Chief Finance Officer which presented the Committee with a summary of a recent NHSG Internal Audit report prepared by PwC. The internal audit report assessed the design and operating effectiveness of key controls for budget setting and staff governance at the Aberdeenshire, Aberdeen City and Moray Health & Social Care Partnerships (HSCPs).

The Committee resolved:-

(i) to note the content of the NHSG Internal Audit Report, as attached at Appendix A; and

(ii) to instruct officers to implement the actions outlined in the action plan of the NHSG Internal Audit report, as attached at Appendix A.

PROFESSOR MIKE GREAVES, Chairperson.

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Audit and Performance Systems Committee

Report Title	Audit & Performance Systems Meeting Dates 2018-19
Lead Officer	Alex Stephen, CFO ACHSCP
Report Author (Job Title, Organisation)	Iain Robertson, Committee Services Officer, Aberdeen City Council
Date of Report	27 October 2017
Date of Meeting	21 November 2017

1: Purpose of the Report

To propose a meeting schedule for the Audit & Performance Systems (APS) Committee for 2018-19.

2: Summary of Key Information

2.1 The Integration Joint Board (IJB) agreed its 2018-19 meeting schedule on 31 October 2017 and the Clinical and Care Governance Committee (CCG) agreed its meeting schedule on 3 October 2017.

2.2 The proposed meeting schedule for the APS committee aligns with the meeting schedules of both the IJB and the CCG Committee and fulfils the conditions for the APS Committee as set out in its terms of reference.

2.3 As per item 6.1 of the Committee's Terms of Reference, the Committee is required to meet once a year in closed session with the Chief Internal Auditor and external auditors and it is proposed that this meeting take place on 20 November 2018 as IJB audited accounts would be published by this point. This would adhere to a decision taken by Committee on 28 February 2017.

2.4 Proposed meeting dates will be submitted to relevant colleagues within Aberdeen City Council and NHS Grampian to ensure the alignment of audit committees to support the internal audit function as requested by the Committee on 20 June 2017.

Audit and Performance Systems Committee

All meetings would take place at 10am in the Health Village:-

- Tuesday 17 April 2018
- Tuesday 19 June 2018
- Tuesday 11 September 2018
- Tuesday 20 November 2018
- Tuesday 26 February 2019

3:	Equalities, Financial, Workforce and Other Implications
3.1.	It is anticipated that a meeting schedule which is publicly accessible on the Partnership's website would be beneficial for Aberdeen City Council, NHS Grampian and Partnership workforces. By scheduling IJB meeting dates up to March 2019, Board members, officers, auditors and stakeholders would be able to plan ahead and effectively prepare for Board meetings.

4:	Management of Risk

Identified risk(s): The Committee would be unable to take timely and informed decisions without an agreed meeting schedule; this would undermine the effectiveness of IJB governance arrangements.

Link to risk number on strategic or operational risk register: Strategic Risk Register (3) Failure of the IJB to function, make decisions in a timely manner etc

How might the content of this report impact or mitigate the known risks: Agreeing a meeting schedule would ensure that reports captured the views of key stakeholders during the consultation process. The Committee would then be in a position to take informed and timely decisions to support the functions and strategic objectives of the IJB.

5:	Recommendations

It is recommended that the Audit & Performance Systems Committee:

1. Agree the 2018-19 meeting dates; and

Audit and Performance Systems Committee

2. Agree that the meeting dates be publicised on the Partnership's website.

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Audit and Performance Systems Committee

Report Title	Strategic Risk Register Review
Lead Officer	Alex Stephen, Chief Finance Officer, ACHSCP
Report Author (Job Title, Organisation)	Alex Stephen, Chief Finance Officer, ACHSCP
Report Number	HSCP.17.096
Date of Report	16.10.17
Date of Meeting	21.11.2017

1: Purpose of the Report

To provide the Audit & Performance (APS) Committee with a revised strategic risk register for comment and discussion.

2: Summary of Key Information

The strategic risk register is a high-level working document which provides details on 11 key risks which might impact on the Integration Joint Board (IJB)'s ability to deliver on its strategic plan.

The strategic risk register is a standing item on ACHSCP's Executive Team Business meeting agenda, where thorough discussion and assessment takes place.

Appendices

1. ACHSCP Strategic Risk Register – November 2017

3: Equalities, Financial, Workforce and Other Implications

Equalities – there are no equalities implications arising directly from the content of this report.

Financial – there are no financial implications arising directly from the content

of this report.

Workforce – there are no workforce implications arising directly from the content of this report.

Other – there are no other implications arising directly from the content of this report.

4:	Management of Risk

Identified risk(s): All

Link to risk number on strategic or operational risk register: All

How might the content of this report impact or mitigate the known risks: Considering the strategic risk register at the APS committee provides regular oversight and scrutiny of all risks represented on the register.

5:	Recommendations

It is recommended that the Audit & Performance Systems committee:

1. Note the content of this report.

2. Discuss the escalation of any risks to the Integration Joint Board for further discussion.

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Strategic Risk Register 2017/18

Risk Rating	Low	Medium	High	Very High
Risk Movement	Decrease	No Change	Increase	

Level of Risk	*Risk Tolerance*
Low	Acceptable level of risk. No additional controls are required but any existing risk controls or contingency plans should be documented. Chief Officers/Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective.
Medium	Acceptable level of risk exposure subject to regular active monitoring measures by Managers/Risk Owners. Where appropriate further action shall be taken to reduce the risk but the cost of control will probably be modest. Managers/Risk Owners shall document that the risk controls or contingency plans are effective. Chief Officers/Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Chief Officers/Managers/Directors/Assurance Committees will periodically seek assurance that these continue to be effective.
High	Further action should be taken to mitigate/reduce/control the risk, possibly urgently and possibly requiring significant resources. Chief Officers/Managers/Risk Owners must document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Chief Officers/Managers/Directors/Executive and Assurance Committees will periodically seek assurance that these continue to be effective and confirm that it is not reasonably practicable to do more. The IJB's may wish to seek assurance that risks of this level are being effectively managed. However the IJB's may wish to accept high risks that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public
Very High	Unacceptable level of risk exposure that requires urgent and potentially immediate corrective action to be taken. Relevant Chief Officer/Managers/Directors/Executive and Assurance Committees should be informed explicitly by the relevant Managers/Risk Owners. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. The IJB's will seek assurance that risks of this level are being effectively managed. However the IJB's may wish to accept opportunities that have an inherent very high risk that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significant incidents(s) of regulatory non-compliance, potential risk of injury to staff and public

Risk Summary:

1. There is a risk of significant market failure in Aberdeen City
2. There is a risk of financial failure , that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and project an overspend
3. Failure of the IJB to function, make decisions in a timely manner etc
4. There is a risk that the outcomes expected from hosted services are not delivered and that the IJB does not identify non-performance in through its systems. This risk relates to services that Aberdeen IJB hosts on behalf of Moray and Aberdeenshire, and those hosted by those IJBs and delivered on behalf of Aberdeen City.
5. There is a risk that the governance arrangements between the IJB and its partner organisations (ACC and NHSG) are not robust enough to provide necessary assurance within the current assessment framework – leading to duplication of effort and poor relationships
6. There is a risk that services provided by ACC and NHS corporate services on behalf of the IJB do not have the capacity, are not able to work at the pace of the IJB's ambitions, or do not perform their function as required by the IJB to enable it to fulfil its functions
7. There is a risk that the IJB and the services that it directs and has operational oversight of fail to meet performance standards or outcomes as set by regulatory bodies
8. There is a risk of reputational damage to the IJB and its partner organisations resulting from complexity of function, delegation and delivery of services across health and social care.
9. Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system
10. There is a risk that the IJB does not maximise the opportunities offered by locality working
11. Workforce planning across the Partnership is not sophisticated enough to maintain future service delivery

- 1 -	
Description of Risk: There is a risk of significant market failure in Aberdeen City	
Strategic Priority: Outcomes, safety and transformation	**Lead Director:** Head of Strategy and Transformation
Risk Rating: low/medium/high/very high **HIGH** **Risk Movement:** increase/decrease/no change **NO CHANGE 09.11.17**	**Rationale for Risk Rating:** • Previous experience of provider failure in City and wider across Scotland • Discussion with current providers and understanding of market conditions across the UK • Impact of Living Wage on profitability depending on some provider models **Rationale for Risk Appetite:** • 3rd and independent sectors key strategic partners in delivering transformation and improved care experience and we have a low tolerance of risk of market failure.
Controls: Robust market and relationship management with the 3rd and independent sector and their representative groups. Market facilitation programme and robust contract monitoring process	**Mitigating Actions:** • Creation of capacity and capability to manage and facilitate the market • Development of provider forum to support relationship and market management • Risk fund set aside with transformation funding • Additional SG funding toward the Living Wage and Fair Working Practices have been agreed and applied by the IJB • Recent experience of managing a residential home should market failure occur.
Assurances:	**Gaps in assurance:**

Market management and facilitation Audit and Performance Systems Committee overview Contract monitoring process	Market or provider failure can happen quickly despite good assurances being in place
Current performance: The Partnership/ACC had to step in and take control of a nursing home in Kingswells on 1st of April 2017. This has provided the Partnership with experience of how to take control and run a residential home should a provider fail. However, capacity only exists to deal with one residential home at a time and if two homes failed at the same time the resources would be stretched. There is an indication through recent court cases that staff providing overnight care (sleepovers) will need to be paid at HMRC rates and this could be back-dated for 6 years. Should this financial liability materialise then this could have a large impact on the financial viability of some of the care providers. A care home provider largely based in the central belt is to close 12 residential homes due to financial pressures.	**Comments:** • NCHC uplift for 2016/17 was 6.4% and 2.8% 2017/18 • IJB agreed payment of living wage to Care at Home providers for 2016/17 and 2017/18 • Development of a commissioning plan with a draft presented to the IJB on the 15th of August 2017.Market Facilitation steering group established September 2016; membership includes ACVO, CASPA and Scottish Care.

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Description of Risk: There is a risk of IJB financial failure with demand outstripping available budget. There is a risk that the IJB cannot deliver on priorities and statutory work, and that it projects an overspend.	
Strategic Priority: Outcomes and transformation	**Lead Director:** Chief Finance Officer
Risk Rating: low/medium/high/very high **HIGH**	**Rationale for Risk Rating:** • Analysis of demographic change and growth in demand year on year • Analysis of current budget pressures known and expected in the Public Sector in Scotland and the UK • Understanding of financial pressures on both partner organisations (ACC and NHS Grampian) **Rationale for Risk Appetite:** The IJB has a low risk appetite to financial failure and understands its requirement to achieve a balanced budget. However the IJB also recognises the significant range of statutory services it is required to meet within that finite budget and has a lower appetite for risk of harm to people.
Risk Movement: increase/decrease/no change*:* **NO CHANGE 09.11.17**	
Controls: Budgets delegated to cost centre level and being managed by budget holders.	**Mitigating Actions:** • Financial information is reported regularly to the Audit & Performance Systems Committee, the Integration Joint Board and the Executive Team. • Reserves strategy, including risk fund • Robust financial monitoring and budget setting procedures

Assurances: • Audit and Performance Systems Committee oversight and scrutiny of budget under the CFO • Board Assurance Framework.	**Gaps in assurance:** • None known
Current performance: Pressure forecast on budget at June 2017, recovery plans are being developed to bring this back into balance. Therefore, risk rating moved to high until recovery plans are implemented. At September 2017 the financial position has improved. Although there is now an overspend of £1.5 million being forecast on the prescribing budget.	**Comments:** • Regular and ongoing budget reporting and tight management control in place • Budget monitoring procedure now well established • Budget holders understand their responsibility in relation to financial management.

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Description of Risk: There is a risk that the IJB fails to function properly within its Integration Scheme, Strategic Plan and Schemes of delegation in particular reference to being able to make appropriate decisions in a timely manner and meet its required functions.	
Strategic Priority: Outcomes, safety and transformation	**Lead Director:** Chief Officer
Risk Rating: low/medium/high/very high **LOW**	**Rationale for Risk Rating:** Failure of the IJB to function is a fundamental risk which would impact on all strategic priorities. Recruitment to the Executive Team is now in place, giving full capacity in the structure.
Risk Movement: increase/decrease/no change **DECREASE 30.10.2017**	**Rationale for Risk Appetite:** Zero appetite.
Controls: • Experience of operating in shadow form • Agreed etiquette of the board and risk appetite statement allowing for balance of timely decision taking with effective challenge and scrutiny • Performance reporting mechanisms	**Mitigating Actions:** • Recruitment to Executive Team & Heads of Locality now complete • Operation of Executive team focussing on priorities • **A review of the standing orders approved by the IJB at it's 31st of October Meeting** •
Assurances:	**Gaps in assurance:**

• Board Assurance Framework • Audit & Performance Systems Committee	• None known
Current performance: • Meeting requirements • Increasing workload experienced following 'go live' and in relation to need to support IJB's committees – being mitigated by further recruitment to senior posts • Senior posts within the Strategy and Transformation team have now been recruited too.	**Comments:** • The process for agreeing and then recruiting into senior posts in the structure has, by necessity, to go at the pace of the partner organisations. This has extended the process and has meant that key posts are either just now being recruited to, or yet to be advertised;

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Description of Risk: There is a risk that the outcomes expected to be delivered by hosted services are not realised and that the IJB fails to

identify non-performance through its own systems. This risk relates to services that Aberdeen IJB hosts on behalf of Moray and Aberdeenshire, and those hosted by those IJBs and delivered on behalf of Aberdeen City.

Strategic Priority: Outcomes and transformation	**Lead Director:** Chief Officer
Risk Rating: low/medium/high/very high **HIGH** **Risk Movement:** (increase/decrease/no change): **INCREASE 09.11.17**	**Rationale for Risk Rating:** • Considered medium risk due to the reporting arrangements being relatively new and needing testing in the first full year of operation **Rationale for Risk Appetite:** • The IJB has some tolerance of risk in relation to testing change.
Controls: • Integration scheme agreement on cross-reporting • NE Strategic Partnership Group • Operational risk register	**Mitigating Actions:** • This is discussed regularly by the three North East Chief Officers • Regular discussion regarding budget with relevant finance colleagues
Assurances: These largely come from the systems, process and procedures put in place by NHS Grampian, which are still being operated, along with any new processes which are put in place by the lead IJB.	**Gaps in assurance:** None currently known

Current performance:	Comments:
No issues to report Governance arrangements are being worked on across the three IJBs, so that budget management, setting and strategic planning are aligned. This work will be presented to the three North East Scotland HSCPs when completed. Work is taking place at an officer level to move this forward. The projected overspend on hosted services is a factor in the IJB's overspend position. This may in future impact on the outcomes expected by the hosted services, hence the movement to a classification of HIGH.	• A meeting of the senior management teams of the three North East Scotland Health and Social Care Partnerships took place in December 2016 in order to establish the operating principles and processes for reporting outcomes from hosted services and governance to IJBs • Further meetings are planned across the year to ensure flow of communication and establish practice of reporting on hosted services

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Description of Risk: There is a risk that the governance arrangements between the IJB and its partner organisations (ACC and NHSG) are not

robust enough to provide necessary assurance within current assurance framework – leading to duplication of effort and poor relationships.	
Strategic Priority: Outcomes, safety and transformation	**Lead Director:** Chief Officer
Risk Rating: low/medium/high/very high **MEDIUM**	**Rationale for Risk Rating:** Considered medium as arrangements are complex and mitigations untested in the 'go live' environments
Risk Movement: (*increase/decrease/no change)* **NO CHANGE 09.11.17**	**Rationale for Risk Appetite:** The IJB has zero appetite for failure to meet its statutory requirements.
Controls: • Scheme of delegation • Integration Scheme • Current governance committees within IJB and NHS • North East Strategic Partnership Group	**Mitigating Actions:** • Consultation and engagement between bodies • Consideration being given by Chief Officers regarding development of Service Level Agreements or other mechanism
Assurances: • Agreement on regular reporting on hosting at each IJB • Regular Chief Officer meetings across Grampian area • Chief Officer a member of both NHS Grampian Senior Leadership Team and Aberdeen City Council's Corporate Management Team	**Gaps in assurance:** • Potential gaps around standard interpretation of schemes
Current performance: Most of the major governance processes have been tested over the last year. However, this does not remove the risk as governance	**Comments:** • Regular performance meetings between the Chief Officer and the Chief Executives of NHS Grampian and Aberdeen City

processes in the IJB and the partner organisations will continue to evolve and improve.	Council take place • Reporting template has been agreed to ensure a consistency of reporting and clear 'line of sight' to Accountable Officers • A Protocol for budget setting has been developed to assist in this complex process and was tested for the first time for the 17/18 budget

Description of Risk: There is a risk that the services provided by ACC and NHS Corporate Services on behalf of the IJB do not have the capacity or are unable to work at the pace of the IJB's ambitions. There is a further risk that they are unable to perform their function as required by the IJB to enable it to fulfil its functions.

