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Aberdeen City Health & Social Care Partnership
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To: Members of the Audit and Performance Systems Committee.

Town House,
ABERDEEN, 6 November 2018.

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, 13 NOVEMBER 2018 at 10.00 am.**

FRASER BELL
CHIEF OFFICER - GOVERNANCE

B U S I N E S S

TERMS OF REFERENCE

DECLARATION OF INTERESTS

1 Members are requested to intimate any declarations of interest (Pages 7 - 8)

DETERMINATION OF EXEMPT BUSINESS

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

STANDING ITEMS

3 Minute of Previous Meeting of 11 September 2018 (Pages 9 - 16)

4 Business Planner (Pages 17 - 22)

STEWARDSHIP AND GOVERNANCE

5 Committee Meeting Schedule (Pages 23 - 26)

FINANCE

6 Financial Monitoring (Pages 27 - 48)

7 Financial Regulations (Pages 49 - 76)

8 Scottish Medium-Term Financial Framework (Pages 77 - 104)

AUDIT AND INSPECTION

9 Joint Inspection of Services for Older People (Pages 105 - 128)

10 NHS Audit Scotland Report (Pages 129 - 172)

CONFIRMATION OF ASSURANCE

11 Confirmation of Assurance

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

Aberdeen City Health & Social Care Partnership
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ABERDEEN CITY INTEGRATION JOINT BOARD

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE TERMS OF REFERENCE

1. Introduction

(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.

(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.

(3) The purpose of the Committee is to provide assurance to the IJB on the robustness of the Partnership's risk management, financial management service performance and governance arrangements.

2. Constitution

(1) The IJB shall appoint the Committee members. The Committee will consist of four voting members of the IJB, with two members appointed from each partner.

3. Chairperson

(1) The Committee will be chaired by a non-office bearing voting member of the IJB and will rotate between NHS Grampian and Aberdeen City Council (ACC).

4. Quorum

(1) Three Members of the Committee will constitute a quorum.

5. Attendance at Meetings

(1) The Chief Officer, Chief Finance Officer, Chief Internal Auditor and other Professional Advisors and senior officers are required as a matter of course, external audit or other persons shall attend meetings at the invitation of the Committee.

(2) The Chief Internal Auditor will be invited to each meeting and the external auditor will attend at least one meeting per annum.

(3) The Committee may co-opt additional advisors as required.

6. Meeting Frequency

(1) The Committee will meet at least four times each financial year. There should be at least one meeting a year, or part thereof, where the Committee meets the external and Chief Internal Auditor without other seniors officers present. A further two developmental sessions will be planned over the course of the year to support the development of members.

7. Authority

(1) The Committee is authorised to instruct further investigation on any matters which fall within its Terms of Reference.

8. Duties

The Committee shall:-

(1) 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.

(2) Prepare and implement the strategy for performance review and monitor the performance of the Partnership towards achieving its policy objectives and priorities in relation to all functions of the IJB.

(3) Ensure 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.

(4) Act as a focus for value for money and service quality initiatives.

(5) 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.

(6) Monitor 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.

(7) Consider matters arising from Internal and External Audit reports.

(8) Review on a regular basis actions planned by management to remedy weaknesses or other criticisms made by Internal or External Audit.

(9) 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.

(10) 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.

(11) Review risk management arrangements, receive annual Risk Management updates and reports and annually review with the full Board the IJB's risk appetite document.

(12) Ensure the existence of and compliance with an appropriate Risk Management Strategy.

(13) Report to the IJB on the resources required to carry out Performance Reviews and related processes.

(14) Consider and approve annual financial accounts and related matters.

(15) Approve and understand the sources of assurance used in the Annual Governance Statement.

(16) Review the Annual Performance Report to assess progress toward implementation of the Strategic Plan.

(17) 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.

(18) Promote the highest standards of conduct by Board Members.

(19) Monitor and keep under review the Codes of Conduct maintained by the IJB.

(20) Provide oversight of Information Governance arrangements and staffing arrangements as part of the Performance and Audit process.

(21) 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.

(22) The Committee shall present the minute of its most recent meeting to the next meeting of the IJB for information.

9. Review

(1) The Terms of Reference will be reviewed annually to ensure their ongoing appropriateness in dealing with the business of the IJB.

(2) As a matter of good practice, the Committee should expose itself to periodic review utilising best practice guidelines.

You must consider at the earliest stage possible whether you have an interest to declare in relation to any matter which is to be considered. You should consider whether reports for meetings raise any issue of declaration of interest. Your declaration of interest must be made under the standing item on the agenda, however if you do identify the need for a declaration of interest only when a particular matter is being discussed then you must declare the interest as soon as you realise it is necessary. The following wording may be helpful for you in making your declaration.

I declare an interest in item (x) for the following reasons ……
For example, I know the applicant / I am a member of the Board of X / I am employed by…
and I will therefore withdraw from the meeting room during any discussion and voting on that item.

OR

I have considered whether I require to declare an interest in item (x) for the following reasons …… however, having applied the objective test, I consider that my interest is so remote / insignificant that it does not require me to remove myself from consideration of the item.

OR

I declare an interest in item (x) for the following reasons …… however I consider that a specific exclusion applies as my interest is as a member of xxxx, which is

(a) a devolved public body as defined in Schedule 3 to the Act;

(b) a public body established by enactment or in pursuance of statutory powers or by the authority of statute or a statutory scheme;

(c) a body with whom there is in force an agreement which has been made in pursuance of Section 19 of the Enterprise and New Towns (Scotland) Act 1990 by Scottish Enterprise or Highlands and Islands Enterprise for the discharge by that body of any of the functions of Scottish Enterprise or, as the case may be, Highlands and Islands Enterprise; or

(d) a body being a company:-

i. established wholly or mainly for the purpose of providing services to the Councillor's local authority; and

ii. which has entered into a contractual arrangement with that local authority for the supply of goods and/or services to that local authority.

OR

I declare an interest in item (x) for the following reasons……and although the body is covered by a specific exclusion, the matter before the Committee is one that is quasi-judicial / regulatory in nature where the body I am a member of:

- is applying for a licence, a consent or an approval
- is making an objection or representation
- has a material interest concerning a licence consent or approval
- is the subject of a statutory order of a regulatory nature made or proposed to be made by the local authority…. and I will therefore withdraw from the meeting room during any discussion and voting on that item.

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Aberdeen City Health & Social Care Partnership
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AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

Minute of Meeting

11 September 2018
Health Village, Aberdeen

Present: Rhona Atkinson (NHS Grampian (NHSG)) Chairperson; and Councillor Samarai; and Jonathan Passmore MBE (NHSG).

Also in attendance: Alex Stephen (Chief Finance Officer, Aberdeen City Health and Social Care Partnership (ACHSCP)), Alison MacLeod (Lead Strategy and Performance Manager, ACHSCP), Gail Woodcock (Lead Transformation Manager, ACHSCP), Martin Allan (Business Manager, ACHSCP), Susie Downie (Transformation Programme Manager, ACHSCP), Kundai Sinclair and Iain Robertson (Governance, Aberdeen City Council (ACC)), Colin Harvey (Internal Audit) and Natalie Dyce (External Audit -via teleconference for agenda item 8 only).

Apologies: Councillor Laing.

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 Committee was asked to determine any exempt or confidential business.

The Committee resolved:-
To agree to consider agenda item 12 (Contracts Register) with the press and public excluded.

MINUTE OF PREVIOUS MEETING – 12 JUNE 2018

3. The Committee had before it the minute of the previous meeting of 12 June 2018.

In reference to item 8(i), Martin Allan (Business Manager, ACHSCP) provided an update on the Care First System in response to Internal Audit's recommendation, he advised that (1) written procedures were updated regularly and communicated to operational staff through the Council's intranet site; (2) data validation reports were regularly run and scrutinised by Service Managers to ensure the system remained up to date; (3) complex care package rate changes would be addressed through contract management processes; (4) system upgrades were taking place to comply with new legislation; (5) the Council's Strategic Commissioning Committee approved the extension of Care First's contract up to March 2020 whilst work on a replacement system was being progressed; and (6) he provided an overview of the Self Directed Support Board's terms of reference, membership and oversight provided by the Strategic Commissioning Programme Board.

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

FORWARD REPORT PLANNER

4. The Committee had before it the Forward Report Planner which tracked Committee requests for further assurance, as well as items of business that were within the Committee's terms of reference which had been referred to Committee by the IJB or Clinical and Care Governance Committee.

Iain Robertson (Governance, ACC) advised that the Planner was intended to be used as a tool to track assurance requested by the Committee or items which had been referred to the Committee by the IJB or Clinical and Care Governance Committee. He explained that the Planner would link in with the standing Confirmation of Assurance item, so that if members requested additional assurance from officers, this request would be added to the Planner and progress could be monitored at subsequent meetings.

The Committee resolved:-
To note the Planner.

AUDIT AND PERFORMANCE SYSTEMS DUTIES REPORT

5. The Committee had before it a report by Alex Stephen (Chief Finance Officer, ACHSCP) which presented the Committee with an intended schedule of reporting to ensure that the Committee is fulfilling all the duties as set out in its terms of reference.

The report recommended:-
That the Committee -
(a) Note the content of the APS Duties report as attached at Appendix A; and
(b) Requests that the Chief Finance Officer present a report back to Committee at the end of the financial year confirming that these duties were met and

outlining the anticipated schedule for meeting these duties in the financial year 2019-20.

Alex Stephen advised that the report outlined the timescales for reports which would be presented to Committee in order to provide assurance that the Committee was meeting duties under its terms of reference.

Thereafter there were questions and comments on items 9 (Hosted Services) and 12 (Performance Reviews) which did not have target reporting dates listed within the report. With regards to Hosted Services, Mr Stephen explained that developing solutions to address this risk was within the remit of the North East Partnership but confirmed that progress was at an early stage. And with regards to Performance Reviews, he advised that a Learning Disabilities Service performance review was ongoing and findings would be circulated to IJB members in due course.

The Committee resolved
(i) to note the content of the APS Duties report as attached at Appendix A; and
(ii) to request that the Chief Finance Officer present a report back to Committee at the end of the financial year confirming that these duties were met and outlining the anticipated schedule for meeting these duties in the financial year 2019-20.

STRATEGIC RISK REGISTER AND RISK APPETITE REVIEW

6. The Committee had before it a report by Martin Allan (Business Manager, ACHSCP) which presented the Committee with a revised version of the Aberdeen City Health & Social Care Partnership's strategic risk register and risk appetite statement.

The report recommended:-
That the Committee -
(a) Approve the revised risk appetite statement, as attached at appendix A; and
(b) Approve the revised strategic risk register, as attached at appendix B.

Martin Allan advised that the risk appetite statement and strategic risk register had been reviewed following the IJB's risk management workshop on 24 April 2018. He highlighted the key changes which had been made and noted that the Executive Team would continue to monitor the register on an ongoing basis. He also recommended that it would be good practice for the Committee to focus on three risks per meeting and provide strategic oversight of the register up until its next formal review by the IJB.

Thereafter there was discussion on the need to further embed risk management within strategic and operational reporting to ensure that performance management, risk management and the Strategic Plan provided the IJB with a framework to take difficult decisions when required.

The Committee resolved:-
(i) to approve the revised risk appetite statement, as attached at appendix A;
(ii) to approve the revised strategic risk register, as attached at appendix B; and

(iii) to agree to monitor three risks within the strategic risk register at each Committee meeting up until the next review period, and to treat the register as a living document.

INTERNAL AUDIT REPORT

7. The Committee had before it a report by Alex Stephen which presented the Committee with a summary of a recent NHSG Internal Audit report prepared by PwC.

The report recommended:-
That the Committee –
(a) Note the content of the NHSG Internal Audit Report, as attached at Appendix A; and
(b) Note the timescales as outlined in the action plan of the NHSG Internal Audit report, as attached at Appendix A.

Colin Harvey (IJB Internal Audit) advised that the recommendations by NHSG's internal auditor and the Partnership's proposed response both seemed reasonable.

Thereafter there was discussion on whether divergence amongst Grampian Partnerships in terms of performance reporting was due to locality planning and whether this was a positive development. Alison MacLeod advised that divergence would be limited as all Partnerships were required to demonstrate achievement against the nine national health and wellbeing outcomes.

The Committee resolved:-
(i) to note the content of the NHSG Internal Audit Report, as attached at Appendix A; and
(ii) to note the timescales as outlined in the action plan of the NHSG Internal Audit report, as attached at Appendix A.

EXTERNAL AUDIT ANNUAL REPORT

8. The Committee had before it a report by Alex Stephen which presented the Committee with the external audit annual report for discussion and noting.

The report recommended:-
That the Committee note the content of the Annual Audit Report for the year ended 31 March 2018, as at appendix A.

Natalie Dyce (IJB External Audit) advised that today's report would complete the 2017-18 annual audit process and she provided an overview of the Partnership's mainstream budget deficits, and its balance and reserves position. Ms Dyce then drew Members attention to External Audit's conclusions and highlighted its findings in terms of four audit dimensions:-

With regards to (1) Financial Sustainability, the auditors took the view that strong transformation and governance arrangements were in place to close the budget gap and they endorsed the development of a Medium-Term Financial Strategy as good practice;

With regards to (2) Governance and Transparency, the auditors found that effective decision making processes were in place following work with the Good Governance Institute and they were satisfied with the level of challenge at Board meetings. The auditors also welcomed that IJB and APS Committee meetings were open to the public and press and papers were accessible to the public online.

With regards to (3) Financial Management, the auditors were content with the quality and frequency of financial reporting to the IJB and were satisfied that the Partnership had appropriate financial capacity in place. They also noted that no audit adjustments had been reported which demonstrated that the Partnership's financial arrangements were robust; and

With regards to (4) Value for Money, the auditors had been provided with evidence which demonstrated the Partnership's efforts to deliver services differently through its Transformation Programme and they noted that an audit recommendation on Workforce Planning had been agreed by the Partnership with a target date for completion of 31 March 2019.

Thereafter there were questions and comments on (1) External Audit's assessment of the Partnership's financial sustainability; and (2) how the Partnership could effectively demonstrate the achievement of value for money.

The Committee resolved:-
To note the content of the Annual Audit Report for the year ended 31 March 2018, as at appendix A.

At this juncture, the Chair informed the Committee that she would take the following two items (Aberdeen Health and Social Care Partnership Annual Report and Performance Monitoring) together as their content and recommendations overlapped.

ABERDEEN HEALTH AND SOCIAL CARE PARTNERSHIP ANNUAL REPORT

9. The Committee had before it a report by Kevin Toshney (Planning and Development Manager, ACHSCP) which presented the ACHSCP Annual Report 2017-18 to Committee to enable it to assess the partnership's progress in achieving the national health and wellbeing outcomes and to consider the desired style and substance of next year's annual performance report.

The report recommended:-
That the Committee –
(a) Consider the approved ACHSCP Annual Report 2017-18 and agree that further analysis of those outcomes and indicators where the partnership's performance was not as good as expected is required;
(b) Request that a progress report on the analysis of the partnership's poorer than expected performance in certain areas is presented to a future Audit & Performance Systems Committee meeting; and
(c) Outline its presentational preferences for next year's annual performance report.

Alison MacLeod explained that the Partnership was statutorily required to publish an annual report and noted that the report had been approved by the IJB at its meeting on 28 August 2018. She advised that the Annual Report was before the Committee today to outline reporting arrangements for the new strategic performance indicators and to seek Committee endorsement to adopt a more creative approach during the development of next year's Annual Report.

Thereafter there were questions and comments on (1) the importance of developing easy-read versions of its key strategic documents to increase accessibility; and (2) whether the Partnership could expand its engagement approach to capture views from service users and hard to reach groups which typically did not respond to consultations.

The Committee resolved:-

(i) to approve the Annual Report 2017-18 and agree that further analysis of those outcomes and indicators where the Partnership's performance was not as good as expected, along with solutions to improve performance is reported as part of the regular quarterly performance reporting to Committee and the IJB; and

(ii) to agree to adopt a more creative approach during the development of next year's Annual Report, and to instruct the Lead Strategy and Performance Manager to present options for consideration at the Committee's next meeting on 13 November 2018.

PERFORMANCE MONITORING

10. The Committee had before it a report by Alison MacLeod (Lead Strategy and Performance Manager, ACHSCP) which advised the Committee of a recent review of performance indicators undertaken by the Lead Strategy and Performance Manager and sought approval of the proposed new set of strategic performance indicators contained in Appendix D.

The report recommended:-

That the Committee –

(a) Approve the proposed new set of strategic performance indicators contained in Appendix D;

(b) Approve the frequency and route of reporting these; and

(c) Approve that these are used as the basis of our Annual Report format for 2018/19.

Alison MacLeod proposed that a streamlined set of both local and national strategic performance indictors be reported to Committee and the IJB on a quarterly basis. She recommended that performance be reported by exception, with a focus on indicators which demonstrated both good and under-performance; as well as areas where significant improvement or deterioration in performance had been recorded. Ms MacLeod explained that a new set of strategic performance indicators may be developed following the ongoing review of the Strategic Plan.

Thereafter there were questions and comments on (1) the format of reports when reporting by exception; and (2) Members agreed that it would be a worthwhile exercise to test the new strategic performance indicators.

The Committee resolved:-

(i) to approve the proposed new set of strategic performance indicators contained in Appendix D;

(ii) to agree to report these strategic performance indicators to Committee and the IJB on a quarterly basis and to request that exception reports be prepared to focus on (1) indicators where good performance had been recorded; (2) indictors where an improvement in performance was required; and (3) indicators where significant improvement or deterioration in performance had been recorded, regardless of performance against target;

(iii) to note that these strategic performance indicators would continue to be reviewed during the wider review of the three year Strategic Plan; and

(iv) to note that following the review of the Strategic Plan, it was the Partnership's intention to use the strategic performance indicators as the basis of next year's Annual Report.

TRANSFORMATION PROGRAMME MONITORING

11. 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 note the information provided in this report.

Gail Woodcock provided an overview of the actions and progress of the Transformation Programme and then delivered a deep dive presentation with Alison MacLeod and Susie Downie (Transformation Programme Manager, ACHSCP) on (1) Organisational Development; and Cultural Change (2) Strategic Commissioning; and (3) Efficient Resources.

Thereafter there were questions and comments on (1) capturing the level of satisfaction for commissioned services staff through contract management processes; (2) the importance of conducting consultations that could capture views from operational staff, with particular focus on in-house carers; (3) the need to develop metrics which would demonstrate if the feedback received from staff and service users reflected a delivery of strategic outcomes; (4) the importance of managing expectations during the implementation of the Transformation Programme, with particular reference to the agreed person centred approach; (5) the level of joint working between the Partnership and the Council to support young carers; (6) the difficulty for young people and care professionals to manage the transition process between children's and adult social care; and (7) the growing need to identify services areas which were not delivering strategic outcomes or securing value for money and explore the option of service re-provision to strengthen the Partnership's financial sustainability.

The Committee resolved:-

(i) to note the information provided in this report;

(ii) to request the Chief Finance Officer to identify service areas which were not delivering strategic outcomes or securing value for money, and present options on possible re-provision of services to the IJB's workshop session on 18 September 2018; and

(iii) to thank Gail Woodcock, Alison MacLeod and Susie Downie for the informative presentation.

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

CONTRACTS REGISTER

12. The Committee had before it a report by Alison MacLeod which provided the Committee with a copy of the Contract Register for Adult Social Care Commissioned Services.

The report recommended:-
That the Committee note the Contract Register for Adult Social Care Commissioned Services contained in appendix a. and the proposals for using this register going forward as detailed in paragraph 3.7.

The Committee resolved:-
To note the Contract Register for Adult Social Care Commissioned Services contained in appendix a. and the proposals for using this register going forward as detailed in paragraph 3.7.

CONFIRMATION OF ASSURANCE

13. The Chair provided Members with an opportunity to request additional sources of assurance for items on today's agenda, and thereafter asked the Committee to confirm it had received reasonable assurance to fulfil its duties as outlined within its Terms of Reference.

The Chair requested additional assurance on (1) Locality Planning and progress to date, in terms of meeting strategic outcomes and (2) Future Financial Planning, which would focus on the financial sustainability of core budgets, how the Partnership planned to reduce overspends and possible areas for disinvestment ahead of the IJB budget setting process.

The Committee resolved:-
(i) to request the Chief Finance Officer to prepare progress reports on (1) Locality Planning and (2) IJB Future Financial Planning and present these reports to the Committee's next meeting on 13 November 2018; and
(ii) otherwise confirm the receipt of reasonable assurance for items on today's agenda.

RHONA ATKINSON, Chairperson.

BUSINESS PLANNER

13 November 2018

Please note that this planner contains a note of items which have been instructed for submission to, or further consideration by, the Audit and Performance Systems Committee (APS). All other actions which have been instructed are not included, as they are deemed to be operational matters after the point of decision. If a date is highlighted in red this means that an item has been delivered at a previous meeting or is overdue.

No.	Minute Reference	APS/IJB/CCG Decision	Update	Terms of Reference	Lead Officer(s)	Expected
1.	IJB 28.08.18 Article 9	**Primary Care Improvement Plan** To note that a PCIP implementation plan would be developed which would be configured around the practice of improvement and that performance would be monitored by the Audit and Performance Systems Committee.	This report will be presented to Committee in February 2019.	Item 8(21)	G Woodcock	26.02.19
2.	IJB 28.08.18 Article 12	**Annual Performance Report** To note that performance monitoring of the Annual Report was within the remit of the APS Committee.	At its meeting on 11 September 2018, the Committee agreed to adopt a more creative approach for next year's Annual Report and instructed the Lead Strategy and Performance Manager to present options for consideration at the Committee's next meeting on 13 November 2018. The adoption of a more creative approach for next year's Annual Report will now be integrated into the broader refresh of the Strategic Plan and review of	Item 8(16)	A MacLeod	26.02.19

No.	Minute Reference	APS/IJB/CCG Decision	Update	Terms of Reference	Lead Officer(s)	Expected
			strategic performance indicators to ensure a cohesive approach is maintained. A report will be presented to Committee in February 2019.			
3.	IJB 28.08.18 Article 14	**Carers: Waiving of Charges and Replacement Care** To request that progress updates on implementation of the Local Guidelines be reported to the Audit and Performance Systems Committee.		Item 8(21)	A MacLeod	26.02.19
4.	IJB 28.08.18 Article 18	**Transformation Decisions** To instruct officers to carry out *a lessons learned exercise* on the speed of the recruitment process and roll-out of the transformation programme and report these findings to the Audit and Performance Systems Committee.	This report will be presented to Committee in February 2019 and be aligned with the transformation progress report.	Item 8(16)	G Woodcock	26.02.19
5.	APS 12.06.18 Article 5	**Contracts Register** To note that a Contracts Register would be presented to Committee at its next meeting.	The Contracts Register was presented to Committee on 11 September 2018. **Recommended for removal**	Item 8(4)	A MacLeod	Received on 11.09.18
6.	APS 12.06.18 Article 7	**Audited Annual Accounts** To note that External Audit would present a further report to Committee	The external audit process for 2017-18 was completed at the Committee's previous meeting on 11 September 2018.	Item 8(14)	N Dyce	Received on 11.09.18

No.	Minute Reference	APS/IJB/CCG Decision	Update	Terms of Reference	Lead Officer(s)	Expected
		on 11 September 2018 which would cover the wider scope areas outlined within Audit Scotland's Code of Audit Practice and this would complete the 2017-18 annual audit process.	**Recommended for removal**			
7.	APS 12.06.18 Article 8	**Internal Audit Report – Care Management** To instruct the ACHSCP Business Manager to present further assurance to the Committee's next meeting, on the how the Partnership would manage and mitigate issues and risks relating to Care First which had been identified by Internal Audit.	A verbal update was provided on 11 September 2018. **Recommended for removal**	Item 8(8)	M Allan	Received on 11.09.18
8.	APS 12.06.18 Article 11	**Confirmation of Assurance** To prepare a Forward Report Planner and for this Planner to be attached to future agendas as a standing item.	An APS Business Planner is now a standing item on the Committee agenda. **Recommended for removal**	Item 8(17)	I Robertson	Received on 11.09.18
9.	IJB 22.05.18 Article 1	**Strategic Risk Register Review** To refer the Strategic Risk Register to the Audit and Performance Systems Committee for further review.	The IJB agreed on 9 October 2018 that the APS Committee would escalate any risk which in the Committee's view, should to be increased. The IJB also instructed the Business Manager to populate gaps within the Risk Appetite Statement relating to Commissioned and Hosted Services and report this to the	Item 8(11)	M Allan	26.02.19

No.	Minute Reference	APS/IJB/CCG Decision	Update	Terms of Reference	Lead Officer(s)	Expected
			next meeting of the Audit and Performance Systems Committee. This Strategic Risk Register will be presented to Committee in February 2019.			
10.	APS 02.03.18 Article 6	**Performance Monitoring** To note that the Head of Strategy and Transformation would report performance quarterly over the year; bi-annually to the IJB and bi-annually to the Audit and Performance Systems Committee.	At its meeting on 11 September 2018, the Committee approved a new set of strategic performance indictors and noted that they would be reported alternatively to the Committee and IJB on a quarterly basis. This will now become operational business. **Recommended for removal**	Item 8(2)	A MacLeod	Received on 11.09.18
11.	APS 02.03.18 Article 8	**Internal Audit** To note that the Committee would receive an annual report from Internal Audit on any recommendations which had not been accepted or actioned by Management.		Item 8(6)	D Hughes	28.05.19
12.	IJB 30.01.18 Article 13	**Strategic Commissioning Plan** To request an annual update on the implementation of the Strategic Commissioning Implementation Plan to both the IJB and APS Committee.		Item 8(4)	A MacLeod	26.02.19
13.	APS 20.06.17	**IJB Complaints Handling Procedure**	At its meeting on 11 September 2018, the Committee approved a	Item 8(21)	A MacLeod	Received on

No.	Minute Reference	APS/IJB/CCG Decision	Update	Terms of Reference	Lead Officer(s)	Expected
	Article 5	To request that a performance report on IJB complaint handling be presented to the Committee on a bi-annual basis.	new set of strategic performance indictors which included an indicator on complaints handling. Performance information on complaint handling will continue to be provided within the Performance Monitoring report and reported to Committee and the IJB on a quarterly basis. This will now become operational business. **Recommended for removal**			11.09.18
14.	IJB 06.06.17 Article 7	**Living Wage/Ethical Care Charter Implementation** To note that monitoring arrangements would be put in place which would include reporting to the Audit and Performance Systems Committee and an update on living wage implementation would be included within the Ethical Care Charter annual performance report.	This report will be presented to Committee in February 2019.	Item 8(21)	A Stephen	26.02.19
15.	APS 11.09.18 Article 5	**APS Committee Duties** The Committee requested the Chief Finance Officer to present a report back to Committee at the end of the financial year confirming that these duties were met and outlining the anticipated schedule for meeting		Item 8(1-22)	A Stephen	28.05.19

No.	Minute Reference	APS/IJB/CCG Decision	Update	Terms of Reference	Lead Officer(s)	Expected
		these duties in the financial year 2019-20.				
16.	APS 11.09.18 Article 13	**Locality Planning** The Committee requested assurance on the progress of locality planning in terms of meeting strategic outcomes.	This report will be presented to Committee in February 2019.	Item 8(16)	A Stephen	26.02.19
17.	APS 11.09.18 Article 13	**Future Financial Planning** The Committee requested assurance on the financial sustainability of core budgets, how the Partnership planned to reduce overspends and possible areas for disinvestment ahead of the IJB budget setting process.	This is contained within the Financial Monitoring Report on today's agenda.	Item 8(4)	A Stephen	13.11.18

Aberdeen City Health & Social Care Partnership
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AUDIT AND PERFORMANCE SYSTEMS

Date of Meeting	13 November 2018
Report Title	Committee Meeting Dates 2019-20
Report Number	HSCP/18/090
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	*Name:* Iain Robertson *Job Title: Committee Services Officer* *Email Address:* *iairobertson@aberdeencity.gov.uk* *Phone Number: 01224 522869*
Consultation Checklist Completed	Yes
Directions Required	*No*
Appendices	None

1. Purpose of the Report

1.1. To propose meeting dates for the Audit and Performance Systems Committee for 2019-20.

2. Recommendations

2.1. It is recommended that the Committee:

a) Approve the meeting schedule for 2019-20;

b) Instruct the Chief Officer to publish the meeting schedule on the Partnership's website; and

c) Agree to re-schedule the Committee's meeting from 26 February 2019 to 12 February 2019.