Strategic Priority: Outcomes and service transformation	**Lead Director:** Chief Officer

Risk Rating: low/medium/high/very high

MEDIUM

Risk Movement: (*increase/decrease/no change)*

NO CHANGE 09.11.17

Rationale for Risk Rating:

- Given the wide range and variety of services that support the IJB from NHS Grampian and ACC there is a possibility of under or non-performance
- Depending on which area this is in (e.g. corporate finance, legal services) the consequences are considered significant
- **There is the potential for budget reductions to impact on services**

Rationale for Risk Appetite:

There is a zero tolerance in relation to not meeting legal and statutory requirements.

Controls:

- IJB Strategic Plan
- IJB Integration Scheme
- Agreed risk appetite statement
- Role and remit of the North East Strategic Partnership Group in relation to shared services

Mitigating Actions:

- Regular reporting at both Executive Management Team and Senior Operational Management team
- Regular and ongoing Chief Officer membership of ACC Corporate Management Team and NHS Grampian Senior Leadership Team
- Consideration in relation to Service Level Agreements being undertaken by the 3 North East Chief Officers.
- Creation of Business Management Team with the partnership with representatives from all corporate services.
-

Assurances:	Gaps in assurance:
• Executive Group reviews performance of corporate services' support regularly • Chief Finance officer role ensure liaison in relation to financial services • Chief Officer regularly discusses these service provisions with Corporate Directors	• None currently significant though note consideration relating to possible future Service Level Agreements
Current performance: • No issues have been identified over the last year of operations, therefore, the Executive Team feel this risk can be reduced to medium. However, risk will be kept under review as partner organisations change their structures and systems.	**Comments:** • Nothing to update on this report.

- 7 –
Description of Risk: There is a risk that the IJB and the services that it directs and has operational oversight of fail to meet performance standards or outcomes as set by regulatory bodies and that, as a result, harm or risk of harm to people occurs.

Strategic Priority: Outcomes, safety, transformation of services	**Lead Director:** Chief Officer
Risk Rating: low/medium/high/very high **MEDIUM** **Risk Movement:** (*increase/decrease/no change)* **NO CHANGE 09.11.17**	**Rationale for Risk Rating:** Risk felt to be moderate, given controls with potential risks in need of mitigation due to go-live implications **Rationale for Risk Appetite:** The IJB has zero tolerance of harm happening to people as a result of its actions or inaction.
Controls: • Clinical and Care Governance Committee and Group Audit and Performance Systems Committee • Risk-assessed performance plans and actions • Development of KPIs reported	**Mitigating Actions:** System re-design and transformation
Assurances: • Executive Group reviews processes and performance regularly • Joint meeting of IJB Chief Officer with two Partner Body Chief Executives • Audit & Performance Systems Committee • Clinical and Care Governance Committee	**Gaps in assurance:** • Formal performance systems not yet developed. • Audit & Performance Systems Committee meets regularly and is establishing reporting mechanisms • Intelligent Board performance model has been agreed and is being populated

Current performance:	Comments:
Council and NHS performance systems remain in place with single reporting in development.	• Clinical and Care Governance Committee and Group have been established and are meeting regularly • Further work with the Good Governance Institute is supporting us in testing our processes robustly as a live organisation to ensure they are fit for purpose • Action plan following last year's formal Inspection of Services for Older People has been agreed and approved by both the IJB and Inspection agencies • Establishing reporting and assurance mechanisms for hosted and commissioned services

- 8 –	
Description of Risk: There is a risk of reputational damage to the IJB and its partner organisations resulting from complexity of function, delegation and delivery of services across health and social care.	
Strategic Priority: All	**Lead Director:** Chief Officer
Risk Rating: low/medium/high/very high **HIGH**	**Rationale for Risk Rating:** Newness of the organisation and agenda for system transformation pose risk of reputational damage
Risk Movement: (*increase/decrease/no change)* **NO CHANGE 09.11.17**	**Rationale for Risk Appetite:** Willing to risk certain reputational damage if rationale for decision is sound.
Controls: • Executive Management Team • IJB and its Committees • Operational management processes and reporting • Board escalation process	**Mitigating Actions:** • Clarity of roles • Staff and customer engagement • Effective performance and risk management
Assurances: • Role of the Chief Officer and Executive Team • Role of the Chief Finance Officer • Performance relationship with NHS and ACC Chief Executives • Communications plan / communications officer	**Gaps in assurance:** None known at this time

Current performance:	Comments:
• Chief Finance Officer appointed on a permanent basis • Communications officer in place to lead reputation management	• Communications strategy and action plan in place and being led by the HSCP's Communications Manager • Communications Group in place comprising of staff across the partnership supporting us in getting the message right and appropriate • Locality leadership groups being established to build our relationship with communities and stakeholders • Regular CO/CEOs meeting supports good communication flow across partners as does CO's membership of the Corporate Management Teams of both ACC and NHSG

- 9 –	
Description of Risk: Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system	
Strategic Priority: All	**Lead Director:** Chief Officer
Risk Rating: low/medium/high/very high **HIGH** **Risk Movement:** (*increase/decrease/no change)* **NO CHANGE 09.11.17**	**Rationale for Risk Rating:** This is the overall risk – each of our transformation programme work streams will also be risk assessed with some programmes being a higher risk than others **Rationale for Risk Appetite:** The IJB has some appetite for risk relating to testing change and being innovative. The IJB has zero appetite for harm happening to people.
Controls: • Strategic Transformation and Commissioning programme management and governance • Audit and Performance Systems Committee • Programme Board structure and Executive Programme board in place • Recruitment to key senior posts	**Mitigating Actions:** • Programme approach being taken in terms of the transformation programme • Recruitment has taken place into senior and key project and programme management posts • Regular reporting to Executive Programme Board • Regular reporting to Audit and Performance Systems Committee and Integration Joint Board

Assurances:	Gaps in assurance:
• Executive Management and Committee Reporting • Programme Management approach • IJB oversight • Board escalation process	• Executive Management team developing financial model for transformation programme to track delivery of change and efficiencies – this is in developing and as such, a gap.
Current performance: Demographic financial pressure is starting to materialise in some of the IJB budgets. The Strategy and Transformation Team is now established and reviewing\supporting the transformation projects	**Comments:** • Challenge of pace of recruitment to key posts given complexity of working across two systems has had an impact on pace • A review of the transformation programme and governance arrangements is being undertaken.

- 10 –	
Description of Risk There is a risk that the IJB does not maximise the opportunities offered by locality working	
Strategic Priority: All	**Lead Director:** Chief Officer
Risk Rating: low/medium/high/very high **MEDIUM**	**Rationale for Risk Rating:** All Head of Locality posts have now been recruited to and are in post.
Risk Movement: (*increase/decrease/no change)* **NO CHANGE 09.11.17**	**Rationale for Risk Appetite:** The IJB has some appetite to risk in relation to testing innovation and change. There is zero risk of financial failure or working out with statutory requirements of a public body.
Controls: • Transformation programme and programme board structure • Audit and Performance Systems Committee	**Mitigating Actions:** • Agreed operational structure that reflects the importance of localities and roles which support transformational potential of working at this level
Assurances:	**Gaps in assurance**

• Regular Transformational Programme Board reports to Executive Management Team and to Audit and Performance Systems Committee • Programme Management approach • Recruitment of new Head of Strategy and Transformation role which will lead on the transformation at Executive level	• None currently known
Current performance: • All Heads of Locality now in post • The locality plans are currently out for consultation and workshops have been arranged with the IJB.	**Comments:** •

- 11 –	
Description of Risk: Workforce planning across the Partnership is not sophisticated enough to maintain future service delivery	
Strategic Priority: All	**Lead Director:** Chief Officer
Risk Rating: low/medium/high/very high **MEDIUM** **Risk Movement:** (*increase/decrease/no change)* **NO CHANGE 09.11.17**	**Rationale for Risk Rating:** • The current staffing complement profile changes on an incremental basis over time • However the number of over 50s employed by the partnership is increasing **Rationale for Risk Appetite:** • Risk should be able to be managed with the adoption of workforce planning structures and processes
Controls: • **Clinical & Care Governance committee reviews operational risk around staffing numbers**	**Mitigating Actions:** • **Development of a workforce plan** • **Career development scheme for nurses**
Assurances: • **Workforce plan once developed for the whole Partnership.**	**Gaps in assurance** • Need more information on social care staffing • Information on social care providers would be useful to determine trends in wider sector

Current performance:	Comments:
• Workforce planned developed, but only covers health staff and not the social care staff. Information expected from Scottish Government during over the next few months which should help improve workforce planning across all partnerships.	

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Aberdeen City Health & Social Care Partnership
A caring partnership

Audit and Performance Systems Committee

Report Title	Revised Board Assurance and Escalation Framework
Lead Officer	Alex Stephen, Chief Finance Officer, ACHSCP
Report Author (Job Title, Organisation)	Alex Stephen, Chief Finance Officer, ACHSCP
Report Number	HSCP/17/061
Date of Report	16/10/2017
Date of Meeting	21/11/2017

1: Purpose of the Report

To present the Audit and Performance Systems (A&PS) Committee with the revised Board Assurance and Escalation Framework for approval.

2: Summary of Key Information

The Board Assurance and Escalation Framework (BAEF).

In order to fulfil its remit, the Integration Joint Board (IJB) needs to be able to demonstrate an effective governance process whereby it can be assured that key risks to the achievement of integration objectives are appropriately identified, communicated and addressed.

The BAEF describes the regulatory framework of the IJB to support its vision, values and principles, within which the A&PS committee will work. Fundamental to the framework are the IJB's strategic priorities and the appetite for risk that the board has across these priorities.

It presents and populates a model where individuals, groups and committees, plans, reports, and reporting processes are mapped at different organisational levels, against two broad assurance requirements: compliance and transformation.

A key element of the assurance framework is the risk management system, whose outputs (i.e. strategic and corporate risk registers, and other reports) contribute significantly to board assurance on key risks to objectives.

Audit and Performance Systems Committee

The appendices illustrate the landscape in which the IJB will operate:

- The committee structure and terms of reference.
- The risk assessment system.
- The risk escalation process.
- The clinical and care governance framework.
- The IJB's cycle of business.

The A&PS committee performs the key role of reviewing and reporting on the effectiveness of the governance structures in place and on the quality of the assurances the Board receives.

Introduction and Revision of the BAEF.

The BAEF was formally approved by the IJB at its meeting in March 2016. The A&PS committee assumed responsibility for the regular review and any necessary escalation of the BAEF at its meeting in May 2016. A revised version of the BAEF was presented to the APS committee at its meeting on the 20th of June 2017, where further revisions were requested, including the standardisation of references to corporate and operational risk registers.

The Executive Team and the Good Governance Institute have undertaken further work to review the BAEF and present the revised version to the A&PS committee (appendix A).

Key changes in this revision include:

- Standardisation of references to board level (strategic) and corporate level (operational) risk registers,
- Additional detail regarding the risk appetite,
- Explanation of the risk assessment methodology, and;
- Further information on the strategic & operational risk registers

Audit and Performance Systems Committee

3:	Equalities, Financial, Workforce and Other Implications

Equalities – there are no equalities implications

Financial – there are no financial implications

Workforce – there are no workforce implications

Other – there are no other implications

4:	Management of Risk

Identified risk(s):

- There is a risk that responsibilities, processes and route of reporting may be unclear in some parts of the system during transition, which could impact on the ability of the A&PS committee to keep the IJB informed about risks of significance to its operations.
- There is a risk that the framework may not be updated in line with the pace of change experienced across the partnership.

Link to risk number on strategic or operational risk register: NA

How might the content of this report impact or mitigate the known risks: This report helps to mitigate the risks as it commits to an annual review of the BAEF to ensure it is updated appropriately. Further, the information provided in the BAEF (appendix A) helps to mitigate the impact of a number of risks in the strategic risk register, by providing the necessary assurance and escalation processes.

5:	Recommendations

It is recommended that the Audit and Performance Systems Committee:

1. Comments on the revised BAEF, as in appendix A.
2. Recommends the revised BAEF is approved by the Integration Joint Board.

Audit and Performance Systems Committee

Aberdeen City Health & Social Care Partnership

A caring partnership

Board Assurance and Escalation Framework

Revised 25.10.2017

Content

Part 1: Introduction

1.1 Background

The partner organisations of Aberdeen City Health and Social Care Partnership (ACHSP), Aberdeen City Council and NHS Grampian (the "Parties"), are committed to successfully integrating health and social care services, to achieve the partnership's vision of:

"a caring partnership, working together with our communities to enable people to achieve healthier, fulfilling lives and wellbeing."

ACHSP has established an Integrated Joint Board (IJB) through the Public Bodies (Joint Working) (Scotland) Act 2014. The remit of the IJB is to prepare and implement a Strategic Plan in relation to the provision of health and social care services to adults in its area in accordance with sections 29-39 of the Public Bodies Act. The arrangements for governance of the IJB itself, including rules of membership, are set out in the Integration Scheme and Standing Orders.

While the Parties are responsible for implementing governance arrangements of services the IJB instructs them to deliver, and for the assurance of quality and safety of services commissioned from the third and independent sectors, the Parties and the IJB are accountable for ensuring appropriate clinical and professional governance arrangements for their duties under the Act. The IJB therefore needs to have clear structures and systems in place to assure itself that services are planned and delivered in line with the principles of good governance and in alignment with its strategic priorities.

The IJB must have in place a robust framework to support appropriate and transparent management and decision-making processes. This framework will enable the board to be assured of the quality of its services, the probity of its operations and of the effectiveness with which the board is alerted to risks to the achievement of its overall purpose and priorities.

1.2 Regulatory framework

The Aberdeen City Health and Social Care Integration Scheme describes the regulatory framework governing the IJB, its members and duties. In particular, the IJB is organised in line with the guidance set out in the Roles, Responsibilities and Membership of the Integration Joint Board - Guidance and advice to supplement the Public Bodies (Joint Working) (Integration Joint Board) (Scotland)

Order 2014. The principles of and codes of conduct for corporate governance in Scotland are set out in "On Board: A Guide for Members of Public Bodies in Scotland", published by the Scottish Government in July 2006. Detailed arrangements for the board's operation are set out in "Roles, Responsibilities and Membership of the Integration Joint Board" Guidance and advice to supplement the Public Bodies (Joint Working) (Integration Joint Board) (Scotland) Order 2014. There are also Standing Orders of the IJB.

The IJB will make recommendations, or give directions where appropriate (i.e. where funding for employment is required) to the decision-making arms of the two Parties as required.