AUDIT AND PERFORMANCE SYSTEMS

3. Summary of Key Information

3.1. Item 6(1) of the Committee's terms of reference outlines that the Committee is required to meet at least four times a year and hold at least one meeting each year with Internal and External Audit in closed session, with no members of the Executive Team being present.

3.2. At is meeting on 21 November 2017, the Committee agreed to hold bi-annual meetings with auditors and this decision has been reflected in the schedule.

3.3. The proposed meeting schedule aligns with meeting schedules for the IJB; the standalone IJB workshop sessions; and the Clinical and Care Governance Committee. The schedule also avoids conflicts with Council committees and significant NHS Grampian meetings.

3.4. No meetings have been scheduled during public holidays or during the Council's Summer recess period.

3.5. The proposed meeting dates have been 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 Committee on 20 June 2017.

3.6. A meeting has been scheduled for 28 May 2019 to enable the Committee to approve the audited annual accounts and adhere to the expedited process required by Aberdeen City Council as result of its bond issue. The Committee will also have the opportunity at this meeting to review the draft Annual Performance Report before it is presented to the June IJB meeting for approval.

3.7. The Committee is requested to review and approve the following meeting schedule:-

10:00am, 28 May 2019 - Health Village;
10:00am, 20 August 2019 - Health Village: **closed meeting with auditors;**
10:00am, 29 October 2019 - Health Village;
10:00am, 25 February 2020 - Health Village; and
10:00am, 28 April 2020 - Health Village: **closed meeting with auditors.**

AUDIT AND PERFORMANCE SYSTEMS

3.8 It is also proposed to re-schedule the Committee's meeting date from 10:00am on 26 February 2019 to 10:00am on 12 February 2019 to ensure the meeting is quorate and decisions can be taken.

4. Implications for IJB

4.1. **Equalities –** It is proposed for Committee meetings to continue to be held in the Health Village which is a modern building and more accessible to equalities groups.

4.2. **Fairer Scotland Duty –** None directly arising from this report.

4.3. **Financial-** None directly arising from this report.

4.4. **Workforce**- It is anticipated that a meeting schedule which is publicly available on the Partnership's website would be beneficial for Aberdeen City Council, NHS Grampian and Partnership workforces. By scheduling Committee meeting dates up to April 2020, Committee members, officers, auditors and stakeholders would be able to plan ahead and effectively prepare for meetings.

4.5. **Legal-** Approval of a meeting schedule would help to ensure that the Committee was able to carry out its statutory duties and functions.

5. Links to ACHSCP Strategic Plan

5.1. Governance documents such the Committee's terms of reference and an annual meeting schedule underpin the Committee's governance arrangements and help ensure that outcomes within the Partnership's Strategic Plan can be effectively and legally delivered.

6. Management of Risk

6.1 **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 the Committee's governance arrangements.

6.2 **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

AUDIT AND PERFORMANCE SYSTEMS

6.3 **How might the content of this report impact or mitigate the known risks:** By agreeing a meeting schedule the Partnership would be able to ensure 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 Partnership.

Aberdeen City Health & Social Care Partnership
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AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Date of Meeting	13 November 2018
Report Title	Finance Update as at end September 2018
Report Number	HSCP.18.087
Lead Officer	Alex Stephen, Chief Finance Officer
Report Author Details	Gillian Parkin (Finance Manager) Jimmie Dickie (Finance Business Partner)
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	a) Finance Update as at end September 2018 b) Summary of risks and mitigating action c) Sources of Transformational Funding d) Progress in implementation of savings - September 2018 e) Virements

1. Purpose of the Report

a) To summarise the current year revenue budget performance for the services within the remit of the Integration Joint Board as at Period 6 (end of September 2018);

b) To advise on any areas of risk and management action relating to the revenue budget performance of the Integration Joint Board (IJB) services; and

c) To note the budget virements so that budgets are more closely aligned to anticipated income and expenditure (see Appendix E).

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems Committee:

a) Notes this report in relation to the IJB budget and the information on areas of risk and management action that are contained herein; and

b) Notes the budget virements indicated in Appendix E.

3. Summary of Key Information

Reported position for period to end September 2018

3.1. An adverse position of £537,000 is reported for the six-month period to the end of September 2018 as shown in Appendix A. A forecasted year-end position has been prepared based on month 6 results. This has resulted in a projected overspend of £633,000 (£884,000 in June 2018) on mainstream budgets. The main areas of overspend are Learning disabilities, Aberdeen City share of hosted services (health), Mental Health and Addiction, and Out of Area Treatments.

3.2. The Leadership Team have been working hard to bring this budget back into balance after early indications that there would be an overspend forecast for this first six months of the financial year. (Detailed actions were reported in the end of June finance update).

3.3. At the last IJB meeting it was noted that a transfer from reservices would be required should it not be possible to reduce the overspend on mainstream budgets and in order to fund the spend forecast on the integration and change projects. The position is tracked below and shows that the position has improved marginally since June.

	01/04/18 £'000	**30/06/18 £'000**	**30/09/18 £'000**
Risk fund	2,500	2,500	2,500
Primary Care Reserve (previous unspent funding)	1,990	1,584	1,491
Integration and Change Funding	3,817	1,164	1,305

8,307	**5,248**	**5,296**

The position highlighted above closely aligns with the Medium-Term Financial Strategy, where it was intended the level of reserves would be reduced in 2018/19 to fund the transformation programme. The forecast position includes the additional income provided for Alcohol and Drugs Partnership (ADP) of £665,000 and winter planning of £185,000 and it is assumed in the forecast position this money will be fully spent by the end of financial. Although in the case of ADP this is very unlikely as the income has only just been received.

3.4. An analysis of variances is detailed below:

Community Health Services (Year to date variance - £328,000 underspend)

Major Movements:

(£24,198)	Across non-pay budgets
£101,402	Under recovery on income
(£406,388)	Staff Costs

Within this expenditure category there is an underspend on staff costs mainly relating to inability to recruit within dental services and ongoing management vacancies. This is currently being offset with an under recovery of income within the public dental service due to the partnership employing less dentists.

Hosted Services (Year to date variance £286,000 overspend)

The main areas of overspend are as follows:

Intermediate Care: £152,116 relates to medical locum costs as a result of the requirement to provide consultant cover at night within Intermediate Care and higher than anticipated expenditure on the Wheelchair Service due to an increase in demand for this service.

Police Forensic Service: is forecast overspend as there has been a legacy under funding issue with this budget. However, it has been assumed this overspend will be covered from a budget transfer from NHS Grampian.

Grampian Medical Emergency Department (GMED): £105,525 relates mainly to pay costs and the move to provide a safer more reliable service which has been a greater uptake of shifts across the service. Non-pay overspend due to repair costs not covered by insurance, increased costs on software and hardware support costs, increased usage of medical surgical supplies and an increase in drug costs. Additional funding has been received from the Scottish Government for out of hours and this has been allocated against this budget.

Hosted services are led by one IJB, however, the costs are split according to the projected usage of the service across the three IJBs. Decisions required to bring this budget back into balance may need to be discussed with the three IJBs, due to the impact on service delivery.

Learning Disabilities (Year to date variance - £263,000 overspend)

Major Movements:

£186,000	Expenditure on needs led care services
£150,000	Under-recovery customer and client receipts
(£42,000)	Underspend against transport

Expenditure on needs led care services will be closely monitored and adjusted for any changes from service reviews. The under-recovery in client and customer receipts is mainly on residential and nursing care.

Mental Health & Addictions (Year to date variance - £175,000 overspend).

Major Movements:

£322,000	Expenditure on commissioned services
(£92,000)	Income Customer and Client Receipts
(£39,000)	Staff vacancies

The overspend on commissioned services is mainly due to increased expenditure on residential services partly offset by increased client contribution and NHS staff vacancies.

Older People & Physical and Sensory Disabilities (Year to date variance - £515,000 overspend)

Major Movements:

£444,000	Kingswells
£96,000	Under-recovery client contributions

The overspend reflects additional profiled expenditure on Kingswells Nursing Home. This additional spend will be managed out by the year end. Client contribution budgets remain closely monitored.

Directorate (£281,000 underspend)

(£102,000)	Under-spend commissioned services
(£145,000)	Under-spend on staff costs

The underspend on commissioned services is mainly on a provision set aside for increased funding for sleepovers.

Primary Care Prescribing (Year to date variance – £87,000 underspend)

As actual information is received two months in arrears from the Information Services Division this position is based on actuals to July 2018 with an estimation of spend for August and September. At present it appears the budgeted level of spend will be close to the forecast at the end of the financial year, however, as has been shown previously spend on this budget line can move by material amounts between the months based on factors largely out with the control of the IJB.

Primary Care Services (Year to date variance - £68,000 overspend)

The position within Primary Care Services represents the impact of the revision of the Global Sum (based on practice registered patient numbers) payments for 2018/19 including protected element now being paid assumed to be offset by revised allocation yet to be received from Scottish Government as part of the new GMS contract.

The premises position continues with an overspend which will include any rental increases impacting on 2018/19 confirmed as a result of rent reviews. The forecast to the end of the financial year is breakeven as it should be possible to reduce this overspend over the next few months.

Out of Area Treatments (Year to date variance - £9,000 underspend)

The reported underspend is non linear and does not reflect known additional costs which are expected to be incurred prior to year end, resulting in a projected overspend for year-end of £211,000. This is due to a known transfer which will happen earlier than previously forecast, an extended length of stay within Brain Injury Rehab and a likely new admission.

The impact of the current position on 2019/20 onwards

The current budget position is based on the following assumptions:

- Vacancy management savings at a central\management team level:

  What has been seen in previous years is that the vacancy management savings don't fall in the same area each year. For example, last financial year there were a number of vacancies in the podiatry team which have been filled this financial year. This year there have been a number of vacancies at a senior level within the organisation and in the primary care team. It is not anticipated that some of these posts will be filled going forward and therefore the assumption on vacancy managements savings should hold for the following year with some work from the senior leadership team.

- Increased demand and cost for learning disability, mental health clients and out of area placements:

  In the medium term financial strategy an additional £600,000 is added each financial year for new learning disability clients. What is becoming clear is that the costs of services for these groups of clients is increasing due to the complexity of the clients needs. As more complex clients are discharged from hospital the costs associated with the providing the social care falls on the IJB. Some of these clients can cost the IJB upwards of £150,000 a year.

- Prescribing is currently forecast to underspend:

  The prescribing budget is currently forecast to underspend. This budget is very volatile and the forecast has moved about significantly over the period of this financial year. The forecast as it currently stands is the best guide that we have at this period of time. Significant work is being undertaken across Grampian to reduce the spend on prescribing and the full year impact will be felt in 2019/20.

- Integration & Change fund expenditure and commitments:

  A high-level review has been undertaken by the finance team on the integration and change fund expenditure forecast to be spent in 2019/20.

Several assumptions have been made in regard to this review, however, the funding available will be enough to cover the costs likely to be incurred.

In conclusion the assumptions in the medium-term financial strategy still stand as reported to the last IJB. The main area of risk arising in relation to these assumptions is in regard to Learning Disability, Mental Health and Out of Authority placements where the costs of providing the services are increasing. It is difficult to put a precise figure on the level of risk at this stage, however, it could be as much as an additional £1 million. A zero-base budgeting exercise is currently being undertaken to quantify the figure.

4. Implications for IJB

Every organisation has to manage the risks inherent in the operation of large and complex budgets. These risks are minimised by the regular review of financial information by budget holders and corporately by the Board and Audit & Performance Systems Committee. This report is part of that framework and has been produced to provide an overview of the current financial operating position.

Key underlying assumptions and risks concerning the forecast outturn figures are set out within Appendix B. Appendix D monitors the savings agreed by the IJB.

4.1. Equalities – none identified.

4.2. Fairer Scotland Duty – none identified.

4.3. Financial – contained throughout the report.

4.4. Workforce – none identified.

4.5. Legal – none identified.

4.6. Other.

5. Links to ACHSCP Strategic Plan

5.1. A balanced budget and the medium financial strategy are a key component of delivery of the strategic plan and the ambitions included in this document.

6. Management of Risk

6.1. Identified risks(s)

See directly below.

6.2. Link to risks on strategic or operational risk register: Strategic Risk #2

There is a risk of financial failure, that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and project an overspend.

6.3. How might the content of this report impact or mitigate these risks:

Good quality financial monitoring will help budget holders manage their budgets. By having timely and reliable budget monitoring any issues are identified quickly, allowing mitigating actions to be implemented where possible.

Should there be a number of staffing vacancies then this may impact on the level of care provided to clients. This issue is monitored closely by all managers and any concerns re clinical and care governance reported to the executive and if necessary the clinical and care governance committee.

Appendix A: Finance Update as at end September 2018

Accounting Period 6	Full Year Revised Budget £'000	Period Budget £'000	Period Actual £'000	Period Variance £'000	Variance Percent %	Year end Forecast Month 6 £'000
Community Health Services	32,110	16,017	15,689	(328)	-2.0	(584)
Aberdeen City share of Hosted Services (health)	21,634	10,800	11,086	286	2.6	389
Learning Disabilities	31,739	15,866	16,129	263	1.7	876
Mental Health and Addictions	20,639	10,346	10,521	175	1.7	523
Older People & Physical and Sensory Disabilities	73,681	36,439	36,954	515	1.4	(224)
Directorate	343	169	(112)	(281)	-166.0	(189)
Criminal Justice	93	37	48	11	28.5	(25)
Housing	1,861	930	855	(75)	-8.1	0
Primary Care Prescribing	40,712	20,264	20,178	(87)	-0.4	(344)
Primary Care	37,188	18,454	18,522	68	0.4	0
Out of Area Treatments	1,517	758	749	(9)	-1.2	211
Set Aside Budget	40,509	20,255	20,255	0	0.0	0
Integration and Change (Transformation)	4,674	2,388	2,388	0	0.0	2,378
Approved transfers from reserves						(3,011)
Reported position excl reserves	**306,698**	**152,724**	**153,261**	**537**		**0**

Appendix B: Summary of risks and mitigating action

	Risks	Mitigating Actions
Community Health Services	Balanced financial position is dependent on vacancy levels.	• Monitor levels of staffing in post compared to full budget establishment. • A vacancy management process has been created which will highlight recurring staffing issues to senior staff.
Hosted Services	There is the potential of increased activity in the activity-led Forensic Service. There is the risk of high levels of use of expensive locums for intermediate care, which can put pressure on hosted service budgets.	• Work is being undertaken at a senior level to consider future service provision and how the costs of this can be minimised. • Substantive posts have recently been advertised which might reduce some of this additional spend.

	Risks	Mitigating Actions
Learning Disabilities	There is a risk of fluctuations in the learning disabilities budget as a result of: • expensive support packages may be implemented. • Any increase in provider rates for specialist services. • Any change in vacancy levels (as the current underspend is dependent on these).	• Review packages to consider whether they are still meeting the needs of the clients. • All learning disability packages are going for peer review at the weekly resource allocation panel
Mental Health and Addictions	Increase in activity in needs led service. Potential complex needs packages being discharged from hospital. Increase in consultant vacancies resulting in inability to recruit which would increase the locum usage. Average consultant costs £12,000 per month average locum £30,000 per month.	• Work has been undertaken to review levels through using Carefirst. • Review potential delayed discharge complex needs and develop tailored services. • A review of locum spend has highlighted issues with process and been addressed, which has resulted in a much improved projected outturn.

	Risks	Mitigating Actions
Older people services incl. physical disability	There is a risk that staffing levels change which would have an impact on the balanced financial position. There is the risk of an increase in activity in needs led service, which would also impact the financial position.	• Monitor levels of staffing in post compared to full budget establishment. • A vacancy management process has been created which will highlight recurring staffing issues to senior staff. • Review packages to consider whether they are still meeting the needs of the clients. • An audit of Carefirst residential packages established that £500k of packages should be closed. These findings were combined with a review of previous years accruals to determine how much the residential care spend should be reduced which also resulted in a favourable reduction in projected spend
Prescribing	There is a risk of increased prescribing costs as this budget is impacted by volume and price factors, such as the increase in drug prices due to short supply. As both of which are forecast on basis of available date and evidence at start of each year by the Grampian Medicines Management Group	• Monitoring of price and volume variances from forecast. • Review of prescribing patterns across General Practices and follow up on outliers. • Implementation of support tools – Scriptswitch, Scottish Therapeutic Utility. • Poly pharmacy and repeat prescription reviews to reduce wastage and monitor patient outcomes.

	Risks	Mitigating Actions
Out of Area Treatments	There is a risk of an increase in number of Aberdeen City patients requiring complex care from providers located outwith the Grampian Area, which would impact this budget.	• Review process for approving this spend.

Appendix C: Sources of Transformational Funding

	2018/19 £m	2017/18 c/fwd £m	Total £m
Integrated Care Fund	3.75	1.59	5.34
Delayed Discharge Fund	1.13	1.10	2.22
Mental Health Access		0.18	0.18
Mental Health Fund		0.28	0.28
Primary Care Pharmacy	0.30	0.39	0.69
Social Care Transformation Funding	13.36	3.13	16.49
Primary Care Transformation		0.30	0.30
Primary Care Improvement Fund	1.05		1.05
Action 15 Mental Health Strategy	0.30		0.30
OOH GMED funding	0.20		0.20
Transforming Urgent Care		0.54	0.54
Keep Well/Public Health		0.16	0.16
Carers Information Strategy		0.16	0.16
Mental Health Innovation		0.02	0.02
6EA Unscheduled Care		0.11	0.11
Winter funding		0.26	0.26
Health Visiting funding	0.09	0.09	0.19
ADP	0.67		0.67
6EA Unscheduled Care	0.04		0.04
Winter funding	0.19		0.19
Veterans Funding	0.18		0.18
	21.25	8.31	29.55
Adjust for social care and Health budget transfer	-16.95		-16.95
Adjust for GMED OOH Funding	-0.20		-0.20
Funding available for IJB commitment	4.10	8.31	12.40
Take off c/forward reserve			-8.31
Add on anticipated allocations			
Primary Care Improvement Plan balance			0.58
REPORTED FULL YEAR BUDGET			**4.68**

Appendix D: Progress in implementation of savings – September 2018

Area	Agreed Target	Status	Action	Responsible Officer
Review processes and ensure these are streamlined and efficient	(250)		**Financial Processes** -Continuing to investigate the use of portal allowing the upload of required documents electronically (by staff or supported individuals) – now paused pending decisions around the future of Care First (or upgrade to Eclipse) or move to another supplier will impact on this. Information Leaflet is in final draft, awaiting printing. **Pre-paid cards** – Small working group nearing completion of procurement pack. Aberdeen City Council IT Team have reviewed technical specification of identified preferred provider to ensure fit with current systems prior to moving forward with direct award under Surrey Framework. Initial screening completed and currently exploring Data Protection Impact of introduction of card. Data Protection Impact Assessment has been drafted and officers are liaising with Information Governance in Aberdeen City Council to finalise. Communications for staff and service users has been drafted based on similar work in other Local Authority areas, final wording awaiting elements to be taken from procurement pack. Awaiting agreement of competition dates to commence recruitment of Finance Officer role to support implementation of	M. Allan

Area	Agreed Target	Status	Action	Responsible Officer
			cards. Asked to consider individuals placed on ACC redeployment register in first instance (which may shorten recruitment timelines) – HR have identified individuals – this has been paused for now – awaiting appointment of card provider prior to appointment of finance officer role.	
Review of out of hours services	(400)		At an initial meeting of the Shortlife Working Group it was agreed to split the work into two areas. The first was to review Sleepovers. Once this was completed we would have a clearer understanding of the requirements for the Responder Service and work on that could then begin. The review would need to begin asap. A saving target of £400,000 has been allocated for financial year 2018/19 and whilst some alternative arrangements have already been identified as part of the transfer of service provision at Donald Dewar Court further work needs to be undertaken as soon as possible.	A. Macleod

Area	Agreed Target	Status	Action	Responsible Officer
Review of Out of Area Commissioning	(250)		**Workstream 1 - Streamlining of Processes and procedures for OOA Placements** *(updating of forms/guidance/flowcharts of processes*). The group have now met on 4 occasions with guidance flowcharts in final form. The group now have a clear spreadsheet of all out of area placements and associated costs. Review positions are now being sought for all Health Out of Area placements on a quarterly basis. **Workstream 2 - Learning Disabilities Cohort** – (*To check current information is correct; to benchmark with other models/areas; and review current placements and merging and existing local complex care packages with consideration of potential local alternatives)*. Identified and profiled all existing out of area placements and current /emerging locally delivered complex/intensive care packages. Aberdeenshire colleagues have undertaken same exercise. Now preparing case pen pictures with a view to determining potential cohorts of clients/needs. Joint meeting currently being organised to take place in late August with Aberdeenshire Colleagues.	A. Stephen

Area	Agreed Target	Status	Action	Responsible Officer
			Workstream 3 – Alcohol, Detox & Chronic/Long Term Alcoholism – *to check current information is correct, to benchmark with other models/areas; and consider potential local alternatives*. This workstream group met in early June to review information around in-patient detox services. Group to undertake a case review of the last 10 admissions to identify whether their needs could be met elsewhere. Group reviewing Service Agreement arrangement and reporting outcomes. Group to meet at the end of August to look at further options for alternative service provision.	
Medicines Management	(200)		• Community Pharmacy operationalising (Grampian Primary Care Prescribing Group) GPCPG report recommendations. • Work commenced on tracking and reporting on impact of GPCPG recommendations. • Development of an Oral Nutrition Supplements Business Case, which is projected to deliver savings and constrain future demand. • Budget currently forecasting to underspend	A Stephen

Appendix D: Budget Reconciliation	£	£
ACC per full council:		£86,855,213
NHS per letter from Director of Finance:		
Budget NHS per letter		£215,579,519
		£302,434,732
New Monies Received to Period 3:		
Scottish Government	£1,524,383	
NHS Adjustments	£832,722	£2,357,105
Reserves:		
Carry Forward Brought Down NHS	£1,229,063	
Carry Forward still to be brought down NHS	£3,952,649	
Carry Forward brought down ACC	£3,130,000	£8,306,965
		£313,098,802
Funding Assumptions:		
Less: Reserves		-£8,306,965
New Funding PCIP\Action 15 = 30%		£579,000
		£305,370,837
Additional revised during quarter 2		
Pay Award (health)		£1,041,466
Child Flu		£1,945
SG – Alcohol and Drugs Partnership		£461,123
SG – 6 Essential Actions		£37,455
SG - Winter funding		£185,605
SG - Veterans		£183,300
SG - Dental		£187,000
Nursing Resource Group		£22,000
Rota virus		£4,720
Meningitis B		£13,921
Primary Care		£41,142
Prescribing reduction		-£848,571
Reported at month 6		**£306,701,943**

Appendix E: Virements

Health 4-6	
Pay Award (health) & Hosted Services	£1,041,466
Alcohol and Drugs Partnership (Scottish Government allocation)	461,123
Nursing Resource Group (training support)	22,000
Dental allocations for Childsmile and Oral Health (Scottish Government allocation)	187,000
Primary Care (NHS reallocation)	41,142
6 Essential Action funding (Scottish Government allocation)	37,455
Veterans Funding (Scottish Government allocation)	183,300
Winter Funding (Scottish Government allocation)	185,605
Reduction to Prescribing budget (Scottish Government adjustment)	-848,571
Rotavirus	4,720
Meningitis B	13,921
Child Flu	1,945
Total Virements	1,331,106

Social Care 4-6- to align budgets to spend	£
Directorate (NHS income)	511,028
Directorate (Charging Policy Income)	526,721
Directorate (other income)	6,888
Directorate (inflation contingency)	-1,044,637
Older People (Client contributions)	217,760

Older People (Rental Income)	-24,698
Older People (In-house client contributions)	-193,062
Learning Disability (Staffing)	1,000
Learning Disability (Commissioned services)	-82,170
Learning Disability (Transfer Payments)	200
Older People (commissioned services)	64,432
Older People (supplies and services)	16,585
Older People (transfer payments)	-47
Learning Disability (admin)	9,008
Learning Disability (transport)	-1,600
Learning Disability (supplies and services)	1,592
Learning Disability (NHS Income)	-9,000
Total Virements	0

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Aberdeen City Health & Social Care Partnership
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AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Date of Meeting	13.11.2018
Report Title	Review of Financial Regulations
Report Number	HSCP.18.094
Lead Officer	Chief Finance Officer
Report Author Details	Alex Stephen Chief Finance Officer AleStephen@aberdeencity.gov.uk
Consultation Checklist Completed	*Yes*
Appendices	*a.* Financial Regulations – Oct 2018 *b.* Reserves Policy

1. Purpose of the Report

1.1. The purpose of this report is to present the Audit & Performance Systems Committee with a revised version of the IJB's Financial Regulations for approval.

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems Committee

a) Approve the revised Financial Regulations, as at Appendix A.

3. Summary of Key Information

3.1. The IJB commissions services from Aberdeen City Council and NHS Grampian. The management of services within these organisations is governed by their own financial regulation.

3.2. Under the Local Government (Scotland) Act 1973, the IJB is required to make arrangements for administration of its financial affairs. At its meeting

on the 26th of March 2016, the IJB agreed a set of financial regulations which detailed the responsibilities, policies and procedures that govern the IJB.

3.3. The IJB requested that the financial regulations are reviewed and updated on a biennial basis.

3.4. The revised financial regulations are attached at appendix A, with tracked changes to easily identify the revisions made.

3.5. The majority of the changes have been to reflect the more mature stage of the IJB as it has now been established for over 2 years. Additionally, some of the terms used have been updated, for example where referring to the Audit & Performance Systems Committee.

3.6. The two major changes to the financial regulations are outlined below:

i. **Reserves (3.7.3):** this section has been updated to reflect that fact we now have a reserves strategy which is reviewed annually.

ii. **Grants (3.8.2):** this section has been updated to allow officers to use their delegated powers. The rationale for this is that some grant applications need to be applied for quickly and seeking IJB approval each time will slow down the process and could result in the IJB loosing valuable help in the delivery of the strategy plan.

3.7. There is one area where we are not currently compliant (item 3.3.4 regarding information on the set-aside budget).

4. Implications for IJB

4.1. **Equalities –** there are no direct equalities implications arising as a result of this report.

4.2. **Fairer Scotland Duty –** there are no direct implications relating to the Fairer Scotland Duty as a result of this report.

4.3. **Financial –** These financial regulations detail the financial responsibilities, and policies and procedures that govern the Integration Joint Board.

4.4. **Workforce –** there are no direct workforce implications arising from the recommendations of this report.