1.3 Purpose of the framework

This governance framework describes the means by which the board secures assurance on its activities. It sets out the governance structure, systems and performance and outcome indicators through which the IJB receives assurance. It also describes the process for the escalation of concerns or risks which could threaten delivery of the IJB's priorities, including risks to the quality and safety of services to service users.

It is underpinned by the principles of good governance[1] [2] [3] and by awareness that ACHSP is committed to being a leading edge organisation in the business of transforming health and social care.

This commitment requires governance systems which will encourage and enable innovation, community engagement and participation, and joint working. Systems for assurance and escalation of concerns are based on an understanding of the nature of risk to an organisation's goals, and to the appetite for risk-taking. The development of a mature understanding of risk is thus fundamental to the development of governance systems. The innovative nature of Health and Social Care Integration Schemes also requires governance systems which support complex arrangements, such as hosting of services on behalf of other IJBs, planning only of services delivered by other entities, accountability for assurance without delivery responsibility, and other models

[1] Good Governance Institute (GGI) and Healthcare Quality Improvement Partnership (HQIP), *Good Governance Handbook,* January 2015,. http://www.good-governance.org.uk/good-governance-handbook-publication/

[2] The Scottish Government, Risk Management – public sector guidance, 2009. http://www.gov.scot/Topics/Government/Finance/spfm/risk

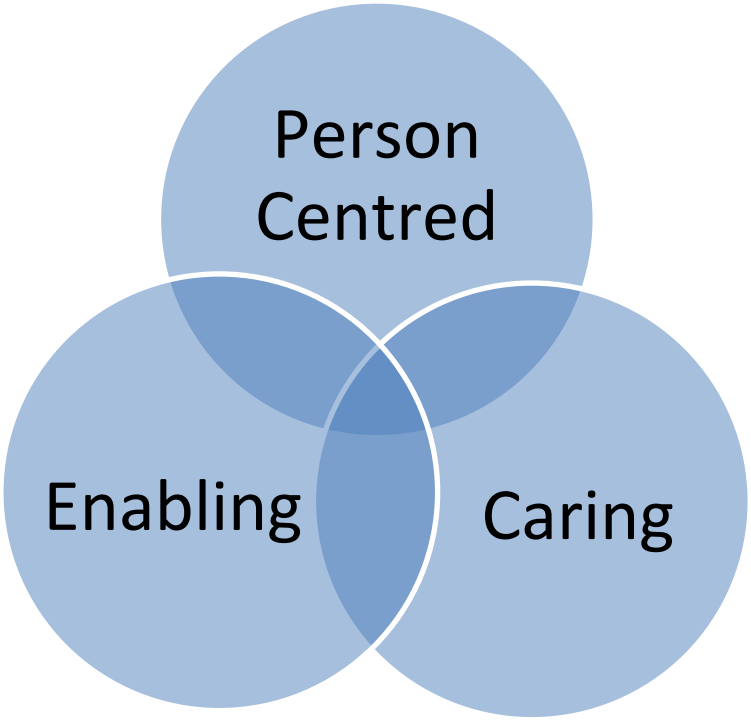
[3] Chartered Institute of Public Finance and Accountancy (CIPFA) and the International Federation of Accountants® (IFAC®). *International Framework: Good Governance in the Public Sector*, (2014) - http://www.cipfa.org/policy-and-guidance/standards/international-framework-good-governance-in-the-public-sector

of care delivery and planning. This framework has been constructed in the light of these complexities and the likelihood that it may be important to amend and revise the systems as our understanding of the integration environment develops.

The structures and systems described are those in place from June 2017. In order to ensure that the framework can best support the IJB in its ambitions going forward, it will be reviewed annually.

1.4 An integrated approach to governance for health and social care

In working towards the vision stated above, the IJB is committed to ensuring that delegated services are:



The integration principles identified by The Scottish Government [4] also underpin decision-making within the IJB.

In 2013, the principles of good governance for both healthcare quality and for quality social care in Scotland were described.[5] These stressed the importance of:

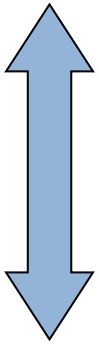
- Embedding continuous improvement
- Providing robust assurance of high quality, effective and safe clinical and care services
- The identification and management of risks to and failure in services and systems
- Involvement of service users/carers and the wider public in the development of services
- Ensuring appropriate staff support and training
- Ensuring clear accountability

The rest of this document and its appendices sets out the structures and systems currently in place to support both assurance of compliance and of transformation of services within the scope of ACHSP business. This framework can be represented graphically as follows in Table 1:

[4] Integration Planning and Delivery Principles, The Scottish Government. http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Principles

[5] Governance for Quality Healthcare, The Scottish Government, 2013. http://www.gov.scot/Topics/Health/Policy/Quality-Strategy/GovernanceQualityHealthcareAgreement

Table 1

	ASSURANCE of COMPLIANCE	ASSURANCE of IMPROVEMENT, INNOVATION and TRANSFORMATION
FOCUS	Compliance with standards and regulation, communication and escalation of concerns and risks	Improving services, measuring and sustaining improvement Challenging work patterns, innovation, redesign and transformation
KEY COMPONENTS	People and Groups: partners; roles; committee structures Plans and Activities: engagement plan; risk management policy and system; audit system Feedback and Reporting processes: concerns and escalation process	
	**Board Level**	
	Corporate Level	
	Service Level	
	Individual Level	
OUTCOMES	IJB measures of success for stakeholders and assurances from internal and external sources	IJB measures of success for stakeholders and assurances from internal and external sources

Part 2: The Framework

2.1 Strategic priorities

From the nine strategic outcomes identified nationally as desired outcomes form integration, the ACHSP has, in its Strategic Plan[6], articulated seven strategic priorities, which form the basis of its governance framework.

- Develop a consistent person centred approach that promotes and protects the human rights of every individual and which enable our citizens to have opportunities to maintain their wellbeing and take a full and active role in their local community.
- Support and improve the health, wellbeing and quality of life of our local population.
- Promote and support self-management and independence for individuals for as long as reasonably possible.
- Value and support those who are unpaid carers to become equal partners in the planning and delivery of services, to look after their own health and to have a quality of life outside the caring role if so desired.
- Contribute to a reduction in health inequalities and the inequalities in the wider social conditions that affect our health and wellbeing.
- Strengthen existing community assets and resources that can help local people with their needs as they perceive them and make it easier for people to contribute to helping others in their communities.
- Support our staff to deliver high quality services that have a positive impact on personal experiences and outcomes.

These priorities underpin:

- Decision-making criteria for service development, planning and delivery; resource allocation etc.
- The Board Assurance Framework of key strategic risks
- Strategic risk register
- Risk registers across all departments and areas of operation
- Individual performance and appraisals
- Evaluation of achievement against objectives

[6] Aberdeen City Health and Social Care Partnership Strategic Plan 2016-19.

2.2 Risk Management

Risk appetite

Risk appetite can be defined as:

The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time'.
(HM Treasury - 'Orange Book' 2006)

The ACHSP recognises that achievement of its priorities may involve balancing different types of risk and that there may be a complex relationship between different risks and opportunities. The IJB has debated its appetite for risk in pursuit of the goals of integration so that its decision-making process protects against unacceptable risk and enables those opportunities which will benefit the communities it serves.

The IJB has consequently agreed a statement of its risk appetite.[7]

This statement is intended to be helpful to the board in decision-making and to enable members to consider the risks to organisational goals of not taking decisions as well as of taking them. As a newly established organisation, the ACHSP's appetite for risk will change over time, reflecting a longer-term aspiration to develop innovation in local service provision. The IJB regularly debates its appetite for risks and opportunities in the pursuit of its objectives and will ensure that the statement on risk appetite reflects these discussions as appropriate.

[7] Aberdeen City Health and Social Care Partnership Risk Appetite Statement – contained within ACHSP Strategic Plan 2016-19.

Risk Management policy and system

The Risk Appetite statement, risk management policy, strategic and corporate risk registers form the risk management framework.

The framework sets out the arrangements for the management and reporting of risks to IJB strategic priorities, across services, corporate departments and IJB partners. In line with the principles set out in the Australia/New Zealand Risk Management Standard 4360 [8], it describes how risk is contextualised, identified, analysed for likelihood and impact, prioritised, and managed. This process is framed by the requirement for consultation and communication, and for monitoring and review.

Identified risks are measured according to the IJB risk assessment methodology described below and recorded onto risk registers. The detailed methodology for assessment of risk appears at Appendix 6. They are escalated according to the flowchart shown at Appendix 7.

Risk Assessment methodology

Risks are measured against two variables: the likelihood (or probability) of any particular risk occurring and the consequence or severity (impact) of that risk should it occur.

For example, there may be a risk of fire in a particular office building. If it happens, this would cause harm or damage to people, property, resources and reputation.

The ***likelihood*** of this occurring will be affected by the strength of fire safety precautions (prevention). The ***consequence*** or ***severity*** of the incident if it does occur will be affected by contingency management (containment, firefighting, evacuation procedures, emergency help, communications etc. by fire safety response).

Risk measurement tables are widely used by organisations and set out levels of both likelihood and consequence, in order to reach an overall risk assessment score. It is rare in the type of services the IJB is concerned with that this is a scientific process but it provides a practical way of comparing different types of risk issues and helping organisations to prioritise between issues so that

[8] Standards New Zealand, AS/NZS ISO 31000:2009 Risk Management – Principles and guidelines is a joint Australia/New Zealand adoption of ISO 31000:2009

they can be managed and the risk reduced. This measurement system is also used to decide when to escalate issues that cannot be managed locally or that are of such significance that the members of the senior team or of the IJB need to be aware of them.

The IJB's risk measurement table is shown below:

DESCRIPTOR	Rare	Unlikely	Possible	Likely	Almost Certain
Probability	Can't believe this event would happen - will only happen in exceptional circumstances.	Not expected to happen, but definite potential exists - unlikely to occur.	May occur occasionally, has happened before on occasions - reasonable chance of occuring.	Strong possibility that this could occure - likely to occur.	This is expected to occur frequently / in most circumstances - more likely to occur than not.

Risk Matrix

Impact / Likelihood	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	Very High	Very High
Likely	Medium	Medium	High	High	Very High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

The outputs from risk assessment are as follows:

1. IJB board level: The Board Strategic Risk Register (SRR)

The fundamental purpose of the SRR is to provide the organisation's Governing Body - i.e. the IJB - with assurance that it is able to deliver the organisation's ***strategic objectives and goals.*** This involves setting out those issues or risks which may threaten delivery of objectives and assure the IJB that they are being managed effectively and that opportunity to achieve goals can be taken: it is the lens through which the IJB examines the assurances it requires to discharge its duties. The IJB uses this document to monitor its progress, demonstrate its attention to key accountability issues, ensure that it debates the right issue, and that it takes remedial actions to reduce risk to integration. Importantly, it identifies the assurances and assurance routes against each risk and the associated mitigating actions.

The IJB's SRR format is shown here with a real example of the kind of issue included in the document (Appendix 1). While many of the issues may be termed strategic, the key thing to remember is that these are issues which may affect the ability to deliver on strategy. It is quite possible that significant operational issues will also be incorporated, therefore. The Senior Operational Management team reviews the Operational Risk Register (ORR) (see next section), and escalates risks classified as 'very high' to the Executive Team, for consideration of inclusion in the SRR (see Appendix 7 – risk escalation process). The Executive Team reviews the SRR in light of their experiences and insight into key issues, including commissioning risk, and recommends the updated version to the Audit & Performance Systems Committee (APSC) for approval and review by the IJB.

The issues identified are measured according to the IJB risk appetite and risk assessment methodology.

The risks are identified by:

- Discussions at Executive Team
- Review of Performance data and dashboards
- Reports from Project Management Board on review of PMO dashboards
- Review of the Operational Risk Register (see below)
- Review of Chief Officer reports and reports from IJB sub committees

The Executive Team agrees issues for inclusion on (and removal from) the SRR, and submits to the IJB or APSC quarterly for formal review

The Audit and Performance Systems Committee reviews the SRR for the effectiveness of the process annually.

2. Corporate Level: Operational Risk Register

While the SRR is a *top-down* record of risks to objectives, the Operational Risk Register (ORR) is a *bottom-up* operational document which reflects the top risks that are escalated through the IJB's delegated services, and gives detail on how they are being managed.

It may well contain risks that have a strategic angle, as well as those which are operational in nature, and will definitely contain risks that affect strategic objectives.

Risks from service risk registers and locality risk registers and (once developed) are escalated to the ORR according to their risk assessment scores.

The IJB has a standardised risk register format which is used for the ORR and all other risk registers. It is shown below with a real risk included as an example.

The Operational Risk Register comprises high scoring risks or those which cannot be managed locally from a range of sources. This document is routinely reviewed by both IJB sub committees to ensure:

- the right risks are being reported and escalated
- actions are being taken to mitigate risk
- these actions have been effective in reducing the risk level
- the IJB is aware of high level risks affecting services and of those where actions are not being taken in a timely manner or have not been successful in reducing the risk

The issues identified are measured according to the risk assessment methodology. They are recorded using the following format:

Table 2

ID	Strategic Priority	Description of Risk	Context	Impact	Date Last Assessed	Controls	Gaps in controls	Likelihood	Consequences	Risk Assessment	Assurances	Risk Owner/Handler	Comments

The risks are identified, using the risk assessment matrix for high scoring risks, from:

- Review of PMO dashboards
- Corporate department risk registers
- Service and locality risk registers and review of reports from service governance groups
- Review of reports from IJB sub committees
- IJB Occupational Health and Safety committee reports

The Head of Operations owns the Operational Risk Register, and the Audit and Performance Systems Committee moderates risks escalated to ensure consistency and appropriateness of issues identified for inclusion and removal.

The Senior Operational Management Team reviews the Operational Risk Register and it will be reported to the Clinical and Care Governance Committee bi-monthly demonstrating the changes in the risk profile of the IJB.

The risk register is shared with the NHS Grampian and Aberdeen City Council through the report consultation process.

3. Service and locality level: Risk registers and reports from governance groups

Service and locality risk registers use the same format as the ORR and are compiled at local level and discussed at local management and governance meetings.

Where risks cannot be satisfactorily managed locally, or where they are above scores as set out in the escalation flowchart, they will be escalated for possible entry onto the ORR. It is critical to emphasise that the risk management system cannot rely on escalation through the risk register process alone. Senior management, through individual manager and directors and through the operational group management structure, has a key role in helping to manage and find solutions to risk issues at all levels of the organisation.

Arrangements have developed over the first year of operations across services, taking into account existing systems. Operational risks managed at the service and department level are monitored by the Chief Officer and Executive Team. The Clinical and Care Governance Group (see Appendix 3) has a key role in identifying risk across services which may affect the safety and quality of services to users. The aims in developing risk communication between services and the IJB will be to achieve consistency in reporting the nature and scale of risks and to clarify how these are reported, escalated and actions monitored. The risk escalation flowchart at Appendix 7 shows the basis for this process.

2.3 Roles and Responsibilities for governance

Committee structure

This section describes the key committees and groups in relation to the IJB governance framework.

The board has established two sub-committees, as follows: **Audit and Performance Systems**, and **Clinical and Care Governance**. These sub committees have powers conferred upon them by the IJB.

In relation to governance and assurance, the **Audit and Performance Systems Committee (APSC)** performs the key role of reviewing and reporting on the effectiveness of the governance structures in place and on the quality of the assurances the Board receives. It has a moderation role in relation to the consistency of risk assessment. It also has oversight of information governance issues.

The **Clinical and Care Governance Committee (CCGC)** provides assurance to the IJB in relation to the quality and safety of services planned and/or delivered by the IJB. Its key role is to ensure that there are effective structures, processes and systems of control for the achievement of the IJB's priorities, where these relate to regulatory compliance, service user experience, safety and the quality of service outcomes. To support this role, the CCGC is informed by the clinical and care governance arrangements in place across NHS Grampian and Aberdeen City Council (see Appendix 4 - Clinical and care governance diagram).