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

4.5. **Legal –** approval of these financial regulations will allow the IJB to comply with its obligation to make arrangements for its financial affairs under the Local Government (Scotland) Act 1973.

4.6. **Other –** there are no other implications arising from the recommendations of this report.

5. Links to ACHSCP Strategic Plan: Robust financial arrangements will help ensure the IJB is able to deliver on its strategic plan.

6. Management of Risk

6.1. **Identified risks(s) & link to strategic risk register:** There is a risk of financial failure, that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and projects an overspend.

6.2. **Link to risks on strategic or operational risk register:** Number 2 (Strategic Risk Register)

6.3. **How might the content of this report impact or mitigate these risks:** The regular review of our financial regulations aims to maintain the integrity of the IJB's financial system and as such will help to mitigate this risk.

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Aberdeen City Health & Social Care Partnership
A caring partnership

ABERDEEN CITY INTEGRATION JOINT BOARD

FINANCIAL REGULATIONS

Date Created	Date Implemented	Review Date
11 March 2016	1 April 2016	10 October 2018

Developed By
Chief Finance Officer

VERSION 2.1

ABERDEEN CITY INTEGRATION JOINT BOARD

FINANCIAL REGULATIONS: INDEX

1. INTRODUCTION and INTERPRETATION

1.1 The Public Bodies (Joint Working) (Scotland) Act 2014 was passed by the Scottish Parliament on 25 February 2014 and provides a framework for the effective integration of adult health and social care services. The Act required the submission of a partnership agreement, known as the Integration Scheme for approval by the Scottish Government. Following a detailed consultation process, the scheme was submitted for approval in December 2015. Following approval by the Cabinet Secretary for Health, Wellbeing and Sport an Order was laid before the Scottish Parliament on 8 January 2016 and the Aberdeen City Integration Joint Board was established as an autonomous legal entity with effect from 6 February 2016. The Integration Scheme has since been reviewed by the IJB and passed to the Scottish Government in March 2018.

1.2 Aberdeen City Council and NHS Grampian recognise that they each have continuing financial governance responsibilities, and agreed to establish Aberdeen City Integration Joint Board as a 'joint arrangement' as defined by IFRS 11. IFRS 11 is the international accounting standard that clarifies the reporting procedures that apply where parties recognise the rights and obligations arising from the arrangements.

1.3 The main objective of these Financial Regulations is to detail the financial responsibilities and policies and procedures that govern the Integration Joint Board. Representatives and Committees of Aberdeen City Integration Joint Board must comply with these Financial Regulations in dealing with the financial affairs of Aberdeen City Integration Joint Board.

1.4 The Aberdeen City Integration Joint Board has appointed a Chief Officer who will be the accountable officer of the Integration Joint Board in all matters except finance where there will be joint accountability with the Chief Finance Officer. The Chief Officer is accountable to the Chief Executives of NHS Grampian and Aberdeen City Council.

1.5 The Aberdeen City Integration Joint Board has appointed a Chief Finance Officer who is the proper officer for the purposes of Section 95 of the Local Government (Scotland) Act 1973. The Chief Finance Officer has a statutory duty to ensure that proper financial administration of the financial affairs of Aberdeen City Integration Joint Board is maintained. The Aberdeen City Integration Joint Board has regard to the current CIPFA guidance on the role of the Chief Finance Officer in Local Government.

http://www.cipfa.org/policy-and-guidance/reports/the-role-of-the-chief-financial-officer-in-local-government

1.6 Should any difficulties arise regarding the interpretation or application of these financial regulations, individuals must seek advice from the Chief Finance Officer before any action is taken.

1.7 The Aberdeen City Integration Joint Board commissions services from Aberdeen City Council and NHS Grampian. The management of services within each of these organisations continues to be governed by the existing Standing Financial Instructions, Financial Regulations, Schedule of Reserved Decisions, Operational Scheme of Delegation and any other extant financial procedures approved by their respective Governance structures. Officers, staff, committees, councillors and non-executive members of these organisations should ensure they comply with their respective financial governance arrangements.

1.8 Any breach or non-compliance with these Regulations must, on discovery, be reported immediately to the Chief Officer or the Chief Finance Officer of Aberdeen City Integration Joint Board. They must then consult with the NHS Grampian Chief Executive and Aberdeen City Council Chief Executive or another nominated or authorised person as appropriate to decide what action should be taken.

1.9 For the avoidance of doubt the breach of or non-compliance with these Regulations may result in disciplinary action being taken against the relevant individuals in line with the policies of the employing organisation.

1.10 These financial regulations should be read in conjunction with the Standing Financial Regulations of NHS Grampian and Aberdeen City Council:

2. ROLES and RESPONSIBILITIES

2.1 INTEGRATION JOINT BOARD MEMBERS RESPONSIBILITY

The Board are responsible for ensuring that proper accounting records are kept, which disclose at any time, the true and fair financial position and enable the preparation of financial statements that comply with the applicable Code of Practice. The Board are also responsible for ensuring that procedures are in place to ensure compliance with all statutory obligations.

2.2 CHIEF OFFICER RESPONSIBILITIES

2.2.1 The Chief Officer has a direct line of accountability to the Chief Executives of NHS Grampian and Aberdeen City Council for the delivery of integrated services. The Chief Officer is responsible for ensuring that progress is being made in achieving the national outcomes and that any locally delegated responsibilities for health and wellbeing and for measuring, monitoring and reporting on the underpinning measures and indicators (including financial) that will demonstrate progress.

2.2.2 The Chief Officer is responsible for ensuring that the decisions of the Board are carried out.

2.2.3 The Chief Officer shall ensure that the Financial Regulations and all associated procedure manuals and documents are made known to appropriate staff members and shall ensure full compliance with them.

2.2.4 The Chief Officer shall prepare budgets following consultation with the Chief Finance Officer. The Chief Officer is also responsible for the preparation of Service Plans and relevant business cases relating to the Services. The Chief Officer shall ensure that the Chief Finance Officer is informed of financial matters that will have a significant impact on the Services, seeking financial advice where necessary.

2.3 CHIEF FINANCE OFFICER RESPONSIBILITIES

2.3.1 The Chief Finance Officer is responsible for governance of the Board's financial resources, ensuring the Partners utilise these in accordance with the Strategic Plan and that the Strategic Plan delivers best value.

2.3.2 The Chief Finance Officer shall ensure that suitable accounting records are maintained and is responsible for the preparation of the Board's Financial Statements following the Code of Practice on Local Authority Accounting in the UK.

2.3.3 The Chief Finance Officer shall ensure that these Financial Regulations are reviewed and kept up to date.

2.3.4 The Chief Finance Officer shall provide the Chief Officer and the Board with an annual governance statement.

2.3.5 The Chief Finance Officer shall be entitled to report upon the financial implications of any matter coming before Aberdeen City Integration Joint Board. To allow the Chief Finance Officer to fulfil this obligation, the Chief Officer will consult with the Chief Finance Officer on all matters involving a potential financial implication that is likely to result in a report to the Board.

2.3.6 The Chief Finance Officer shall ensure that arrangements are in place to properly establish the correct liability, process and accounting for VAT. For major works, service transformation and other changes in service delivery, the Chief Finance Officer must be consulted on the financial impacts, including VAT implications.

3. FINANCIAL PLANNING and MANAGEMENT

3.1 ANNUAL BUDGET

3.1.1 The Chief Finance Officer will report to Aberdeen City Integration Joint Board each year on the process, timetable, format and key assumptions in drafting the annual budget.

3.1.2 The Chief Finance Officer of Aberdeen City Integration Joint Board, Section 95 Officer of Aberdeen City Council and the Director of Finance of NHS Grampian will agree a timetable for preparation of the annual budget of Aberdeen City Integration Joint Board and the exchange of information between Aberdeen City Integration Joint Board, Aberdeen City Council and NHS Grampian.

3.1.3 The Chief Officer will submit annually to the Board a Strategic Plan setting out proposals for the delivery of services within the remit of the Board for, at minimum, the next 3 years. This will include the Integrated Budget and the notional budget for directed hospital services. The Strategic Plan will detail the reason for any projected surplus or deficit and how this will be used / addressed.

3.1.4 The Chief Officer and the Chief Finance Officer will develop a case for the Integrated Budget based on the Strategic Plan and present it to the Council and NHS Grampian for consideration and agreement as part of the annual budget setting process.

3.1.5 The Chief Finance Officer will prepare and issue guidance, instructions and a timetable to all involved in the preparation of the annual budget.

3.1.7 Following agreement of the Strategic Plan by the Board, and confirmation of the Integrated Budget by the Partners, the Chief Officer will provide Directions in writing to the Partners regarding operational delivery of the Strategic Plan. The Directions will include the functions that are being directed, how they are to be delivered and the resources to be used in delivery of the direction in accordance with the Strategic Plan. Directions will be confirmed by the Chief Officer by 31 March of the financial year proceeding the financial year under Direction.

3.1.8 The responsibility for delivering the delegated services for Aberdeen City Integration Joint Board to Aberdeen City Council and NHS Grampian shall lie with the Chief Officer of the Integration Joint Board.

3.2 ACCOUNTING POLICIES

3.2.1 The IJB is subject to the audit and accounts provisions of a body under section 106 of the Local Government (Scotland) Act 1973. The Chief Finance Officer is responsible for the preparation of the Board's Financial Statements following the Code of Practice on Local Authority Accounting in the UK.

3.3 BUDGET MONITORING

3.3.1 It is the joint responsibility of the Chief Officer and the Chief Finance Officer of the Aberdeen City Integration Joint Board to report to the Board regularly, timeously and accurately on all matters of budget management and control. The reports should include projections for the full financial year and any implications for the following financial years. These reports will include recovery action proposed where a year end budget variance is identified.

3.3.2 The Director of Finance, NHS Grampian and the Section 95 Officer, Aberdeen City Council will provide the Chief Finance Officer of the Aberdeen City Integration Joint Board with information on a monthly basis regarding the costs incurred for the services directly managed by them. Information should be provided in an agreed format.

3.3.3 The Director of Finance, NHS Grampian will provide the Chief Finance Officer of Aberdeen City Integration Joint Board with financial information on a monthly basis regarding the hosted services. Information should be in an agreed format and produced timely to enable inclusion in the financial monitoring reports.

3.3.4 The Director of Finance, NHS Grampian will provide the Chief Finance Officer of Aberdeen City Integration Joint Board with information regarding the use of the amounts set aside for hospital services. A frequency will be formally agreed but as a minimum, information will be provided on a quarterly basis.

3.3.5 The Chief Finance Officer will report monthly to the Chief Officer on the financial performance and position. These reports will be timely, relevant and reliable and will include information, analysis and explanation in relation to:

- Reviewing budget savings proposals
- Actual income and expenditure
- Forecast outturns and annual budget
- Explanations of significant variances
- Reviewing action required in response to significant variances
- Identifying and analysing financial risks
- Use of reserves
- Any adjustments to the annual budget (e.g. new funding allocations)

3.3.6 The Chief Finance Officer will work with the Section 95 Officer of Aberdeen City Council and Director of Finance of NHS Grampian to ensure managers are provided with monthly financial reports that are timely, relevant and reliable. These reports will include information and analysis in relation to:

- Budget available to managers
- Actual income and expenditure
- Forecast outturns.

3.3.7 The Chief Finance Officer will be consulted on all reports being submitted to the Board to ensure that any financial implications arising have been considered. Each Board report should include a Financial Implications section.

3.3.8 It is a requirement of the Public Bodies (Joint Working) (Scotland) Act 2014 that an annual performance report is presented to the Board and the financial contents therein should comply with the requirements as set out in the Act.

3.4 VIREMENT

3.4.1 Virement is the process of transferring budget between budget headings with no change to the overall net budget.

3.4.2 The Chief Officer is expected to deliver the agreed outcomes within the total delegated budget. Any virement must not create additional overall budget liability, unless additional income is being passed on from either of the partners.

3.4.3 Any proposal for virement involving a new policy, or variation of existing policy, which will impact upon the strategic plans of the Aberdeen City Integration Joint Board, will be subject to the approval of the Aberdeen City Integration Joint Board.

3.4.4 Virement can be used in the following situations and with reference to the flow chart at **APPENDIX 1**;

- The Chief Finance Officer has been notified; and
- The virement does not create an additional financial commitment into future financial years unless funded by additional income.

3.4.5 The virement process cannot be used in the following situations:

- for transfers between IJB and non-IJB budgets;
- for expected savings on finance costs or recharges;
- ;
- any savings against a property which has been declared surplus under the Council's or NHS's surplus asset procedure;
- to reinstate an item deleted by the Integration Joint Board during budget considerations unless approved by the Integration Joint Board.

3.4.6 The Chief Finance Officer must maintain separate budgets for any hosted services managed on behalf of Grampian wide partners. Virement to and from these to Integration Joint Boards requires authorisation of all the three Integration Joint Boards before being implemented.

3.4.7 To the extent that any virement would transfer budget between Partners the Chief Finance Officer is required to notify the Partner bodies.

3.5 FINAL ACCOUNTS PREPARATION

3.5.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires that the Aberdeen City Integration Joint Board is subject to the audit and accounts provisions of a body under Section 106 of the Local Government (Scotland) Act 1973 (Section 13). This will require audited annual accounts to be prepared with the reporting requirements specified in the relevant legislation and regulations (Section 12 of the Local Government in Scotland Act 2003 and regulations under Section 105 of the Local Government (Scotland) Act 1973).

3.5.2 Financial statements will be prepared to comply with the Code of Practice on Local Authority Accounting and other relevant professional guidance.

3.5.3 The draft annual accounts and final accounts shall be submitted to the Board and Audit and Performance Systems Committee (if applicable) for their scrutiny and review.

3.5.4 The timetable for audit and publication of Aberdeen City Integration Joint Boards annual accounts shall be agreed in advance with the external auditors of Aberdeen City Council and NHS Grampian. Audited annual accounts shall be signed and published in line with statutory deadlines.

3.6 TREASURY MANAGEMENT

3.6.1 The Integration Joint Board will not undertake any cash transactions but rather these will be on a notional basis through the Direction of expenditure undertaken by the Partners. Any cash correction arising as a result of the direction by the Board will be undertaken directly between the Partners. The Integration Joint Board will not operate a bank account.

3.7 RESERVES

3.7.1 The Public Bodies (Joint Working) (Scotland) Act 2014 empowers the Integration Joint Boards to hold reserves, which should be accounted for in the financial accounts and records of Aberdeen City Integration Joint Board. Aberdeen City Integration Joint Board has a Reserves Policy that is held outwith these Financial Regulations.

3.7.2 Unless otherwise agreed, any unspent budget will be transferred into the reserves of the Aberdeen City Integration Joint Board at the end of each financial year.

3.7.3 A policy on reserves has been prepared by the Chief Finance Officer and was approved by the Aberdeen City Integration Joint Board. The policy will be reviewed annually, during the medium term financial strategy process and is attached as an appendix to these regulations.

3.8 GRANT FUNDING APPLICATIONS

3.8.1 Where opportunities arise to attract external funding, relevant officers shall consider the conditions surrounding the funding to ensure they are consistent with the aims and objectives of Aberdeen City Integration Joint Board and the Strategic Plan.

3.8.2 All grant funding to be secured by the Aberdeen City Integration Joint Board from external bodies is required to receive approval from the Integration Joint Board prior to an application being made by the accountable body to ensure financial implications and match funding requirements are considered, where the match funding required has not been reported to the IJB previously as is less than £50,000.

3.8.3 The Chief Finance Officer shall ensure that arrangements are in place to:-

- receive and properly record such income in the accounts of the accountable body;
- ensure the audit and accounting arrangements are met; and
- ensure the funding requirements are considered prior to entering into any agreements.

4. FINANCIAL SYSTEMS and PROCEDURES

4.1 INCOME

4.1.1 There is no income to the Integration Joint Board by way of cash transaction. Transfer of resources will be made by NHS Grampian and Aberdeen City Council in respect of the agreed delegated functions. Payment will then be made by the Integration Joint Board for the delivery of these services. The accounting for these transactions will be via book entries in the ledgers of NHS Grampian and Aberdeen City Council.

4.2 AUTHORITY TO INCUR EXPENDITURE

4.2.1 The Chief Officer shall have the authority to incur expenditure within the approved delegated resources from Aberdeen City Integration Joint Board to

Aberdeen City Council and NHS Grampian in-line with any supplementary budget that has been approved by the Aberdeen City Integration Joint Board, and subject to the provisions of these Financial Regulations.

4.2.2 Expenditure shall be aligned with the Strategic Plan.

4.3 SCHEME of DELEGATION

4.3.1 Detail included in separate documentation.

4.4 PROCUREMENT and COMMISSIONING

4.4.1 The Public Bodies (Joint Working) (Scotland) Act 2014 provides that the Aberdeen City Integration Joint Board may enter into a contract with any other person in relation to the provision to the Integration Joint Board of goods and services for the purposes of carrying out functions conferred on it by the Act.

4.4.2 Procurement activity will be undertaken in accordance with the guidance prevailing in the Partner organisation to which the Board has given operational Direction for the use of financial resources.

4.5 IMPRESTS

4.5.1 There will be no facility for petty cash unless authorised by the Aberdeen City Integration Joint Board Chief Finance Officer and the necessary security arrangements have been established and have been deemed adequate.

4.5.2 Imprest facilities will be operated within NHS Grampian and Aberdeen City Council and will be contained within their respective established arrangements.

5. FINANCIAL ASSURANCE

5.1 AUDIT & PERFORAMANCE SYSTEMS COMMITTEE

5.1.1 Aberdeen City Integration Joint Board is required to make appropriate and proportionate arrangements for overseeing the system of corporate governance and internal controls. For this purpose the Aberdeen City Integration Joint Board has agreed to the establishment of an audit committee (the Audit and Performance Systems Committee) and will approve terms of reference. This Committee should operate in accordance with Financial Reporting Council professional guidance for Audit Committees.

5.2 EXTERNAL AUDIT

5.2.1 The Accounts Commission will appoint the external auditors to the Aberdeen City Integration Joint Board.

5.2.2 External Audit will be required to submit an annual plan to the Aberdeen City Integration Joint Board / Audit & Performance Systems Committee.

5.2.3 External Audit will be required to submit a final report to Aberdeen City Integration Joint Board / Audit & Performance Systems Committee..

5.2.4 The External Auditor appointed to Aberdeen City Integration Joint Board for the purposes of conducting their work, shall:-

- Have a right of access to all records, assets, personnel and premises, including those of partner organisations in carrying out their duties in relation to IJB activity.

- Have access to all records, documents and correspondence relating to any financial and other transactions of the Board and those of partner organisations where it relates to their business with the Board.

- Require and receive such explanations as are necessary concerning any matter under examination.

5.3 INTERNAL AUDIT - RESPONSIBILITY

5.3.1 The role of Internal Audit is to understand the key risks faced by the Aberdeen City Integration Joint Board and to examine and evaluate the adequacy and effectiveness of the system of risk management and internal control as in support of the governance arrangements operated by the Board.

5.3.2 The Aberdeen City Integration Joint Board shall secure the provision of a continuous internal audit service to provide an independent and objective opinion on the control environment comprising risk management, governance and control of the delegated resources.

5.3.3 Following a decision by Aberdeen City Integration Joint Board on who will provide the Internal Audit service, a Chief Internal Auditor will be nominated.

5.3.4 Where the internal audit services are provided by either NHS Grampian or Aberdeen City Council (or indeed a shared service), such provision should be subject to a formal service level agreement and subject to periodic review.

5.3.5 The operational delivery of internal audit services within NHS Grampian and Aberdeen City Council will be contained within their respective established arrangements.

5.3.6 The Internal Audit Service provided to Aberdeen City Integration Joint board will undertake its work in compliance with the Public Sector Internal Audit Standards.

5.3.7 Prior to the start of each financial year the Aberdeen City Integration Joint Board Chief Internal Auditor will prepare and submit a strategic risk based audit plan to the Aberdeen City Integration Joint Board for approval. It is preferable that this

be shared with the relevant Committees of NHS Grampian and Aberdeen City Council.

5.3.8 The Chief Internal Auditor shall report to the Integration Joint Board via the Audit & Performance Systems Committee at regular intervals throughout the year on the outcomes of audit work completed and on progress towards delivery of the agreed annual plan; and provide an annual assurance opinion based on the overall findings from the audit.

5.3.9 Such Internal Audit work shall not absolve senior management of the responsibility to ensure that all financial transactions are undertaken in accordance with the Financial Regulations and Standing Orders and that adequate systems of internal control exist to safeguard assets and secure the accuracy and reliability of records.

5.3.10 It shall be the responsibility of senior management to ensure that access and explanations requested by Internal Audit are provided in a timely manner.

5.3.11 The Chief Internal Auditor has the right to report direct to the Integration Joint Board in any instance where he or she deems it inappropriate to report to the Chief Officer, Chief Finance Officer or Audit & Performance Systems committee.

5.3.12 Where recommendations resulting from Internal Audit work have been agreed, the Chief Officer shall ensure that these are implemented within the agreed timescale. Regular progress reports will be sought by Internal Audit and it is the responsibility of the Chief Officer to ensure that these are provided when requested along with explanations of any recommendations not implemented within the agreed timescale.

5.4 INTERNAL AUDIT - AUTHORITY

5.4.1 The Chief Internal Auditor or their representatives shall have the authority, on production of identification to obtain entry at all reasonable times to any premises or land used or operated by Aberdeen City Integration Joint Board in order to review, appraise and report on the areas detailed below:-

- The adequacy and effectiveness of the systems of financial, operational and management control and their operation in practice in relation to the business risks to be addressed.

- The governance arrangements in place by reviewing the systems of internal control, risk management practices and financial procedures.

- The extent of compliance with policies, standards, plans and procedures approved by the Board and the extent of compliance with regulations and reporting requirements of regulatory bodies.

- The suitability, accuracy, reliability and integrity of financial and other management information and the means used to identify, measure and report such information.

5.4.2 In addition, the Chief Internal Auditor or their representatives, for the purposes of conducting their work, shall:-

- Have a right of access to all records, assets, personnel and premises, when carrying out their duties in relation to IJB activity.

- Have access to all records, documents and correspondence relating to any financial and other transactions of the Board and those of partner organisations where it relates to their business with the Board.

- Require and receive such explanations as are necessary concerning any matter under examination.

5.5 FRAUD, CORRUPTION & BRIBERY

5.5.1 Every member of Aberdeen City Integration Joint Board and its representatives shall observe these Financial Regulations within the sphere of their responsibility. They have a duty to bring to the immediate attention of the Chief Finance Officer/ Chief Internal Auditor any suspected fraud or irregularity in any matter that would contravene these regulations.

5.5.2 There are a range of confidential routes available to the Aberdeen City Integration Joint Board and its representatives who wish to ask for advice or to report suspected fraudulent activity;

- Your Line Manager
- Your HR Manager
- NHS Counter Fraud Services (CFS) Fraud Hotline on – 08000 15 16 28
- NHS Grampian's Fraud Liaison Officer – Assistant Director of Finance (Financial Services) on 01224 556211
- Aberdeen City Council's Counter Fraud Manager on 01224 522585

All information provided is treated in the strictest of confidence and individuals who raise genuine concerns are protected by law, regardless of the outcome of any investigation that they initiate.

The fraud policies of both NHS Grampian and Aberdeen City Council are available via their respective Intranets.

5.5.3 When a matter arises where it is suspected that an irregularity exists in the exercise of the functions of Aberdeen City Integration Joint Board, the Chief Finance Officer in conjunction with the Chief Internal Auditor and the Chief

Officer, will take such steps as may be considered necessary by way of investigation and report.

5.6 INSURANCE

5.6.1 The Chief Officer in conjunction with the Chief Finance Officer will ensure that the risks faced by the Board are identified and quantified and that effective measures are taken to reduce, eliminate or insure against them.

5.6.2 As of 1 April 2016 the Aberdeen City Integration Joint Board will apply to become members of the Clinical Negligence and Other Risks Scheme (CNORIS) scheme. Initially, the cover provided will be in relation to indemnity for Aberdeen City Integration Joint Board Members only. The cover to be provided is in respect of decisions made by Members in their capacity on the Board. All other cover required should be provided by NHS Grampian and Aberdeen City Council.

5.6.3 The Chief Officer is responsible for ensuring that there are adequate systems in place for the prompt notification in writing to the Chief Finance Officer of any loss, liability, damage or injury which may give rise to a claim, by or against the Board.

5.6.4 The Chief Officer in conjunction with the Chief Finance Officer shall annually or at such other period as may be considered necessary, review all insurances. Any required changes should be reported to Aberdeen City Integration Joint Board.

5.6.5 The Chief Officer in conjunction with the Chief Finance Officer of Aberdeen City Integration Joint Board will review the requirement for membership of the Scottish Government (CNORIS) on an annual basis.

5.7 VAT

5.7.1 HMRC have confirmed that there is no VAT registration requirement for Integration Joint Boards under the VAT act 1994 as it will not be delivering any services that fall within the scope of VAT.

5.7.2 Should the activities of the Board change in time and it becomes empowered to provide services, then it is essential the VAT treatment of any future activities or services delivered are considered in detail by the Chief Finance Officer to establish if there is a legal requirement for the Integration Joint Boards to register for VAT.

5.7.3 The Chief Officer and Chief Finance Officer must remain cognisant of possible VAT implications arising from the delivery of the Strategic Plan. The Partner organisations should be consulted in early course on proposals which may have VAT related implications for them.

5.8 GIFTS and HOSPITALITY / REGISTER of INTEREST

5.8.1 Members and employees should comply with their respective codes of conduct when offered gifts, gratuities and hospitality. NHS Grampian and Aberdeen City Council both maintain a register of gifts and hospitality offered.