It also assures the IJB that services respond to requirements arising from regulation, accreditation and other inspections' recommendations. The Committee will consider and approve high value clinical and care risks, consider the adequacy of mitigation, the assurance provided for that mitigation and refer residual high risks to the Board. It has a key role in assuring the board that learning from governance systems across services, including learning arising from incidents, complaints and identified risks, is shared and embedded as widely as possible.

The IJB's **Executive Team** is an executive group with oversight of the implementation of IJB decisions. It oversees risk registers, financial and operational delivery, the innovation and transformation programmes and assures the Audit and Performance Systems Committee of transformation progress. The group also assures the board on progress towards the achievement of its strategic priorities through the Performance Management Framework.

There are existing **governance arrangements within the providers of services delegated to the IJB**. Arrangements to standardise reporting systems through the IJB's governance structures are being progressed and will be reported in due course.

A diagram illustrating the structure appears at Appendix 2. A summary of the purpose, membership and reporting arrangements for these groups appears at Appendix 3.

Individual responsibilities

1. Board and corporate level:

The Chief Officer provides a single point of accountability for integrated health and social care services.

The Board and all its members must as a corporate body ensure good governance through the structures and systems described in this document. To ensure that the IJB is well-led and that all members are supported in this responsibility, a board development programme will be constructed to transfer knowledge and skills. To provide assurance that the Board has the capability and competence required, an annual self-assessment and periodic (minimum 3 yearly) independent assessment will be undertaken.

2. Professional level:

There are existing clinical and professional leadership structures in place to support clinical and care governance. These are:

- Lead Nurse
- Chief Social Work Officer
- Lead Allied Health Professional (AHP)
- Primary Care Clinical Leads (GPs)
- Public Health Lead
- Clinical Lead

3. Locality level:

The IJB is consulting on the key requirements for a management structure to lead on the delivery of services. This will require that there is a direct line of sight to the appropriate clinical and professional lead roles, and must take into account the location of services: some are locality based and others not. The development plan is that each of the six delivery points will have a single leader responsible for the good clinical and care governance of services within their remit.

2.4 Reporting of information to provide assurance and escalate concerns

The framework shown in Table 1 in section 1.4 can be populated as shown in Table 3 below. Locality managers will work with their partners in local services to develop systems for reporting from their various governance forums through to the IJB, as indicated in Table 3 below. In addressing the nature of assurance, it is important to note that the IJB, the APSC, and the CCGC operate assurance mechanisms to review *process* as well as *performance*, and in this regard the work of the APSC is the key governance mechanism for auditing *process*. The Committee-level Good Governance Matrices and effectiveness' audits also inform assurance around process.

Table 3

FOCUS	**Assurance of compliance, performance, improvement and transformation**						
	Individuals	**Plans / activities**	**Groups / Partners**	**Reporting and feedback processes**			
				Compliance with standards	**Risk escalation and review**	**Performance monitoring**	**Improvement and Transformation reporting**
Board level	Chair Chief Officer Board members Chairs / CEOs of the Partners	Strategic plan RM strategy Strategic Risk Assurance Register Corporate Risk register Performance framework Audit plan Standing Orders Integration Scheme	Board Executive group Audit and Performance Systems Committee Clinical and Care Governance Committee Other IJBs Scrutiny / governance arms of Parties	Review of BAEF Review of risk scoring Review of Performance dashboard PMO report Audit reports to Board Exception and action plan review Bi-annual review of integration scheme Bi-annual review of strategic plan			
	Directors Senior	Strategic and Operational risk	Executive Group Senior	Financial monitoring Corporate risk register review			

Corporate level	Managers PMO	registers Performance dashboard Business planning Budget monitoring Joint Complaints Procedure	Management Teams Cluster Management Group Strategic Planning Group Clinical and Care Governance Group	Risk moderation and review
Service level	Clinical leads and Social work leads Professional leads Locality managers Service managers Service users	Communication and Engagement plan Clinical and care governance policies Risk registers and assessments	Community partners Service governance forums 'Deep Dive' activity	Risk register system Governance reports Real time feedback Response to complaints Service level dashboards
Individual level	Staff members Service users Carers	Communication and Engagement plan Raising concerns policy Safeguarding alerts Risk assessment Incident reporting	Staff forums IJB engagement activity	Objective setting and review Supervision and line management Staff surveys Feedback mechanisms (see assurance source section)

2.5 Sources of assurance

Quality of services

Current providers have a range of clinical and care governance arrangements in place. Through these, the IJB has access to assurances which support the delivery of high quality care and ensure good governance. These assurances include:

- Quality Strategies
- Policies on raising concerns
- HR Policies
- Safeguarding Policy (Vulnerable Adults)
- Incident reporting and investigation policies and procedures
- Information Governance policies and processes
- Board member visits to service areas ('Deep Dive' activity)
- Staff Surveys
- Joint Staff Forum
- Staff Induction Programmes
- Leadership Programmes
- Performance and Appraisal Development Process
- Compliance reports – health and social care
- Learning lessons systems

Engagement

The IJB regards the engagement of its partners and stakeholders in the planning and delivery of services as essential to achieving the goals of integration. The nature and level of engagement varies from group to group and the range of stakeholder with whom the IJB engages is broad, including:

- Service users
- Carers and families
- Staff
- The 'Our Ideas' Partnership suggestions website and system

- Commissioners
- Other providers in the acute and primary care health and social care sectors
- The independent and voluntary sector
- Housing, education providers, North East Partnership (IJBs)

Engagement will include consultation; communication of information; involvement in decision-making around planning and transforming services; feedback on services and other issues of concern or interest.

The ACHSP Communication and Engagement plan is in place in order to support engagement across these groups, and to provide a source of assurance that appropriate activities have been identified and implemented. It includes consideration of how to engage with hard to reach communities. The plan will include measures to assess its effectiveness over time. These will be reported through the IJB's Executive Group.

Newsletters	Groups
• Health Village newsletter • NHSG Team Brief • Scottish Care newsletter/ e-bulletin • SHMU community newsletters • Aberdeen Partnership Newsletter • ACVO e-bulletin • VSA Carers News	• Care at Home Providers Group Forum • Individual Independent providers • Care and Support Providers Aberdeen • Individual Third sector providers • Housing providers / associations • NHS Grampian Public Forum • City Voice • Civic Forum • Sheltered Housing Network • Joint Strategy groups • GP Cluster Management Groups • Cluster Operational Groups (COGs) • Implementation Group (CIGs) • Public Health Co-ordinators Network • Local Community councils • Mental Health and Learning Disability forums • Joint Staff Forum • Learning Partnerships

Other internal and external sources of assurance

In addition to the assurances emanating from the IJB's clinical and care governance framework, and its engagement with partners and stakeholders, there are numerous internal and external sources which relate to the delegated services. These include:

- Internal Audit
- External Audit
- External inspection agencies (Care Inspectorate and Healthcare Improvement Scotland)
- Health and Safety Executive
- Mental Welfare Commission
- Externally commissioned independent investigations e.g. Ombudsman and homicide investigations
- Clinical Audit
- Audit Scotland
- Scottish Council for Voluntary Organisations (SCVO)
- Royal College reviews
- Accreditation
- Information Services Division (ISD) Scotland
- Benchmarking with other health and social care providers
- Involvement in and learning from case reviews
- Voluntary Health Scotland
- Coroner's Inquests

The IJB will also commission external reviews of specific services where the need for additional independent assessments and assurance are identified.

Appendices

1 Strategic Risk Register format

2 Committee diagram

3 Roles of committees and groups

4 Programme Board Governance Diagram

5 Clinical and care governance diagram

6 Risk assessment tables

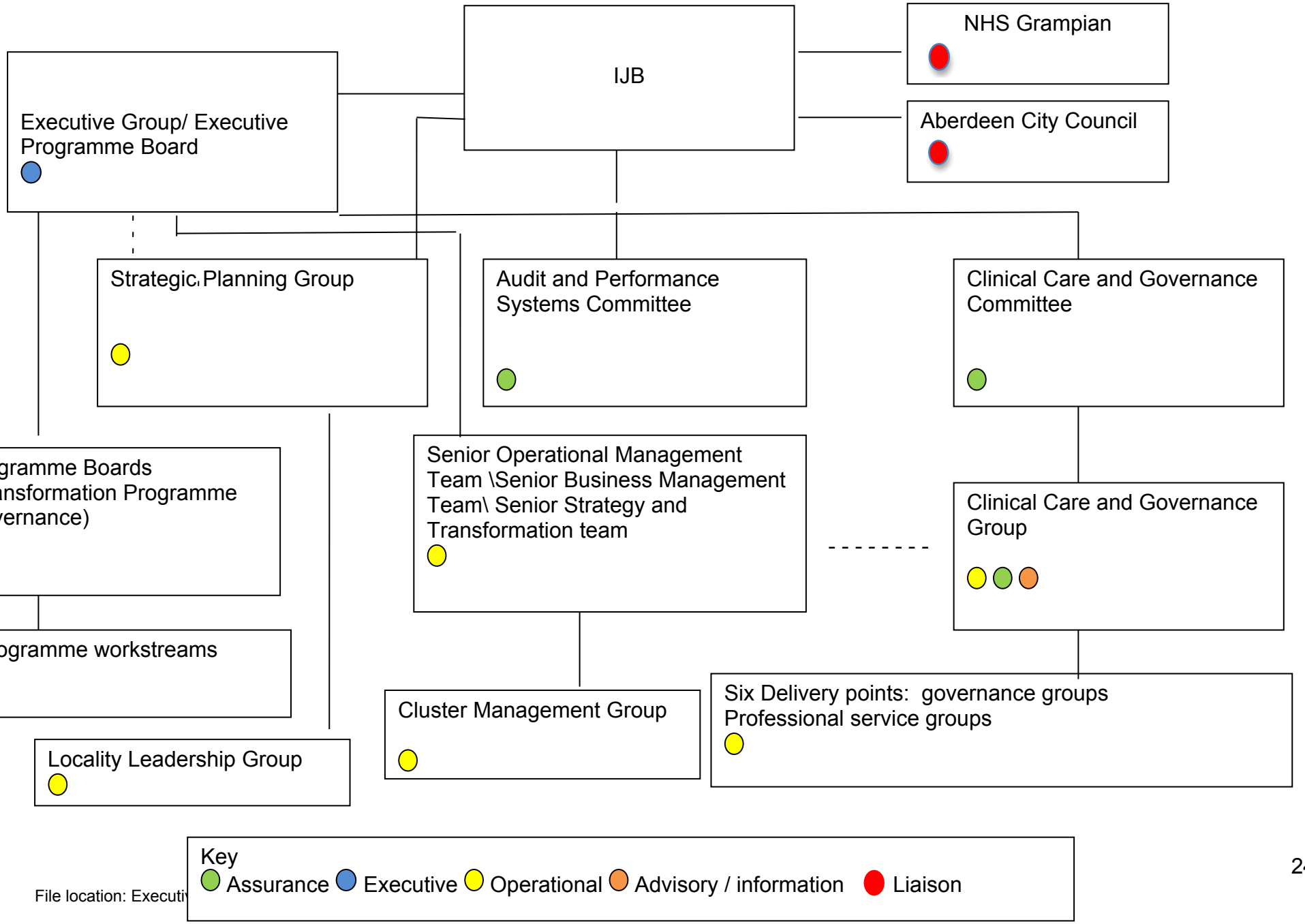
7 Risk escalation process

8 Cycle of business (continually developed)

Appendix 1 – Strategic risk register format

- 1 -	
Description of Risk:	
Strategic Priority:	**Lead Director:**
Risk Rating: low/medium/high/very high **Medium**	**Rationale for Risk Rating:** **Rationale for Risk Appetite:**
Risk Movement: increase/decrease/no change **NO CHANGE**	
Controls:	**Mitigating Actions:**
Assurances:	**Gaps in assurance:**
Current performance:	**Comments:**

Appendix 2 - Board committee diagram



Appendix 3 – Roles of the Committees

Name of committee or group	Principal function/s	Membership	Reports to	Reports received / reviewed
Executive Group	Robust and effective management processes are required to ensure management oversight of: • Care and Clinical Governance • Risk Management and oversight of Service and Corporate Risk Registers • Financial governance and performance oversight • Service performance • Staff governance • Health and Safety • Executive oversight of change programmes • Ensuring IJB's strategic plans are	The core membership is as follows: • Chief Officer – chair • Executive Assistant – co-ordinates papers, provides analysis and follows up actions, minutes meeting • Chief Finance Officer – financial reporting • Clinical Lead – Clinical Governance reporting • Head of Operations – Operational performance • Head of Strategy and Transformation - performance	IJB	The following will report as required to the Executive Group: • Lead Service Managers - Social Work • Lead Service Managers – Nursing, AHPs, Public Health, Primary Care Development and Intermediate Care and Rehab • Integration Programme Manager • Chief Officers – Moray and Aberdeenshire in relation to performance of 'hosted services' • General Manager Mental Health and Learning Disabilities (NHS) • Designated service health and safety leads • Partnership representatives / trade union representatives • Service Improvement and Quality • Chief Social Work Officer

Name of committee or group	Principal function/s	Membership	Reports to	Reports received / reviewed
	operationalised • Good decision making and development of business cases			• Health Intelligence • Business Managers
Strategic Planning Group	The role of the Strategic Planning Group is overseeing the development of the strategic commissioning plan and in continuing to review progress, measured against the statutory outcomes for health and wellbeing, and associated indicators. The strategic commissioning plan should be revised as necessary (and at least every three years), with the involvement of the Strategic Planning Group.	Prescribed groups of persons to be represented in strategic planning group: • health professionals; • users of health care; • carers of users of health care; • commercial providers of health care; • non-commercial providers of health care; • social care professionals; • users of social care; • carers of users of social care; • commercial providers of social care; • non-commercial providers of social care; • non-commercial providers of social housing; and third sector bodies carrying out activities related to health care or social care.	Executive Group	Locality Leadership Group
Audit and Performance Systems Committee	To review and report on the relevance and rigour of the governance structures in place and	The Committee will be chaired by a non-office bearing voting member of the IJB and will rotate between NHS and ACC. The Committee will consist of not less	IJB	Annual audit plan

Name of committee or group	Principal function/s	Membership	Reports to	Reports received / reviewed
	the assurances the Board receives. These will include a risk management system and a performance management system underpinned by an Assurance Framework.	than 4 members of the IJB, excluding Professional Advisors. The Committee will include at least two voting members, one from Health and one from the Council. The Board Chair, Chief Officer, Chief Finance Officer Chief Internal Auditor and other Professional Advisors and senior officers as required as a matter of course, external audit or other persons shall attend meetings at the invitation of the Committee. The Chief Internal Auditor should normally attend meetings and the external auditor will attend at least one meeting per annum.		
Clinical and Care Governance Committee	To provide assurance to the IJB on the systems for delivery of safe, effective, person-centred care in line with the IJB's statutory duty for the quality of health and care services.	The Committee shall be established by the IJB and will be chaired by a voting member of the IJB. The Committee shall comprise of: • 4 voting members of the IJB • Chief Officer • Chief Social Work Officer • Chair of the Clinical and Care Governance Group/ Clinical Lead (GP) • Chair of the Joint Staff Forum • Professional Lead – Nurse/AHP • Public Representative • Third sector Sector representatives	IJB	CCG Group report Feedback/Incidents Reporting Escalations from CCG Group
Clinical and Care Governance	To oversee and provide a coordinated approach to	• Clinical Lead (Chair)	Clinical and Care	Reports from services: AHP

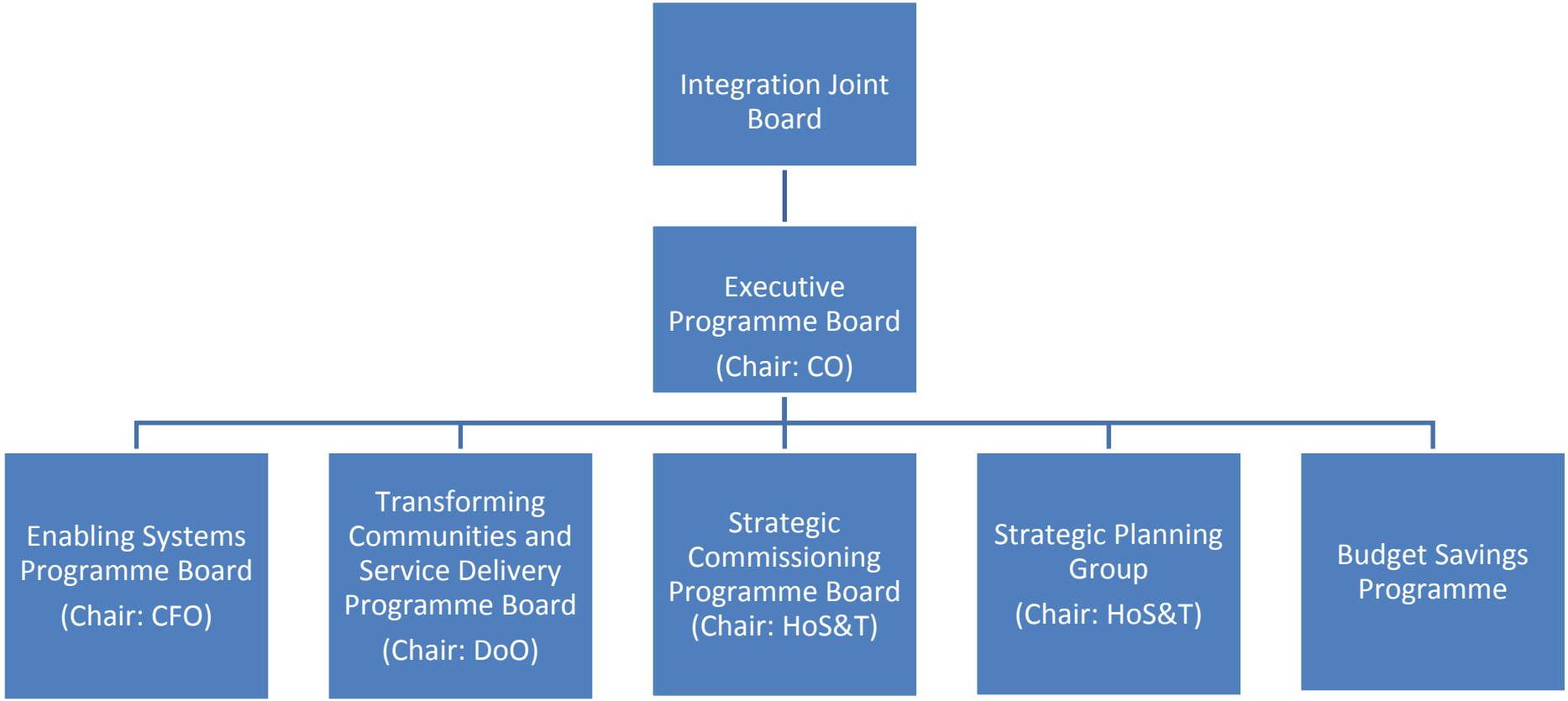
Name of committee or group	Principal function/s	Membership	Reports to	Reports received / reviewed
Group	clinical and care governance issues within the Aberdeen City Health and Social Care Partnership.	• Clinical and Care Governance Lead • Head of Operations • Lead Social Work Manager • Lead Nurse • Public Health Lead • Clinical Governance Coordinator/Facilitator • Patient/Public Representative • Lead Allied Health Professional • GP Representative • Dental Clinical Lead or Dental Service Representative • Lead Optometrist • Representative from Sexual Health Service • General Practice Patient Safety Lead • Woodend Hospital and Link@ Woodend Representative • Representative from Commissioned Service • Partnership Representative • Representative from Community Mental Health and Learning Disability Services • Representative from Acute Sector • Public Partner	Governance Committee	Dentistry Optometry Pharmacy Nursing General Practice Social Work/Care Woodend Hospital and Links @ Woodend Biannual Reports Falls Pharmacy/medication Patient Safety in Primary Care
Locality Leadership Group	To deliver the locality planning requirements of the Public Bodies (Joint	Chair and Vice Chair to be agreed by Group and appointed for a fixed 2-year period.	Strategic Planning Group	

Name of committee or group	Principal function/s	Membership	Reports to	Reports received / reviewed
	Working) (Scotland) Act 2014, in respect of the Aberdeen City Health and Social Care Partnership. The Locality Leadership Group will play a key role in ensuring the delivery of the Aberdeen City Health and Social Care Strategic Plan, including contributing to the delivery of its associated strategic outcomes. The role of the Locality Leadership Group will include developing and ensuring appropriate connections and partnerships across the Locality to improve the health and wellbeing of the locality population and reduce the health inequalities that we know impact poorly on people's lives. The locality leadership group will influence, and be influenced by, the city's Strategic Planning Group and ultimately the Integration Joint Board.	▪ Health and Social Care Partnership Locality Manager ▪ GP Locality Lead ▪ Other GPs (TBC) ▪ Representative of Acute Sector (Unit Operational Manager) ▪ AHP Representative ▪ Nursing Representative ▪ Community Mental Health/ LD/ Rehab representation ▪ Unscheduled care representative (Out of hours/ A&E) ▪ Geriatric Medicine representative ▪ Social Care Representative (Bon Accord Care & Adult Social Care) ▪ Housing sector representative ▪ Third sector representative ▪ Independent Sector Representative ▪ Carer representative ▪ Patient representative ▪ Community representatives ▪ People managing services in the locality area Other locality stakeholders as determined by the group Further to the above membership, the group may arrange reports/ attendance at meetings from non-members as required, such as;		

Name of committee or group	Principal function/s	Membership	Reports to	Reports received / reviewed
	The locality leadership group will also influence and be influenced by Community Planning Partnership processes.	▪ Primary Care Dentistry Locality Representative ▪ Primary Care Optometry Locality Representative ▪ Primary Care Pharmacy Locality Representative		
Executive Programme Board	♦ Provide direction to programme board and working groups ♦ Identify prioritised projects ♦ Approve Business Cases ♦ Ensure programme progress including ensuring that progress is supported to continue at pace Approve significant changes to programmes	♦ Executive Team ♦ Lead Transformation Manager	♦ Seek IJB approval to incur expenditure for projects where required under standing orders (full life costs) Report on progress and performance to IJB	Papers from Enabling Systems/Strategic Commissioning/Transforming Communities and Service Delivery Programme Boards
Enabling Systems/Strategic Commissioning/Transforming	♦ Support and enable progress at pace across transformation portfolio ♦ Review and approve Project Proposal Documents ♦ Consider "deep dives" into working group programmes to be assured of progress Ensure delivery of anticipated benefits and where these are no longer	♦ Chair (ET Member) ♦ Lead Transformation Manager (lead officer & vice chair) ♦ Operational Managers ♦ Lead Professional Managers ♦ Independent Sector ♦ Third Sector ♦ ACC Communities and Housing ♦ Acute Sector Finance	Executive Programme Board	Workstreams and project groups

Name of committee or group	Principal function/s	Membership	Reports to	Reports received / reviewed
	deliverable, redirect projects/ programmes accordingly			

Appendix 4 – Transformation Programme Governance Diagram



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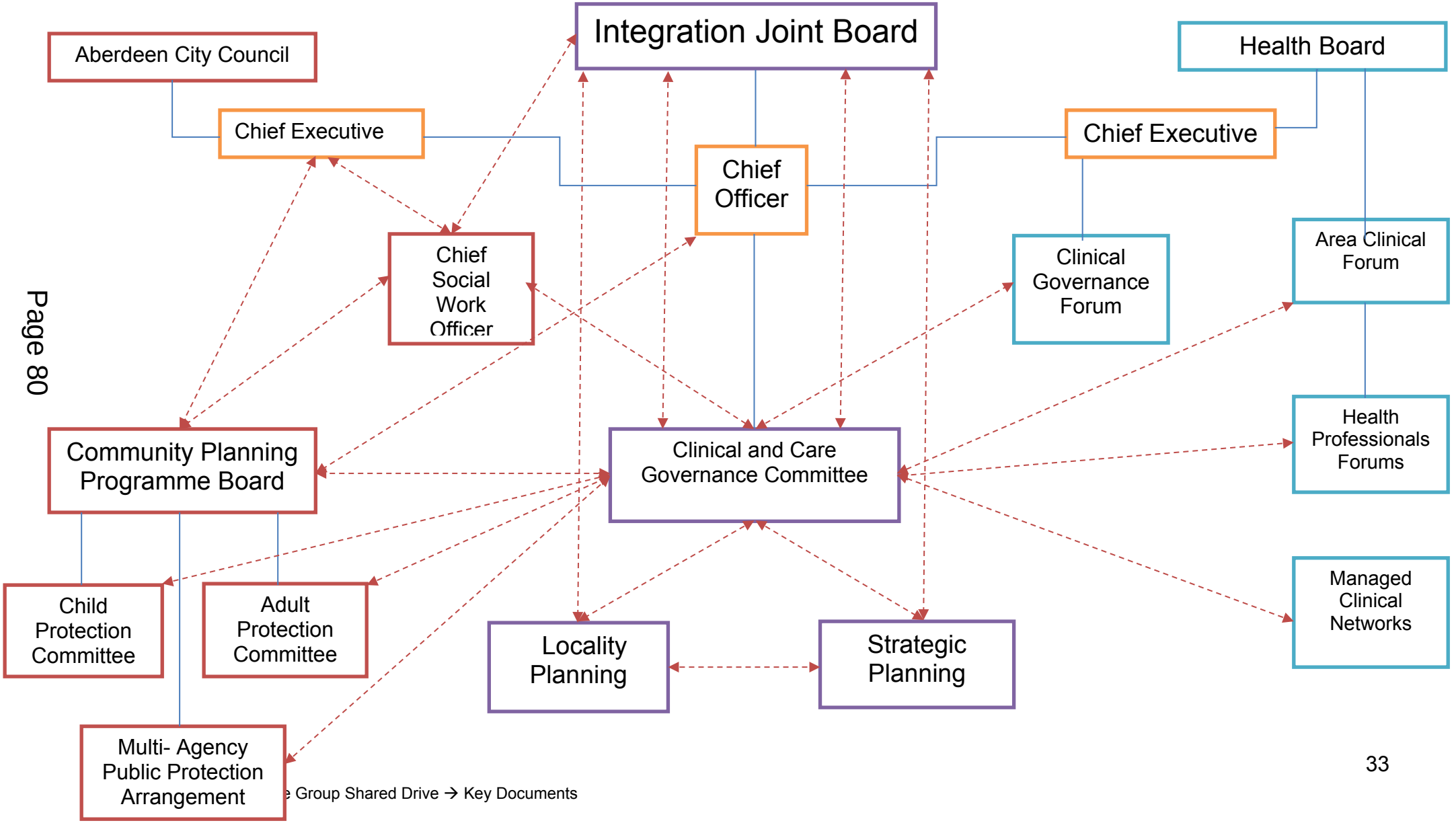
Appendix 5 – Clinical and care governance diagram



Appendix 6 – Risk assessment tables

NHS Scotland Core Risk Assessment Matrices

Table 1 - Impact/Consequence Definitions

Descriptor	Negligible	Minor	Moderate	Major	Extreme
Patient Experience	Reduced quality of patient experience/ clinical outcome not directly related to delivery of clinical care.	Unsatisfactory patient experience/clinical outcome directly related to care provision – readily resolvable.	Unsatisfactory patient experience/clinical outcome, short term effects – expect recovery <1wk.	Unsatisfactory patient experience/ clinical outcome; long term effects –expect recovery >1wk.	Unsatisfactory patient experience/clinical outcome, continued ongoing long term effects.
Objectives/ Project	Barely noticeable reduction in scope, quality or schedule.	Minor reduction in scope, quality or schedule.	Reduction in scope or quality of project; project objectives or schedule.	Significnt project over-run.	Inability to meet project objectives; reputation of the organisation seriously damaged.
Injury (physical and psychological) to patient/ visitor/staff.	Adverse event leading to minor injury not requiring first aid	Minor injury or illness, first aid treatment required.	Agency reportable, e.g. Police (violent and aggressive acts). Significnt injury requiring medical treatment and/or counselling.	Major injuries/long term incapacity or disability (loss of limb) requiring medical treatment and/or counselling.	Incident leading to death or major permanent incapacity.
Complaints/ Claims	Locally resolved verbal complaint	Justified written complaint peripheral to clinical care.	Below excess claim. Justified complaint involving lack of appropriate care.	Claim above excess level. Multiple justified complaints	Multiple claims or single major claim. Complex justified complaint.
Service/ Business Interruption	Interruption in a service which does not impact on the delivery of patient care or the ability to continue to provide service.	Short term disruption to service with minor impact on patient care.	Some disruption in service with unacceptable impact on patient care. Temporary loss of ability to provide service.	Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked.	Permanent loss of core service or facility. Disruption to facility leading to significant "knock on" effect.
Staffing and Competence	Short term low staffing level temporarily reduces service quality (< 1 day). Short term low staffing level (>1 day), where there is no disruption to patient care.	Ongoing low staffing level reduces service quality **Minor error** due to ineffective training/implementation of training.	Late delivery of key objective/ service due to lack of staff. **Moderate error** due to ineffective training/ implementation of training. Ongoing problems with staffing levels	Uncertain delivery of key objective /service due to lack of staff. **Major error** due to ineffective training/implementation of training.	Non-delivery of key objective/ service due to lack of staff. Loss of key staff. **Critical error** due to ineffective training / implementation of training.
Financial (including damage/loss/ fraud)	Negligible organisational/ personal financial loss (£<1k).	Minor organisational/ personal financial loss (£1-10k).	Significnt organisational / personal financial loss (£10-100k).	Major organisational/personal financial loss (£100k-1m).	Severe organisational/ personal financial loss (£>1m).
Inspection/Audit	Small number of recommendations which focus on minor quality improvement issues.	Recommendations made which can be addressed by low level of management action.	Challenging recommendations that can be addressed with appropriate action plan.	Enforcement action. Low rating. Critical report.	Prosecution. Zero rating. Severely critical report.
Adverse Publicity/ Reputation	Rumours, no media coverage. Little effect on staff morale.	Local media coverage – short term. Some public embarrassment. Minor effect on staff morale/ public attitudes.	Local media – long-term adverse publicity. Significnt effect on staff morale and public perception of the organisation.	National media/adverse publicity, less than 3 days. Public confidnce in the organisation undermined. Use of services affected.	National/International media/ adverse publicity, more than 3 days. MSP/MP concern (Questions in Parliament). Court Enforcement. Public Enquiry/FAI.

Table 2 - Likelihood Definitions

Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Probability	• Can't believe this event would happen • Will only happen in exceptional circumstances.	• Not expected to happen, but definite potential exists • Unlikely to occur.	• May occur occasionally • Has happened before on occasions • Reasonable chance of occurring.	• Strong possibility that this could occur • Likely to occur.	This is expected to occur frequently/in most circumstances more likely to occur than not.

Table 3 - Risk Matrix

Likelihood	Consequences/Impact				
	Negligible	Minor	Moderate	Major	Extreme
Almost Certain	Medium	High	High	V High	V High
Likely	Medium	Medium	High	High	V High
Possible	Low	Medium	Medium	High	High
Unlikely	Low	Medium	Medium	Medium	High
Rare	Low	Low	Low	Medium	Medium

References: AS/NZS 4360:2004 'Making It Work' (2004)

Table 4 - NHSG Response to Risk

Describes what NHSG considers each level of risk to represent and spells out the extent of response expected for each.