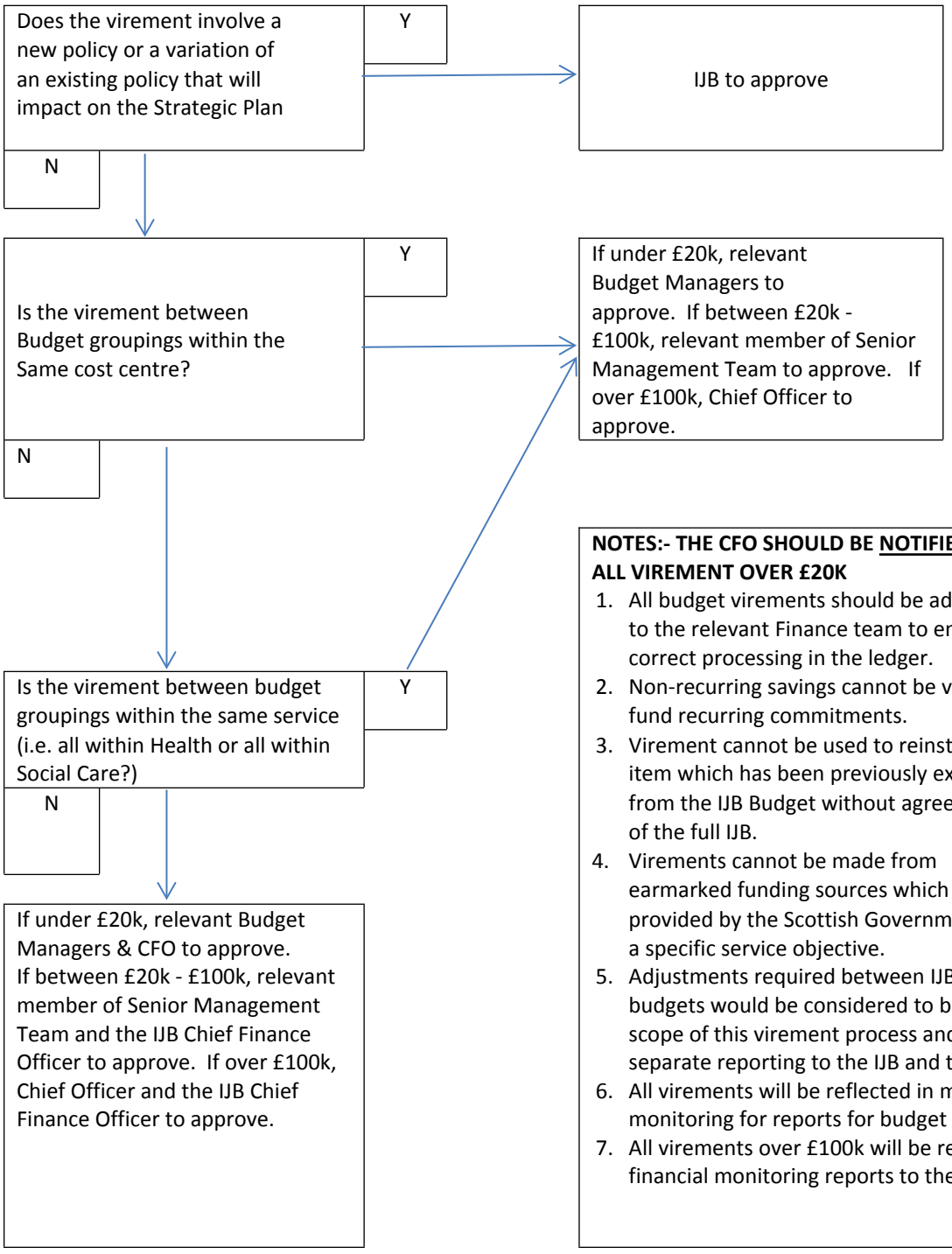
5.8.2 A central register of gifts and hospitality will be maintained by the Aberdeen City Integration Joint Board. For the offers of any hospitality or gift, approval must be sought from the relevant line manager prior to acceptance and for offers exceeding £30 details must be intimated in writing for including in the register. Reference should be made to the respective codes of conduct.

5.8.3 A separate Register of Interests for boardmembers is to be maintained by the Clerk to the Aberdeen City Integration Joint Board.

6 REVIEW OF FINANCIAL REGULATIONS

6.1 These Financial Regulations shall be subject to review on an ongoing basis, and at a minimum of every 2 years by the Aberdeen Integration Joint Board Chief Finance Officer and where necessary, subsequent amendments will be submitted to Aberdeen City Integration Joint Board for approval. Financial Regulations should be considered alongside other Governance documents including Standing Orders and Scheme of Delegation.

APPENDIX 1 – IJB VIREMENT APPROVAL RESPONSIBILITY CHART



NOTES:- THE CFO SHOULD BE NOTIFIED OF ALL VIREMENT OVER £20K

1. All budget virements should be advised to the relevant Finance team to ensure correct processing in the ledger.
2. Non-recurring savings cannot be vired to fund recurring commitments.
3. Virement cannot be used to reinstate an item which has been previously excluded from the IJB Budget without agreement of the full IJB.
4. Virements cannot be made from earmarked funding sources which are provided by the Scottish Government for a specific service objective.
5. Adjustments required between IJB and non IJB budgets would be considered to be outside the scope of this virement process and require separate reporting to the IJB and the Partners.
6. All virements will be reflected in monthly monitoring for reports for budget managers.
7. All virements over £100k will be reported in the financial monitoring reports to the IJB.

Appendix A – Reserves Policy

Reserves Policy.pdf

Aberdeen City Integration Joint Board

RESERVES POLICY

Date Created	Date Implemented	Review Date
September 2016	October 2016	April 2017

Developed By Chief Finance Officer	Reviewed By Chief Officer	Approved by

VERSION 1.1

CONTENTS

1. Background

1.1 In July 2014 CIPFA, through the Local Authority Accounting Panel (LAAP), issued guidance in the form of LAAP bulletin 99 - *Local Authority Reserves and Balances* in order to assist local authorities (and similar organisations) in developing a framework for reserves. The purpose of the bulletin is to provide guidance to local authority chief finance officers on the establishment and maintenance of local authority reserves and balances in the context of a framework, purpose and key issues to consider when determining the appropriate level of reserves.

1.2 The Aberdeen City Integration Joint Board Audit Committee (IJB) is subject to the audit and accounts regulations and legislation of a body under Section 106 of the Local Government (Scotland) Act 1973 and is classified as a local government body for accounts purposes by the Office for National Statistics (ONS). The IJB is able to hold reserves which should be accounted for in the financial accounts of the Board.

1.3 The purpose of this Reserves Policy is to:

- outline the legislative and regulatory framework underpinning the creation, use or assessment of the adequacy of reserves;
- identify the principles to be employed by the IJB in assessing the adequacy of the its reserves;
- indicate how frequently the adequacy of the IJB's balances and reserves will be reviewed and;
- set out arrangements relating to the creation, amendment and the use of reserves and balances.

1.4 In common with local authorities, the IJB can hold reserves within a usable category.

2. Statutory / Regulatory Framework for Reserves

Usable Reserves

2.1 Local Government bodies - which includes the IJB for these purposes - may only hold usable reserves for which there is a statutory or regulatory power to do so. In Scotland, the legislative framework includes:

Usable Reserve -	Powers
General Fund -	Local Government (Scotland) Act 1973

2.2 For each reserve there should be a clear protocol setting out:

- the reason / purpose of the reserve;
- how the reserve links to the strategic plan,
- how and when the reserve can be used;
- procedures for the reserves management and control; and
- The timescale for review to ensure continuing relevance and adequacy.

3. Operation of Reserves

3.1 Reserves are generally held to do three things:

- create a working balance to help cushion the impact of uneven cash flows and avoid unnecessary temporary borrowing;

- create a contingency to cushion the impact of unexpected events or emergencies – this also forms part of general reserves; and

- create a means of building up funds, often referred to as earmarked reserves, to meet known or predicted liabilities.

3.2 The balance of the reserves normally comprises of three elements:

- funds that are earmarked or set aside for specific purposes. In Scotland under Local Government rules, the IJB cannot have a separate Earmarked Reserve within the Balance Sheet, but can highlight elements of the General Reserve balance required for specific purposes. The identification of such funds can be highlighted from a number of sources including:

    - future use of funds for a specific purpose, as agreed by the IJB; or

- funds which are not earmarked for specific purposes, but are set aside to deal with unexpected events or emergencies; and

- funds held in excess of the target level of reserves and the identified earmarked sums. Reserves of this nature can be spent or earmarked at the discretion of the IJB.

4. Role of the Chief Finance Officer

4.1 The Chief Finance Officer is responsible for advising on the targeted optimum levels of reserves the IJB would aim to hold (the prudential target). The IJB, based on this advice, should then approve the appropriate reserve strategy as part of the budget process

5. Adequacy of Reserves

5.1 There is no guidance on the minimum level of reserves that should be held. In determining the prudential target, the Chief Finance Officer must take account of the strategic, operational and financial risks facing the IJB over the medium term and the IJB's overall approach to risk management.

5.2 In determining the prudential target, the Chief Finance Officer should consider the IJB's Strategic Plan, the medium term financial outlook and the overall financial environment. Guidance also recommends that the Chief Finance Officer reviews any earmarked reserves as part of the annual budget process and development of the Strategic Plan.

5.3 In light of the size and scale of the IJB's responsibilities, over the medium term it is proposed to hold a prudent level of general reserves. The reserves will be reviewed annually as part of the IJB's Budget and Strategic Plan; and in light of the financial environment at that time. The level of other earmarked funds will be established as part of the annual financial accounting process.

6. Reporting Framework

6.1 The Chief Finance Officer has a fiduciary duty to ensure proper stewardship of public funds.

6.2 The level and utilisation of reserves will be formally approved by the IJB based on the advice of the Chief Finance Officer. To enable the IJB to reach a decision, the Chief Finance Officer should clearly state the factors that influenced this advice.

6.3 As part of the budget report the Chief Finance Officer should state:

- the current value of general reserves, the movement proposed during the year and the estimated year-end balance and the extent that balances are being used to fund recurrent expenditure;

- the adequacy of general reserves in light of the IJB's Strategic Plan, the medium term financial outlook and the overall financial environment;

- an assessment of earmarked reserves and advice on appropriate levels and movements during the year and over the medium term; and

- if the reserves held are under the prudential target, that the IJB should be considering actions to meet the target through their budget process.

7. Accounting and Disclosure

7.1 Expenditure should not be charged direct to any reserve. Any movement within Revenue Reserves is accounted for as an appropriation and is transparent. Entries within a reserve are specifically restricted to ‘contributions to and from the revenue account’ with expenditure charged to the service revenue account.

Aberdeen City Health & Social Care Partnership
A caring partnership

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Date of Meeting	13.11.2018
Report Title	Scottish Government Medium Term Health & Social Care Financial Framework
Report Number	HSCP.18.092
Lead Officer	Alex Stephen, Chief Finance Officer
Report Author Details	Alex Stephen Chief Finance Officer AleStephen@aberdeencity.gov.uk
Consultation Checklist Completed	*Yes*
Appendices	*a.* Scottish Government Medium Term Health & Social Care Financial Framework

1. Purpose of the Report

1.1. This report presents the Audit & Performance Systems Committee with the Scottish Government's Medium-Term Health & Social Care Financial Framework.

1.2. This Framework explores Health and Social Care expenditure and reform analysis. It underlines the imperative of using our total resources across the whole system to drive best value, reform and long-term financial sustainability of the Health and Social Care system.

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems Committee:

a) Note the Scottish Government's Medium-Term Health & Social Care Financial Framework, as attached at appendix A.

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

3. Summary of Key Information

Background

3.1. On 4 October 2018, the Scottish Government published its Medium-Term Health & Social care Financial Framework. This came on the back of the Scottish Government's more general Five-Year Financial Strategy, published in May 2018, which covered public finances as a whole, but included specific reference to health.

3.2. The Five-Year Financial Strategy can be found here:

https://beta.gov.scot/binaries/content/documents/govscot/publications/publication/2018/05/scotlands-fiscal-outlook-scottish-governments-five-year-financial-strategy/documents/00535972-pdf/00535972-pdf/govscot:document/

3.3. The financial framework presented at Appendix A aims to consider the whole health and social care system and how this supports the triple aim of better care, better health and better value. It outlines that investment, while necessary, must be matched with reform to drive further improvements in our services - considering the health and social care landscape at a strategic level.

Increased Pressures on Health and Social Care Budgets

3.4. The financial framework highlights that the demand for health and social care will increase faster that the rate of growth of the wider economy, and that over time, the share of GDP spent on these services will gradually increase. The factors for this growth are broadly classified into three areas: price effects; demographic change; and non-demographic growth.

Integration Authorities

3.5. The Aberdeen City Health & Social Care Partnership will play a key role in driving forward the initiatives, as described in the Health & Social care delivery plan through the continued integration of health and social care.

3.6. Scottish Government spending policy commitments are outlined for the medium to long term. They demonstrate a commitment to reshaping

expenditure patterns across the health and social care sector, with a gradual rebalancing of expenditure toward care delivery out with a hospital setting.

3.7. The financial framework also provides details of where efficiency savings maybe generated.

4. Implications for IJB

4.1. Equalities – there are no direct implications arising from the recommendations of this report

4.2. Fairer Scotland Duty - there are no direct implications arising from the recommendations of this report

4.3. Financial – the financial implications are outlined throughout this report and the appendix A (Scottish Government Medium Term Health & Social Care Financial Framework). The financial framework outlines the Scottish Governments plans for increased health and social care spending, but also indicates the additional pressures the budgets face.

4.4. Workforce - there are no direct implications arising from the recommendations of this report

4.5. Legal - there are no direct implications arising from the recommendations of this report

4.6. Other - there are no direct implications arising from the recommendations of this report

5. Links to ACHSCP Strategic Plan

5.1. The Scottish Government's Medium-Term Health & Social Care Financial Framework outlines the investment that will be available nationally for health and social care integration. It's expenditure commitments align with the principles of integration, as outlined in the IJB's strategic plan, particularly:

"over the course of the next five years, hospital expenditure will account for less than 50% of frontline NHS expenditure. This relates to the policy commitment to 'shift the balance of care;"

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

"funding for primary care will increase to 11% of the frontline NHS budget by 2021/22"

6. Management of Risk

6.1. **Identified risks(s):** There is a risk of financial failure, that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and projects an overspend.

6.2. **Link to risks on strategic or operational risk register:** Number 2 (Strategic Risk Register)

6.3. **How might the content of this report impact or mitigate these risks:** The Scottish Government Medium Term Health & Social Care Financial Framework contains an analysis of historical expenditure trends, future demand forecasts and government spending policy commitments. Being aware of this framework when making decisions which will help to mitigate these risks.

Scottish Government
Riaghaltas na h-Alba
gov.scot

Scottish Government Medium Term Health and Social Care Financial Framework

October 2018

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October 2018

The Scottish Government, Edinburgh 2018

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at
The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-78851-999-1

Published by The Scottish Government, October 2018

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS431126 (10/18)

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Introduction

Our NHS celebrated its 70th Birthday this year and it is clear that our most cherished of public services has had to evolve, changing to reflect advances in medicine and the changing needs of our people. Our NHS, and the wider health and social care system, will need to continue to adapt, recognising changing demands and that people are living longer, thanks in no small part to the NHS and the care and treatment it has provided.

Our staff do an outstanding job, day in and day out. The vast majority of people get a fantastic and timely service, demonstrated in high satisfaction levels. For example - 90% of Scottish inpatients say NHS hospital care and treatment was good or excellent.