Level of Risk	Response to Risk
Low	Acceptable level of risk. No additional controls are required but any existing risk controls or contingency plans should be documented. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective.
Medium	Acceptable level of risk exposure subject to regular active monitoring measures by Managers/Risk Owners. Where appropriate further action shall be taken to reduce the risk but the cost of control will probably be modest. Managers/Risk Owners shall document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Managers/Directors/Assurance Committees will periodically seek assurance that these continue to be effective.
High	Further action should be taken to mitigate/reduce/control the risk, possibly urgently and possibly requiring significnt resources. Managers/Risk Owners must document that the risk controls or contingency plans are effective. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. Relevant Managers/Directors/Executive and Assurance Committees will periodically seek assurance that these continue to be effective and confirm that it is not reasonably practicable to do more. The Board may wish to seek assurance that risks of this level are being effectively managed. However NHSG may wish to accept high risks that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significnt incidents(s) of regulatory non-compliance, potential risk of injury to staff and public.
Very High	Unacceptable level of risk exposure that requires urgent and potentially immediate corrective action to be taken. Relevant Managers/Directors/Executive and Assurance Committees should be informed explicitly by the relevant Managers/Risk Owners. Managers/Risk Owners should review these risks applying the minimum review table within the risk register process document to assess whether these continue to be effective. The Board will seek assurance that risks of this level are being effectively managed. However NHSG may wish to accept opportunities that have an inherent very high risk that may result in reputation damage, financial loss or exposure, major breakdown in information system or information integrity, significnt incidents(s) of regulatory non-compliance, potential risk of injury to staff and public.

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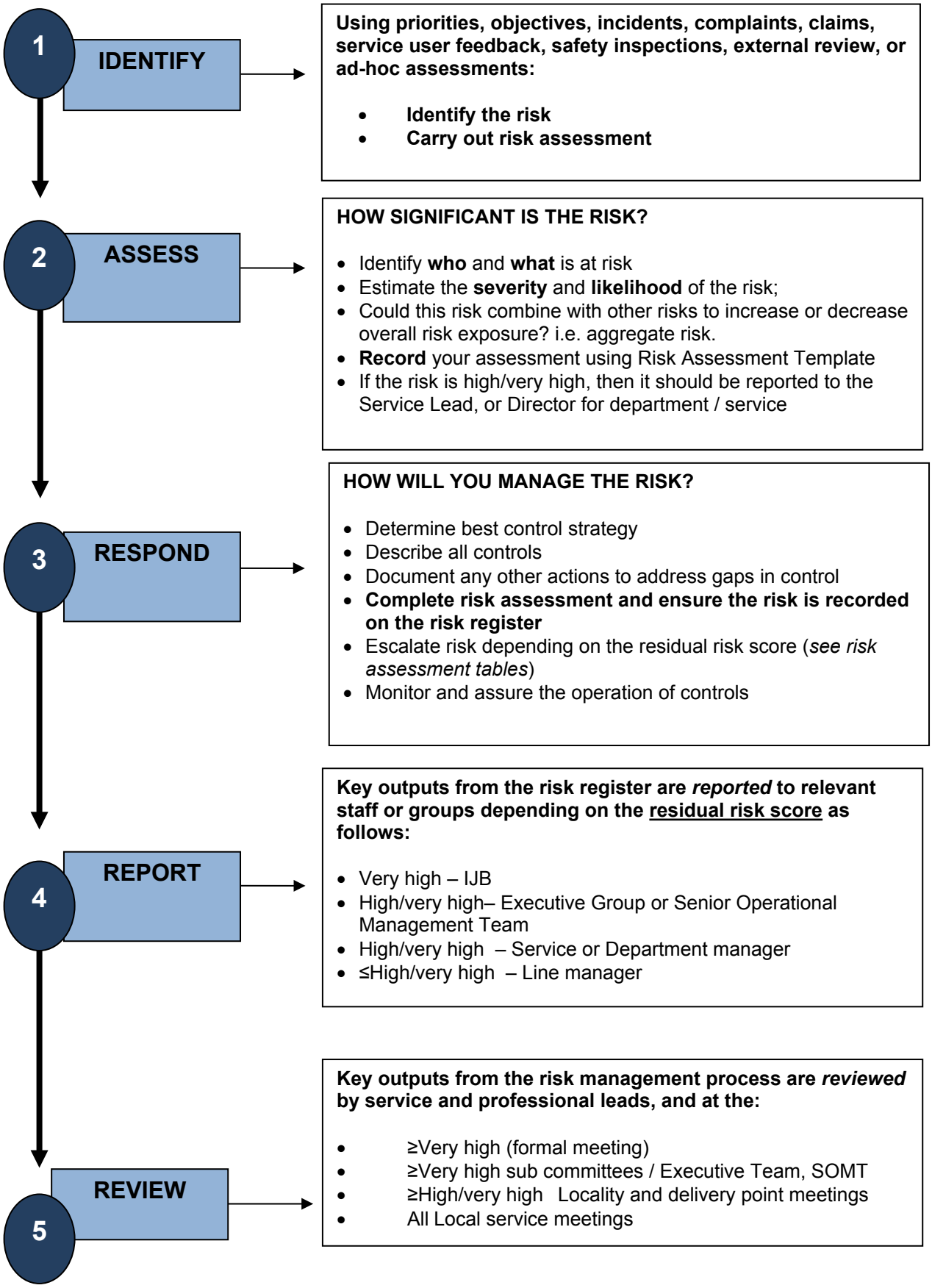
Appendix 7 – Risk escalation process



Appendix 8 – Cycles of business

Business Type	Report Title	Lead Officer	Committee	Frequency	Last Reported	Reporting Date(s) for 2017/18
Audit	Annual Internal Audit Plan	D. Hughes	APS	Annual	Apr-17	Apr-18
Audit	Statement of Internal Financial Controls from Internal Auditors	D. Hughes	APS	Annual	Jun-17	Jun-18
Audit	External Auditor Plan	KPMG	APS	Annual	Feb-17	Feb-18
Audit	External Auditor Report	KPMG	APS	Annual	NA	Aug-17
Audit	Internal and External Auditors Private Meeting	NA	APS	Annual	Apr-17	Sep-17
Finance	Financial monitoring	A. Stephen	IJB & APS	Quarterly	Jun-17(APS)	Aug-17 (IJB), Nov-17 (APS), Feb-18 (APS), Jun-18 (IJB)
Finance	Unaudited Annual Accounts	A. Stephen	APS	Annual	Jun-17	Jun-18
Finance	Audited Annual Accounts	A. Stephen	APS	Annual	Sep-16	Aug-17
Finance	Annual Budget	A. Stephen	IJB	Annual	Mar-17	Mar-18

Finance	Review of Financial Regulations	A. Stephen	APS	Annual	Sep-17	Sep-18
Governance	Chief Social Worker Annual Update	B. Oxley	IJB	Annual	Jan-17	Jan-18
Governance	Board Assurance Framework Review	A. Stephen	APS	Annual	Jun-17	Jun-18
Governance	Governance Statement	A. Stephen	APS	Annual	Apr-17	Apr-18
Governance	Review of Committee Members	J. Proctor	IJB	Annual	Jun-17	Jun-18
Governance	Report on Directions	J. Proctor	IJB	Annual	NA	Mar-18
Governance	Review of Standing Orders and Scheme of Delegation	J. Anderson	IJB	Annual	NA	Oct17
Performance	Annual Performance Report	J. Proctor	IJB	Annual	Jun-17	Jun-18
Performance	Review of Performance Management Framework	S. Shaw	APS	Annual	NA	Sep-17
Performance	Performance Management Framework	S. Shaw	APS	Quarterly	NA	Aug-17 (IJB), Nov-17 (APS), Feb-18 (APS), Jun-18(IJB)
Risk	Strategic Risk Register	J. Proctor	IJB & APS	Quarterly	Feb-17	Aug-17 (IJB), Nov-17 (APS), Feb-18 (IJB), Jun-18 (IJB)

Risk	Operational risk register	Tom Cowan	CCG	Bi-monthly	Feb-17	Every meeting
Strategic	Strategic Plan - Review and Update	S. Shaw	IJB	Annual	NA	TBC
Transformation	Transformation Plan Monitoring	S Shaw	APS	Quarterly	Feb-17	Sept-17, Feb-18
Transformation	Review of Transformation Process	S Shaw	APS	Annually		Sept-17
Transformation	IJB Annual Update	S Shaw	IJB	Annual	NA	Jan-18

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Aberdeen City Health & Social Care Partnership
A caring partnership

Audit and Performance Systems Committee

Report Title	Post Integration Review Audit
Lead Officer	Chief Finance Officer
Report Author (Job Title, Organisation)	Chief Finance Officer
Report Number	HSCP/17/097
Date of Report	16 October 2017
Date of Meeting	21 November 2017

1: Purpose of the Report

The purpose of this report is to present the planned Post Integration Review Internal Audit report.

2: Summary of Key Information

The Executive Summary of the attached Internal Audit report contains the summary of key information.

A number of the dates provided for implementation of the recommendations fall into the next calendar year. This is to provide officers with the time to undertake the work in the context of their other work commitments and for the relevant approvals where necessary to be obtained. The dates are agreed by officers and the internal audit section as being reasonable with regard to the work required to close off the recommendation. If the Internal Audit section and (or) officers felt that a recommendation needed to be closed off urgently because of the risk it exposed the organisation to then it would, most probably through the audit process itself.

In order to provide more information to the committee on the timelines required to close off these recommendations further information is contained within appendix 1 of this report.

Appendix 2 contains the internal audit report. For the purposes of providing clarity and assurance to the APS Committee, recommendation 2.4.12 indicates 'The IJB should ensure transformation programme budgets are adequately controlled'. Officers have agreed to this statement and provided assurance to the Internal Auditor that the budgets are being adequately controlled. Officers have also indicated that to provide even more control over budgets that a change management process should be developed and implemented and this is what the

recommendation and implementation date refers to.

3:	Equalities, Financial, Workforce and Other Implications

Equalities – there are no equalities implications arising directly from the content of this report.

Financial – there are no equalities implications arising directly from the content of this report.

Workforce – there are no equalities implications arising directly from the content of this report.

Other – there are no equalities implications arising directly from the content of this report.

4:	Management of Risk

Identified risk(s):
Good governance and internal controls are fundamental to the delivery of the strategic plan and therefore applicable to most of the risks within the strategic risk register.

Link to risk number on strategic or operational risk register:
Risk numbers 1 to 10 of the strategic risk register.

How might the content of this report impact or mitigate the known risks:
Risk is inherent in all business operations. Management implement controls to mitigate identified risks and it is the role of Internal Audit to periodically review the systems of internal control to provide assurance to those charged with governance regarding their adequacy. The Internal Audit plan is developed on a risk basis, the detail of which was agreed by Aberdeen City Council's Audit, Risk and Scrutiny Committee.

5:	Recommendations

It is recommended that the Audit & Performance Systems Committee:

1. Review, discuss and comment on the issues raised within this report and the attached in appendix 2.

2. Note the further assurances provided in Appendix 1 re the timelines for completion of the recommendations.

Appendix 1

Recommendation 2.1.6 commissioning plans delivered and costed – March 2018

This was agreed to come back to the IJB on the 12 December. If it is not agreed at this meeting and further work is required then the next opportunity the IJB will have to agree it is the 30 January 2018.

Recommendation 2.2.3 – Risk management framework – March 2018

This is on Audit & Performance Systems agenda for the 21 November and if agreed will go to the IJB on 12 December, If not agreed at the meeting on the 21 November then will not be signed off by APS until 13 February and then potentially the IJB on 27 March.

Recommendation 2.3.7 – Asset Strategy – June 2018

A team is in the process of being established to develop this strategy and therefore this needs a great deal of work to move forward. The team will do everything it can to achieve this deadline, however, as the work still needs to be fully scoped, there is a risk that the level of work and process means that June 2018 is not achievable.

Recommendation 2.4.2 – Locality Budget timetable – March 2018

This resources and staff required to move this recommendation forward will largely be working solely on supporting the budget setting and budget monitoring processes over the next few months. While this recommendation is looking for a timetable, the setting of the budgets needs to run in parallel with the move to localities and the timetable associated with this.

Recommendation 2.4.10 – Benefits Realisation Framework – March 2018

Framework is going to Executive Programme Board on the 6 December 2017 and then a workshop with the IJB on the 9 January 2018 and to APS for approval on the 13 February 2018.

Recommendation 2.4.12 – Change Management Process – March 2018

Introduced to Executive Programme Board at last meeting. The process will be submitted to APS for approval on the 13 February 2018.

Aberdeen City Health & Social Care Partnership
A caring partnership

Internal Audit Report

Aberdeen City Health & Social Care Partnership

Post Integration Review

Issued to:
Judith Proctor, Chief Officer
Alex Stephen, Chief Finance Officer
Sally Shaw, Head of Strategy and Transformation
Tom Cowan, Head of Operations
External Audit

EXECUTIVE SUMMARY

The objective of this audit was to provide assurance over whether integration objectives are on line to be achieved including: that there has been evaluation of actual risk and financial performance against pre-integration assumptions, performance on relevant integration milestones, lessons learned, and that the Partnership is on course to deliver the planned long term benefits.

A review of performance against the pre-integration assumptions will be included within the Partnership's annual performance report, which will be shared with the Partners.

Data to demonstrate delivery of some local and national outcomes is still being sourced internally and by the Scottish Government, and officers are developing both a benefits realisation framework and improvement plan. Performance is considered more regularly by the Integration Joint Board and the individual Partners at Chief Officer level, but is not considered to be required by Partners' Committees or Boards.

Appropriate governance arrangements are in place, however a scheme of delegation, protocol for Directions, service delivery and commissioning plans, and a change management process, are still under development. Dates have now been set for their delivery.

1. INTRODUCTION

1.1 Aberdeen City Health and Social Care Partnership formed in February 2016, following approval of its Integration Scheme. Publication of its Strategic Plan, and delegation of service delivery by its Partners: NHS Grampian and Aberdeen City Council, was completed to allow the Partnership to commence operations in April 2016.

1.2 The Partnership manages its strategy and operations via an Integration Joint Board (IJB), supported by Committees, an Executive Team, and officers within the Partners reporting to the Chief Officer. Resources and budgets have been delegated to the Partnership, which directs services from the Partners via official Directions in order to fulfil the requirements of its Strategic Plan.

1.3 The objective of this audit was to provide assurance over whether integration objectives are on line to be achieved including: that there has been evaluation of actual risk and financial performance against pre-integration assumptions, performance on relevant integration milestones, lessons learned, and that the Partnership is on course to deliver the planned long term benefits.

1.4 The factual accuracy of this report and action to be taken with regard to the recommendations made have been agreed with Judith Proctor, Chief Officer to the IJB.

2. FINDINGS AND RECOMMENDATIONS

2.1 Governance Arrangements

2.1.1 The IJB was established as a legal entity in its own right, created by Parliamentary Order which came into force on 6 February 2016. This followed setting of its Integration Scheme and agreement of its Strategic Commissioning Plan (Strategic Plan). These two key documents formed the basis of the Partnership and set out its vision for the future. The main focus up to 1 April 2016, when services were formally delegated by Aberdeen City Council and NHS Grampian, was on the production and approval of these documents, and preparing the Board to take ownership of the Plan.

2.1.2 Committee papers show the development of the IJB itself and the wider policy landscape. There are effective structures in place to monitor and report progress and lessons learned, and to report exceptions to the appropriate Committee or Board as relevant.

2.1.3 The IJB has appropriate governance arrangements in place to support its operations and delivery of its strategy, including the Integration Scheme and Strategic Plan, Financial Regulations and a Risk Management Strategy. These key documents are in place and are being developed and further reviewed as necessary.

2.1.4 A Scheme of Delegation has been drafted but the IJB is awaiting the conclusion of a review of Aberdeen City Council's governance arrangements in order to align it with Partners. Although this reduces the risk of having to revisit the Scheme pending conclusion of other changes, it means an element of the Partnership's governance arrangements is not yet in place.

Recommendation
The IJB should progress development of its Scheme of Delegation.

Service Response / Action
Agreed. Delegation from the IJB is set out in the Board Assurance and Escalation Framework and Standing Orders. Work still needs to be progressed to update the Council's scheme of delegation to reflect the Chief Officer's role as a proper officer of the Council. Revisions to the Council's scheme of delegation are still being worked through.

Implementation Date	Responsible Officer	Grading
December 2017	Chief Finance Officer	Significant within audited area

2.1.5 Service delivery and Commissioning plans have not yet been developed or costed, and reliance is largely being placed on Partners' existing service delivery mechanisms: service delivery largely continues in line with Partners' prior arrangements, though these have not been set out in specific plans for approval by either Partners or the IJB in 2016/17. Changes are being managed under transformation programmes, or would be subject to separate Directions.

2.1.6 A draft Commissioning Plan has been drafted and was agreed by the IJB in August as ready for consultation. It will come back to the IJB in December for sign off. Further delays in its production could affect the Partnership's ability to deliver the Strategic Plan. The Partnership has noted that delays in recruitment of the Head of Strategy and Transformation (now concluded), and in progressing consultancy work due to sickness absence, have impacted on development of the Plan.

Recommendation		
The IJB should ensure service delivery and commissioning plans are developed and costed.		
Service Response / Action		
Agreed. A report was provided to the IJB in August 2017 with an implementation plan for consultation. This will be further developed for formal agreement in 2018.		
Implementation Date	**Responsible Officer**	**Grading**
March 2018	Head of Strategy and Transformation	Significant within audited area

2.1.7 The Integration Scheme sets out that the IJB will, through the Chief Officer, have an appropriate role in the operational delivery of services by the Parties in the carrying out of integration functions. However it also states that NHS Grampian and the Council will be responsible for the operational delivery of delegated services in implementation of Directions of the IJB.

2.1.8 The Chief Officer is responsible for the operational management of delegated services, and is a member of the Partners' senior management teams. The Chief Officer is line managed by and reports to the Chief Executives of both NHS Grampian and Aberdeen City Council, and provides regular updates on operational and financial performance and progress towards achieving the Partnership's objectives. However, these are not regularly reported to the Partners' respective Boards or Committees. Therefore, except through the Chief Officer to their senior management teams, the Partners have limited oversight of operational delivery of delegated services. Officers have however highlighted that voting membership of the IJB comprises both Elected Members of the Council and Non-Executive (and 1 Executive) Directors of NHS Grampian and the make-up of the IJB's committees also reflects this in relation to operational and performance reporting.

2.1.9 The Council receives a quarterly report from its Chief Executive regarding the IJB's governance arrangements, which includes some financial information. However this does not currently demonstrate performance against the Partnership's strategic or operational objectives. These are, as required by the legislation however reported to the IJB and performance reports are publically available.

2.1.10 Although the Strategy is owned and controlled by the IJB, Partners will still need oversight of progress with transformation, in order to demonstrate that the planned outcomes for their investment in the Partnership are being realised. Officers consider that this is provided in the Annual report which is shared with Partner organisations as required by the legislation and via the regular public reporting undertaken through the IJB.

2.1.11 The Scottish Government's Guidance for Integration Financial Assurance recommended that Boards document their evaluation of actual risk and financial performance against pre-integration assumptions. Although no separate report was prepared to document this, Officers consider that this requirement was met through the 2017/18 budget setting process, during which the Board considered the risks and assumptions, and set out its plans for the following financial year. In addition the IJB was required to publish an Annual Performance Report within four months of the year end. However, these are annual exercises, and more regular reporting would provide additional assurance.

Recommendation
The IJB should ensure that operational and financial performance, and details of progress with achieving the Partnership's objectives are provided to partners regularly for reporting to a relevant Board or Committee.

Service Response / Action
Not Agreed. Partners have delegated activities to the IJB and place assurance on the IJB to monitor regular and in-year performance. Voting membership of the IJB comprises both Elected Members of ACC and Non-Executive and Executive Directors of NHS Grampian from whom assurance can be obtained, and the Chief Executives have line of sight for accountability. Annual reporting, and the reports presented by Aberdeen City Council's Chief Executive, is considered sufficient and appropriate in reducing the risk of multiple lines of reporting and oversight.

Internal Audit Comment	**Grading**
Service position noted	Important within audited area

2.1.12 A process for issuing directions has developed, and decisions made on these are transparent and appropriately evidenced. However, development of a protocol or procedure would provide more assurance over consistency of the approach to developing and issuing directions. A protocol is being drafted for agreement by the Partners' Chief Executives.

Recommendation
The IJB should agree a protocol or procedure for development and issue of Directions.

Service Response / Action
Agreed. A procedure has now been put in place.

Implementation Date	**Responsible Officer**	**Grading**
Implemented	Chief Finance Officer	Important within audited area

2.2 Risk Management

2.2.1 Risk management has been well integrated into the IJB's reporting arrangements, and Committee agendas. Each report presented to the Board and Committees identifies key risks and mitigations. The Audit and Performance Systems Committee (APSC) receives updates to the strategic and operational risk registers as a standing item at every meeting.

2.2.2 However, some risk areas may not be updated for each Committee cycle, which could impact on the assurance provided over mitigations. Recent changes to presentation of the strategic risk register show changes more clearly. However, whilst the operational register now includes 'last updated' dates, this is not always being completed, and some areas do not appear to have been recently reviewed.

Recommendation
The IJB should ensure risk registers are kept up to date.

Service Response / Action
Agreed. Audit & Performance Systems (APS) Committee considered a report which recommended the operational risk be reported to the Clinical & Care Governance Committee and that both risk registers will be reported quarterly, with the strategic risk register quarterly update being reported two times a year to the IJB and APS

committee. The IJB received an update in August 2017.

Implementation Date	Responsible Officer	Grading
Implemented	Head of Strategy & Transformation	Important within audited area

2.2.3 The Risk Management Framework agreed in March 2016 has not been reviewed within 1 year as originally planned. The Partnership anticipates reviewing this in June 2017.

Recommendation
The IJB should review its Risk Management Framework as planned.

Service Response / Action
Agreed. This was included in the review of the Board Assurance and Escalation Framework reported to APS Committee in June 2017. A further review is being undertaken by the Good Governance Institute

Implementation Date	Responsible Officer	Grading
March 2018	Head of Strategy & Transformation	Important within audited area

2.3 Financial Governance

2.3.1 The Integration Scheme sets out that in order to give assurance to the Parties that the delegated budgets are being used for their intended purposes, financial monitoring reports will be produced for the Parties in accordance with timetables to be agreed at the start of each financial year. The format of such reports was to be agreed by the Director of Finance of NHS Grampian and the Section 95 Officer of the Council, in conjunction with the Chief Finance Officer of the IJB.

2.3.2 Regular financial performance monitoring has developed and is well presented, including detail of anticipated variances in outturn, and mitigating actions being taken. The Partnership is also considering improvements to the monitoring format following the 2016/17 year end process. However, a budget monitoring protocol or procedure, agreed between the Chief Finance Officer and the Partners' Finance Teams would provide more assurance over consistency going forward.

Recommendation
The CFO, in conjunction with the Partners' Finance Teams, should develop a budget monitoring procedure.

Service Response / Action
Agreed.

Implementation Date	Responsible Officer	Grading
December 2017	Chief Finance Officer	Important within audited area

2.3.3 Performance monitoring is still under development, within a defined Framework. There are currently only limited financial metrics – only the achievement of the IJB budget and associated savings.

2.3.4 Further financial measures could provide more assurance, however as there are separate reports to the APSC and IJB in respect of budget monitoring and transformation programme progress and expenditure it may not be necessary to provide these in the form of a performance indicator.

2.3.5 There appears to have been limited attempts so far to combine financial and non-financial performance. Doing so could better demonstrate the Partnership's achievement of Best Value, and the impact of its resource allocation decisions.

Recommendation
The IJB should consider combining financial and operational performance indicators.

Service Response / Action
Agreed – consideration will be given to including financial performance indicators in the performance management framework. However, it needs to be established whether these would add any value to the performance management framework. It is anticipated that either APSC or the IJB will receive quarterly updates on the finances, risk and performance management at the same meeting.

Implementation Date	Responsible Officer	Grading
December 2017	Chief Finance Officer\Head of Strategy and Transformation	Important within audited area

2.3.6 The 2017/18 budget has been set and a budget protocol agreed between the Partners and IJB.

2.3.7 There is no capital plan for the IJB at present: input is instead provided to the Partners' capital planning processes. The IJB needs to determine the asset requirements to support the Strategic Plan, and will need to identify and seek to incorporate any major changes to existing programmes at an early stage, as lead times for delivery could be significant.

Recommendation
The IJB should develop an asset management strategy.

Service Response / Action
Agreed – an officer in the IJB is already working on this, however, resourcing issues means that the priority to date has been on the projects already approved.

Implementation Date	Responsible Officer	Grading
June 2018	Chief Finance Officer	Significant within audited area

2.4 Transformation

2.4.1 Localities are key to supporting and delivering many of the planned changes to service delivery arrangements. A timetable for Locality Planning has only recently (March 2017) been developed and shared with the IJB (June 2017), as there had been delays in recruitment of Heads of Locality and other elements of the management structure. Locality Leadership Groups have been set up and engagement is ongoing with regard to the Localities, and the intention is for each to support the development of the Plans, which are anticipated to be in place by December 2017.

2.4.2 Locality budgets are also still to be developed. It will be difficult to demonstrate financial performance at a locality level until the budgets have been devolved. It is also a requirement to include the proportion of the budget spent on each locality in the annual performance report.

Recommendation		
The IJB should set a timetable for development of its Locality Budgets.		
Service Response / Action		
Agreed.		
Implementation Date	**Responsible Officer**	**Grading**
March 2018	Chief Finance Officer	Significant within audited area

2.4.3 For Transformation Programmes, a "Programme Management approach" is being taken, and the IJB receives regular updates. A new reporting style (Highlight Report) introduced in February 2017 improved the presentation of progress with the various programmes. It also more clearly links the programmes with the relevant elements of the Strategic Plan.

2.4.4 The report recognised that much of the programme is at the 'define' (or design) stage, rather than implementation, and this is slower than desired due to gaps in programme management capacity which Officers have attributed to the length of time recruitment processes take across partner organisations. Work is still ongoing to progress recruitment to fill these posts, many of which were originally identified and agreed in April 2016. This includes Heads of Locality posts, which impacts on locality planning and budgeting, as well as Programme Management posts.

2.4.5 Some elements of the programmes are still to be defined in detail, or have end dates specified. Others show end dates towards the end of the current Strategic Plan, suggesting outcomes and benefits may take some time to achieve. In some cases only short term milestones have been listed and future actions have not yet been timetabled.

2.4.6 Whilst there is an understandable desire to co-produce the outcomes, and wait for posts to be filled before progressing further elements of the programmes, and these new posts are required to provide sufficient capacity to facilitate the level of engagement required, it will take time to engage and plan with the relevant communities. It is important that the programme is updated to provide assurance over progress with meeting the ambitions set out in the Strategic Plan, within the period for which it was set.

2.4.7 Progress with the development of a Framework for Performance, Governance and Improvement was reported to the IJB in January 2017. Thereafter, summary performance data has been provided, including performance against a number of key areas, including a baseline or national benchmark where available. Although indicators have been identified to demonstrate achievement of Local and National Outcomes, in many cases reports indicate there is currently no data to support them. The Scottish Government has instigated a review of national indicators, and officers are working to determine whether all of the identified local indicators remain relevant, or if further data can be obtained. Forecasts and thresholds have still to be developed.

2.4.8 In order to determine whether benefits have been achieved from the transformational programmes, there needs to be a way of identifying the planned and actual impact on outcomes. Success criteria need to be defined in advance in order to demonstrate that resources are being planned and used effectively.

2.4.9 Officers are working on benefits planning and realisation. This includes a move to a new business case approach which requires anticipated benefits for each project to be clearly articulated at the outset, so that their achievement can be measured thereafter, and decisions made going forward. Changes to the internal review and reporting structure for programmes have also been implemented.

2.4.10 Progress will be measured using the suite of performance indicators. However, once this is in place it is still likely to be difficult to isolate the impact of individual changes. This could make it difficult to measure success and to inform future investment and disinvestment decisions.

Recommendation
The IJB should conclude its work on the Benefits Realisation Framework to ensure it can monitor progress and benefits realised against plans and forecasts for each programme.

Service Response / Action
Agreed.

Implementation Date	Responsible Officer	Grading
March 2018	Lead Transformation Manager	Significant within audited area

2.4.11 Transformational plans have been costed, however the costings are subject to variation. Changes are being approved via formal reports to the Board. Progress has been constrained by a shortage of capacity, particularly at programme and senior management levels. The Board has been advised that recruitment is ongoing, and the Service stated that recruitment to Programme Manager posts was ongoing in the first week of July 2017. In the meantime there is potential slippage, resulting in a potential underspend against transformation programmes. In contrast, two of the programmes which have not spent all of the funding allocated to them in the first year have been assigned additional budget.

2.4.12 There is a risk that the scope of programmes, and associated spending, may develop to use the available budget, rather than to fulfil the original remit. It is however recognised that it is difficult to scope and budget for these transformational change programmes.

Recommendation
The IJB should ensure transformation programme budgets are adequately controlled.

Service Response / Action
Agreed.

Initial assumptions were based on less information than is now available. As a result of ongoing iterative improvement processes, including revisions to initial assumptions as new information becomes available, financial allocations to programmes have changed to more accurately reflect the scope of the projects.

A change management process is being developed which will support this, and will be included in regular performance reports.

Implementation Date	Responsible Officer	Grading
March 2018	Lead Transformation Manager	Important within audited area

AUDITORS: D Hughes
C Harvey

Appendix 1 – Grading of Recommendations

GRADE	DEFINITION
Major at a Corporate Level	The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss, or loss of reputation, to the Council.
Major at a Service Level	The absence of, or failure to comply with, an appropriate internal control which could result in, for example, a material financial loss to the Service/area audited. Financial Regulations have been consistently breached.
Significant within audited area	Addressing this issue will enhance internal controls. An element of control is missing or only partial in nature. The existence of the weakness identified has an impact on a system's adequacy and effectiveness. Financial Regulations have been breached.
Important within audited area	Although the element of internal control is satisfactory, a control weakness was identified, the existence of the weakness, taken independently or with other findings does not impair the overall system of internal control.

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Aberdeen City Health & Social Care Partnership
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Audit and Performance Systems Committee

Report Title	Audit Scotland Report 'NHS in Scotland 2017'
Lead Officer	Chief Finance Officer
Report Author (Job Title, Organisation)	Chief Finance Officer
Report Number	HSCP.17.098
Date of Report	9 November 2017
Date of Meeting	21 November 2017

1: Purpose of the Report

To provide the Committee the opportunity to discuss and comment on the Audit Scotland Report 'NHS in Scotland 2017'.

2: Summary of Key Information

It is generally accepted as good practice for the audit committee of public bodies to review relevant national reports and reflect on the recommendations in the content of their own organisation. Given that Integration Joint Boards hold a critical role in the delivery of Health and Social Care services and are mentioned frequently in the report it is considered worthwhile for the Committee to review this report.

The attached report from Audit Scotland outlines the challenges facing the NHS and Scottish Government in funding and operating the NHS in a time of public sector funding restraint and changing demographics impacting on the number of patients.

The report provides recommendations to the Scottish Government and the NHS to consider. Aberdeen City IJB's improved performance around delayed discharges is specifically highlighted on page 29 of the report. NHS Grampian's financial planning assumptions are highlighted on page 28 of the report.

3: Equalities, Financial, Workforce and Other Implications

There are no equality, financial or workforce implications arising directly from

this report.

4:	Management of Risk

Identified risk(s): None to the IJB or Partnership as a direct result of this report.

5:	Recommendations

It is recommended that the Audit & Performance Systems Committee:

1. Review, discuss and comment on the report attached as appendix 1.

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NHS in Scotland 2017

AUDITOR GENERAL

Prepared by Audit Scotland
October 2017

NHS in Scotland 2017

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Contents

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

Exhibit data

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

Summary

Key messages

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

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

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

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

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

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

Recommendations

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

The Scottish Government should (paragraphs 63–70):

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

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

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

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

To improve governance, accountability and transparency:

The Scottish Government should (paragraphs 61–62):

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

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

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

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

The Scottish Government should (paragraph 87):

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

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

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

Introduction

Healthcare in Scotland needs to be delivered differently in future

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

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

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

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

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

the way healthcare is planned and delivered is changing

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

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

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

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

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

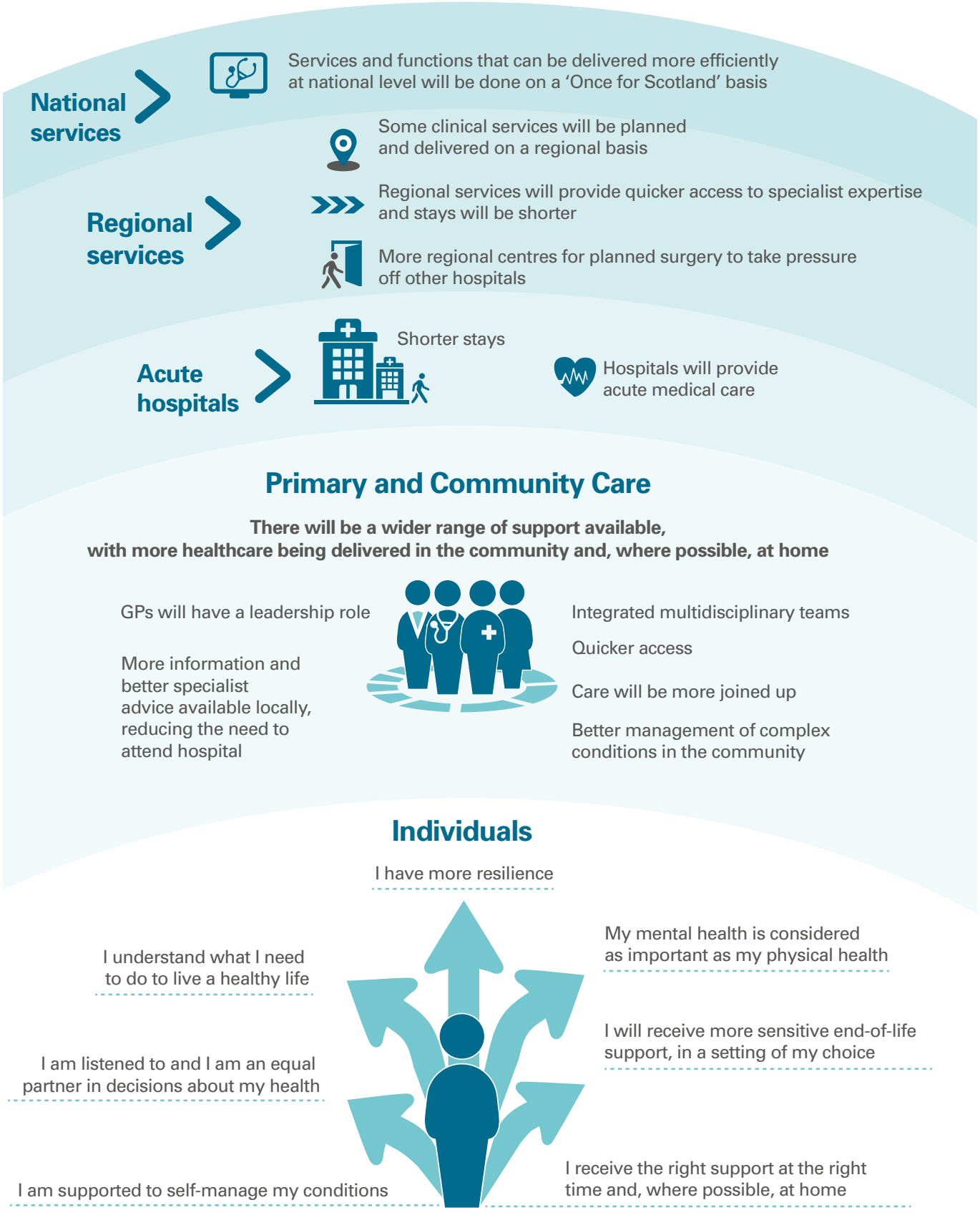
7. It is not yet clear how planning at each of the different levels will work together in practice. It is important that roles and responsibilities at each level, and how they link together, are well defined to ensure:

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

Exhibit 1

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

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

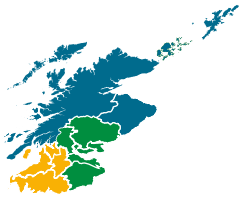


Source: Audit Scotland based on *Health and Social Care Delivery Plan,* Scottish Government, December 2016.

Exhibit 2

Planning levels in the Scottish health system

Multiple planning levels for healthcare are being developed.

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

Source: Audit Scotland

Part 1

The NHS in Scotland in 2016/17

Key messages

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

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

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

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

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

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

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

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

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

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

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

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

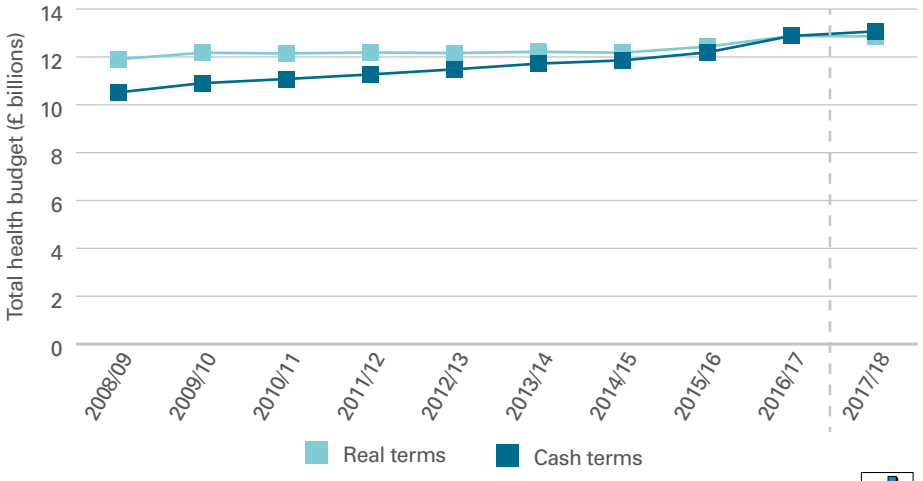
11. In 2016/17, the NHS budget included £250 million ring-fenced for social care funding for health and social care integration. Although this funding was for social care, it was included in the health budget and NHS boards were required to give this funding directly to Integration Authorities. Without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

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

Exhibit 3

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

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



Source: Audit Scotland

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

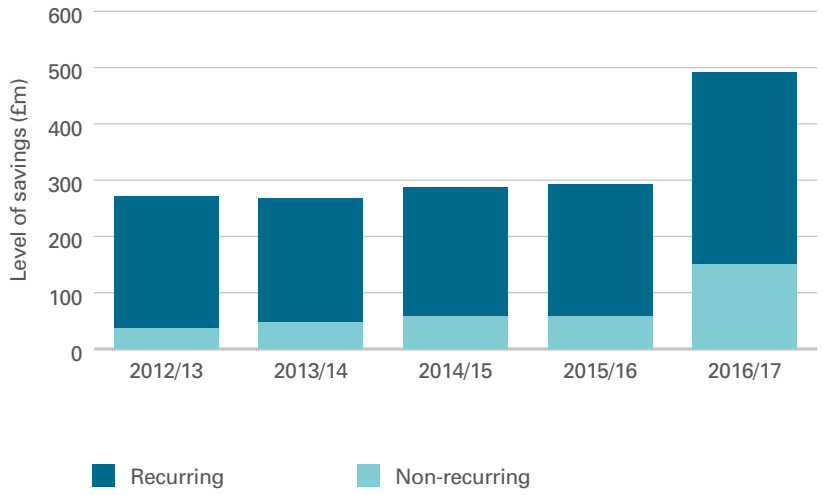
NHS boards' increasing use of one-off savings is unsustainable

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

Exhibit 4

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

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



Note: Figures are in cash terms.

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

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

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

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

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

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

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

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

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

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

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

Exhibit 5
Cost pressures in 2016/17

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

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

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

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

Backlog maintenance costs have reduced but remain considerable

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

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

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

Spending on drugs continues to rise

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

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

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

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

Cont.

Exhibit 5 (continued)

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

Clinical negligence costs have increased

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

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

Source: Audit Scotland

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

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

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

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

Case study 1

Financial pressures in NHS Grampian

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

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

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

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

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

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

Exhibit 6

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

Demand for NHS services continues to increase.

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

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

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

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

Outpatients

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

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

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

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

Inpatients and day cases

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

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

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

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

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

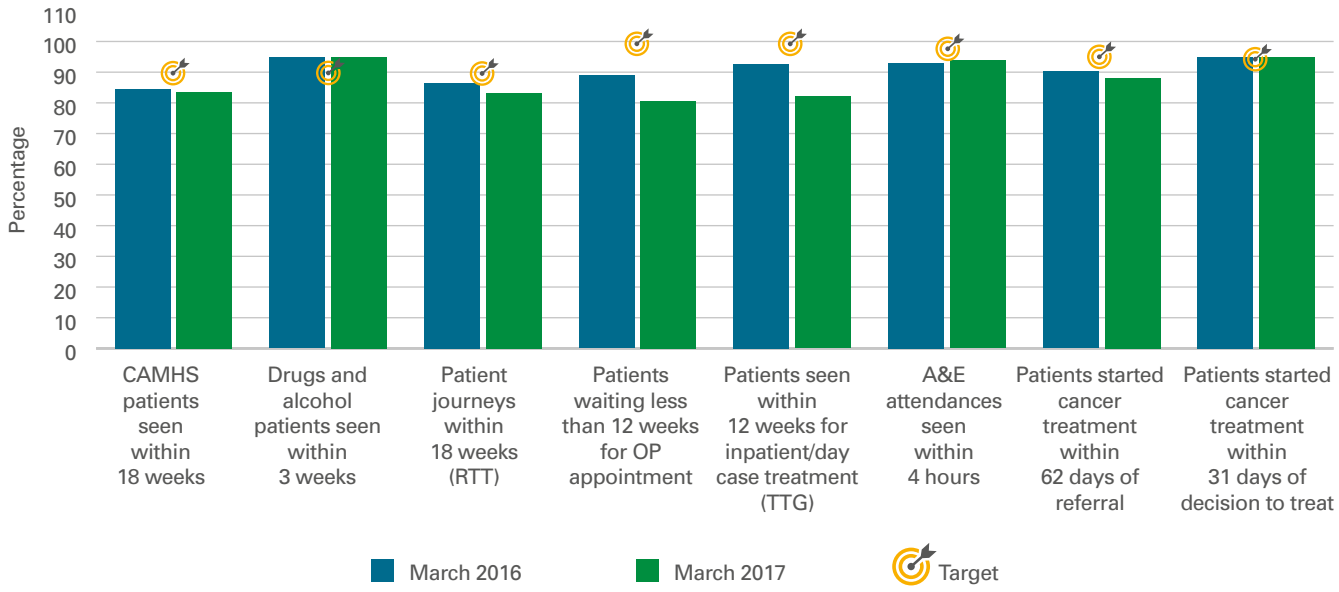
against LDP standards does indicate the pressure the healthcare system is under. An independent review of the national LDP standards is currently under way and an interim report was due to be published by August 2017.

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

Exhibit 7

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

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



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

Source: See Appendix 3 for sources

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

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

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

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

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

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

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

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

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

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

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

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

Scotland's health is not improving and significant inequalities remain

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part 2

Achieving change

Key messages

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Case study 2

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Case study 3

Realistic medicine activity in NHS Lothian

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

Source: Audit Scotland and NHS Lothian

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

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

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

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

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

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

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

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

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

Governance arrangements for overseeing activity and scrutinising progress need finalised

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Case study 4

Future role of the GP within a wider multidisciplinary team

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Endnotes

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

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

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

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

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

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

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

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

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

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

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13 Information provided by Scottish Government, July 2017.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33 Ibid.

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

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

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

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

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

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

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

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

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

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

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

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

50 Ibid.

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

52 Ibid.

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

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

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

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

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

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

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

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

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

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

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

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

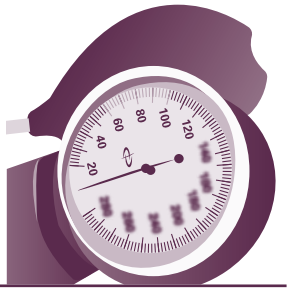
65 ***Changing models of health and social care***, Audit Scotland, March 2016.

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

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

Appendix 1

Audit methodology



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

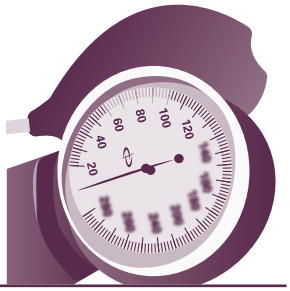
Our findings are based on evidence from sources that include:

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

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

Appendix 2

Financial performance 2016/17 by NHS board

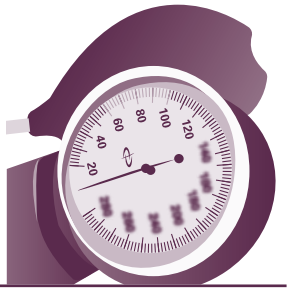


Board	Core revenue outturn (£m)	Total savings made (£m) Annual Audit Report	Non-recurring savings in Annual Audit Report	NRAC: distance from parity
Ayrshire and Arran	743.7	25.4	20%	0.7%
Borders	220.5	8.1	53%	2.3%
Dumfries and Galloway	311.1	12.7	43%	4.6%
Fife	665.6	30.8	71%	-0.2%
Forth Valley	532.5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

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

Appendix 3

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



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

Key	Green = Standard met
	Red = Standard missed

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

Sources:

CAMHS Waiting Times – Number of patients seen during the month by health board, Quarter ending March 2017; ISD Scotland, September 2017

Drugs and alcohol – Waiting times for referral to treatment, quarter ending March 2017; ISD Scotland, September 2017

18 weeks referral to treatment (RTT), Month ending March 2017; ISD Scotland, August 2017

New Outpatient Appointment: Waiting Times for Patients waiting at Month end, Census date at 31 March 2017, August 2017

Inpatient or day case admission: waiting times for patients seen, Quarter ending March 2017; ISD Scotland, August 2017

Accident and Emergency: attendances and time in department by NHS board and month, Month ending March 2017; ISD Scotland, July 2017

Performance against the 62 day standard from receipt of an urgent referral with suspicion of cancer to first treatment by NHS board, Quarter to March 2017; ISD Scotland, September 2017

Performance against the 31 day standard from date decision to treat to first cancer treatment by NHS board, Quarter to March 2017, ISD Scotland, September 2017.

NHS in Scotland 2017

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