Planning for the future of our health and social care services requires a clear financial context which outlines the challenges facing the system, but at the same time looks at our approach to addressing these pressures – through a combination of investment and reform.

This Financial Framework aims to consider the whole health and social care system and how this supports the triple aim of better care, better health and better value. It outlines that investment, while necessary, must be matched with reform to drive further improvements in our services - considering the health and social care landscape at a strategic level. It has been developed with input from NHS Boards, COSLA, Local Government and Integration Authorities.

Context

This framework and supporting data will be updated as reform plans evolve, allowing local systems to develop plans within an overall set of financial parameters and alongside workforce and service considerations. Throughout this document, 2016/17 is used as the baseline year for data, reflecting that this is the latest year of published information from the NHS Cost Book and Local Government Local Financial Returns.[1]

Determining the factors which contribute to the wider financial context we will operate within is far from simple, not least as the Scottish Government does not have all the flexibility and levers to manage and plan its finances, as much of this remains reserved to the UK Government.

Additionally, our public finances continue to face the impact of the financial constraints imposed on us by the UK Government's austerity approach – a £2.6 billion real terms reduction in the our discretionary block grant between 2010/11 and 2019/20.

1 For NHS Costs Book see: http://www.isdscotland.org/Health-Topics/Finance/Costs/ and for Local Financial Returns see: https://beta.gov.scot/publications/scottish-local-government-financial-statistics-2016-17/pages/9/

Perhaps the greatest threat to our future finances is the damage caused by Brexit. The economic damage of Brexit could reduce Scotland's GDP by £12.7 billion by 2030 compared with staying in the EU[2] and it is impossible to ignore the risk it creates to some of the planning assumptions in this framework.

The UK Government funding announcement for NHS England in June 2018 included projections through to 2023/24[3] – and indicated associated Barnett resource consequentials for the devolved administrations. The funding assumptions in this document cover the same time period and are predicated on the assumption that the funding the UK Government has promised will be delivered as a true net benefit to the Scottish Government's budget. Clearly any actions by the UK Government which did not deliver this additional funding as a net benefit would have potential consequences on funding for Scotland's public services.

It should also be noted that the funding announced by the UK Government for NHS England in June fell some way short of the resource required to address the fundamental challenges facing the health and social care services in England. It did not, for example, touch on necessary funding for social care and public health services.

Health and Social Care Delivery Plan

The *Health and Social Care Delivery Plan*[4] set out a framework for the delivery of services, bringing together the National Clinical Strategy and our key reform programmes, such as Health and Social Care Integration. Its aim is to ensure that Scotland provides a high quality service, with a focus on prevention, early intervention and supported self-management, and if people need hospital services, they are seen on a day case basis where appropriate, or discharged as soon as possible.

Over the last ten years there has been significant investment in the health service – with the health budget having increased to a record level. Striking progress against key challenges to our nation's health and healthcare has been seen, with steady falls in mortality from the 'Big Three' – cancer, heart disease and stroke.

Bold action has been taken in Scotland in public health improvement, including major and innovative developments such as the ban on smoking in public places, raising the age for purchasing tobacco from 16 to 18 and the introduction of a minimum unit price for alcohol. Those aged 65 and over are entitled to free personal care when they need it, with extension to those under 65 who need it being delivered by April 2019, and there is free nursing care for anyone at any age who requires these services.

The Integration of Health and Social Care aims to ensure that people are supported at home to live independently for as long as possible, ensuring that people's care needs are anticipated and planned appropriately. This is focused on the key areas of reducing the inappropriate use of hospital services and shifting resource to primary and community care.

We recognise that like other health and social care systems around the world, we do face inflationary pressures, which could be exacerbated by the uncertainty that is being created by Brexit. Achieving long-term financial sustainability and making best use of resources is critical to delivering on the Delivery Plan's objectives.

The guiding principle underpinning this framework is simple – that we continue to deliver a service for our patients that is world class and that takes forward our ambition that everyone is able to live longer, healthier lives at home, or in a homely setting.

2 Scottish Government, Scotland's Place in Europe: People, Jobs and Investment

3 UK Government, UK Government's 5-year NHS funding plan

4 Scottish Government, Health and Social Care Delivery Plan, December 2016. http://www.gov.scot/Resource/0051/00511950.pdf

Health and Social Care Expenditure

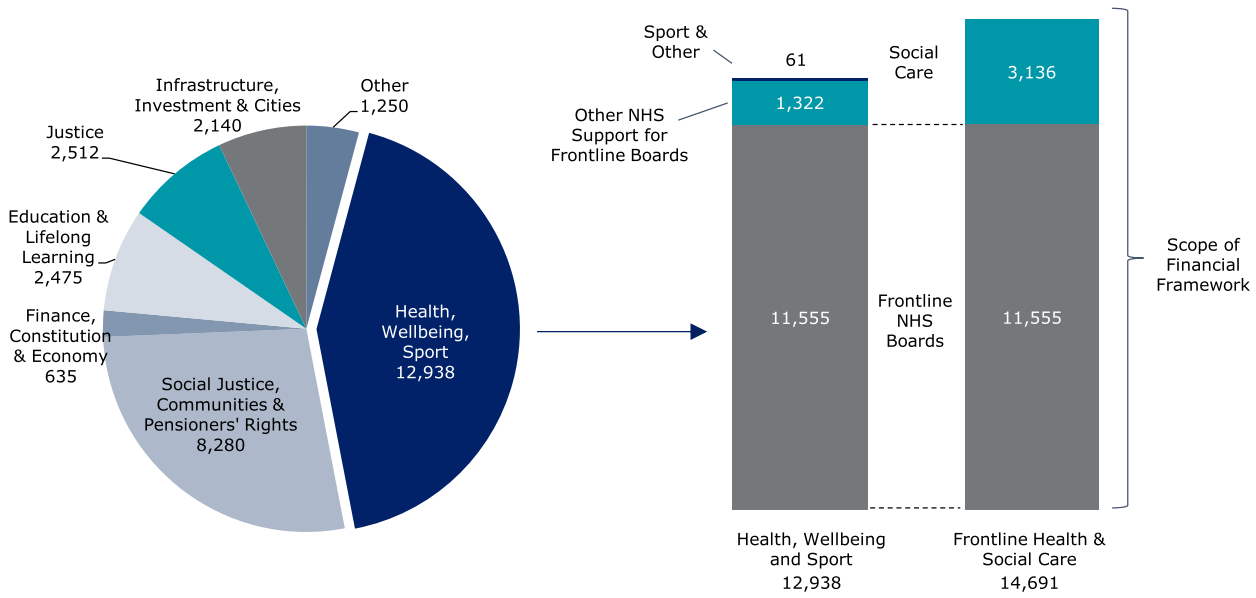
Scottish Government Expenditure

The total Scottish Government budget was £30.2 billion[5] in 2016/17, with funding for the Health and Sport portfolio at record levels of £12.9 billion. Health expenditure is the largest component of the Scottish Government's budget, with spending on the NHS accounting for 43% of total Government expenditure, compared to 37% in 2010/11. Given that there has been a reduction to Scotland's fiscal budget by 8.4% in real terms between 2010/11 and 2019/20, this proportion is expected to increase in future years due to the protection to health spend, with the Scottish Government's commitment to increase the health budget by £2 billion over the lifetime of the current parliament and passing on further Barnett resource consequentials arising from the funding settlement for the NHS in England.

The majority of health expenditure is accounted for by the 18 frontline NHS Boards (£11.6 billion), which comprise the 14 territorial NHS Boards, as well as NHS24, the Golden Jubilee Hospital, the State Hospital and the Scottish Ambulance Service. The analysis within this framework document is focused on frontline NHS Board expenditure plus Local Government net expenditure on Social Care (£3.1 billion in 2016/17). Together, this accounts for £14.7 billion in expenditure in 2016/17 on health and social care. More than £8 billion of this total is now managed by 31 Integration Authorities, which have responsibility for commissioning health and social care services for their local populations. Integration Authorities' budgets are comprised of approximately £5 billion from frontline NHS Boards and £3 billion from Local Authorities.

It should be noted that there is health expenditure delivered through NHS National Services Scotland, Healthcare Improvement Scotland, NHS Education for Scotland and NHS Health Scotland, and also through activity administered centrally within the Scottish Government, including capital expenditure. For the purposes of this document, this expenditure is not included in our analysis.

FIGURE 1. SCOTTISH GOVERNMENT REVENUE BUDGET 2016/17 (£m)

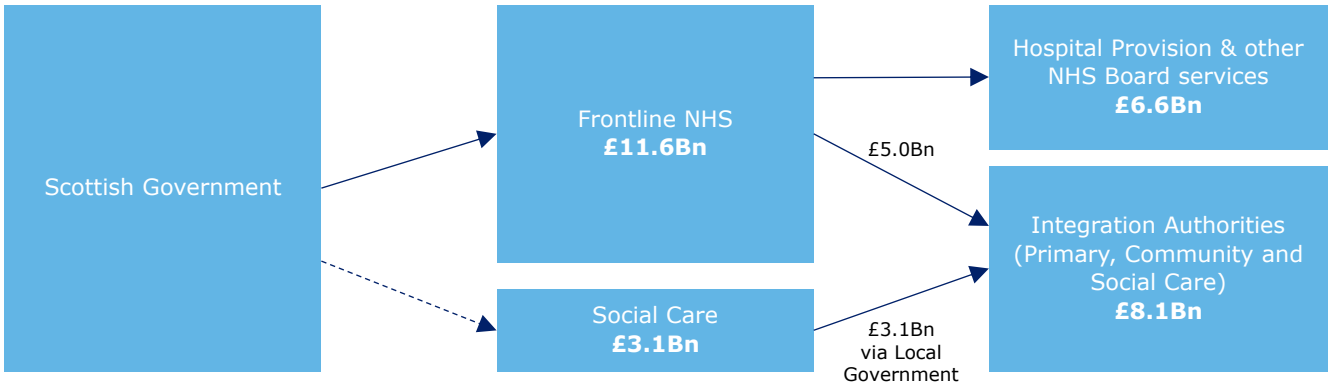


Source: Scottish Government. Draft Budget 2016-17

5 Scottish Government, Total Departmental Expenditure Limit, Draft Budget 2016/17

Figure 2 below illustrates how funding for health and social care is allocated within Scotland following the creation of Integration Authorities.

FIGURE 2. HEALTH AND SOCIAL CARE FUNDING FLOWS IN SCOTLAND

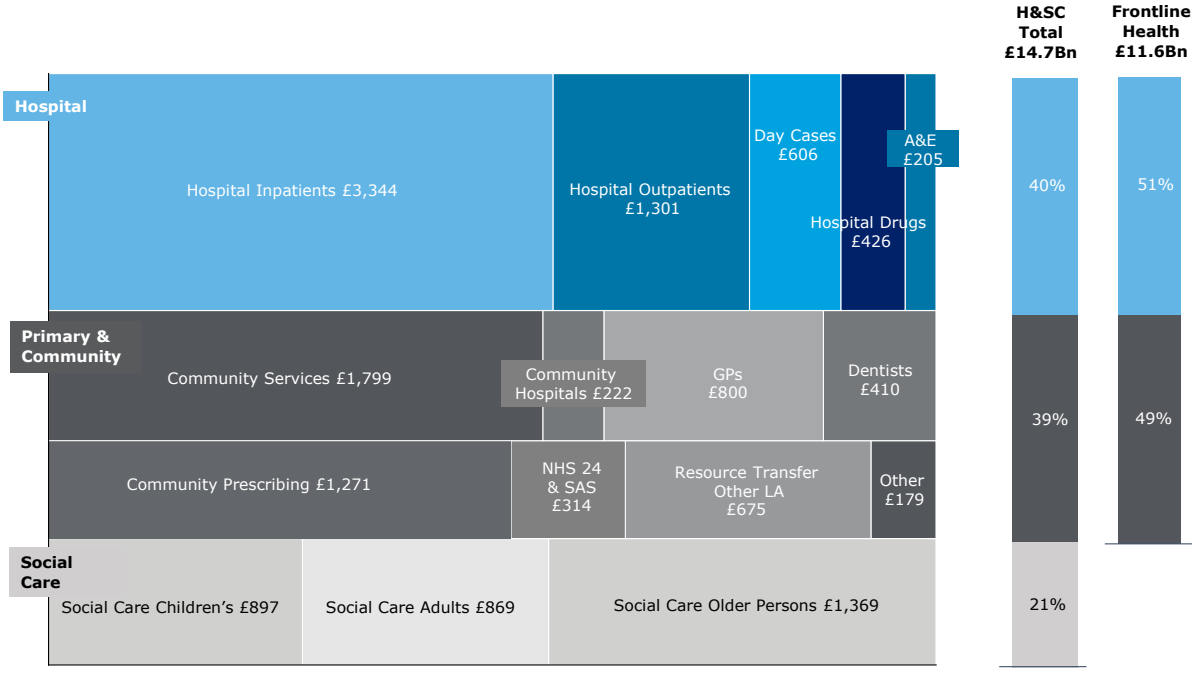


Health and Social Care Expenditure

Figure 3 provides an overview of the composition of health and social care expenditure in Scotland in 2016/17. It illustrates that the majority of NHS expenditure is concentrated on the hospital sector (51%), with the largest area of expenditure on inpatient hospital services (£3.3 billion). Areas of significant expenditure include £2 billion spent on community health services (the provision of district nurses, community hospital services and teams), £1.3 billion on the provision of hospital outpatient appointments, £1.3 billion on GP prescribed drugs and a similar amount on social care support for the elderly.

Overall, the NHS budget accounts for approximately 79% of joint health and social care expenditure. Approximately 60% of frontline health board budgets are delegated to Integration Authorities, covering at least adult primary care and most unscheduled adult hospital care. All of adult social care budgets are also included in Integration Authorities' budgets and some also have responsibility for children's services.

FIGURE 3. HEALTH AND SOCIAL CARE EXPENDITURE 2016/17 (£m)



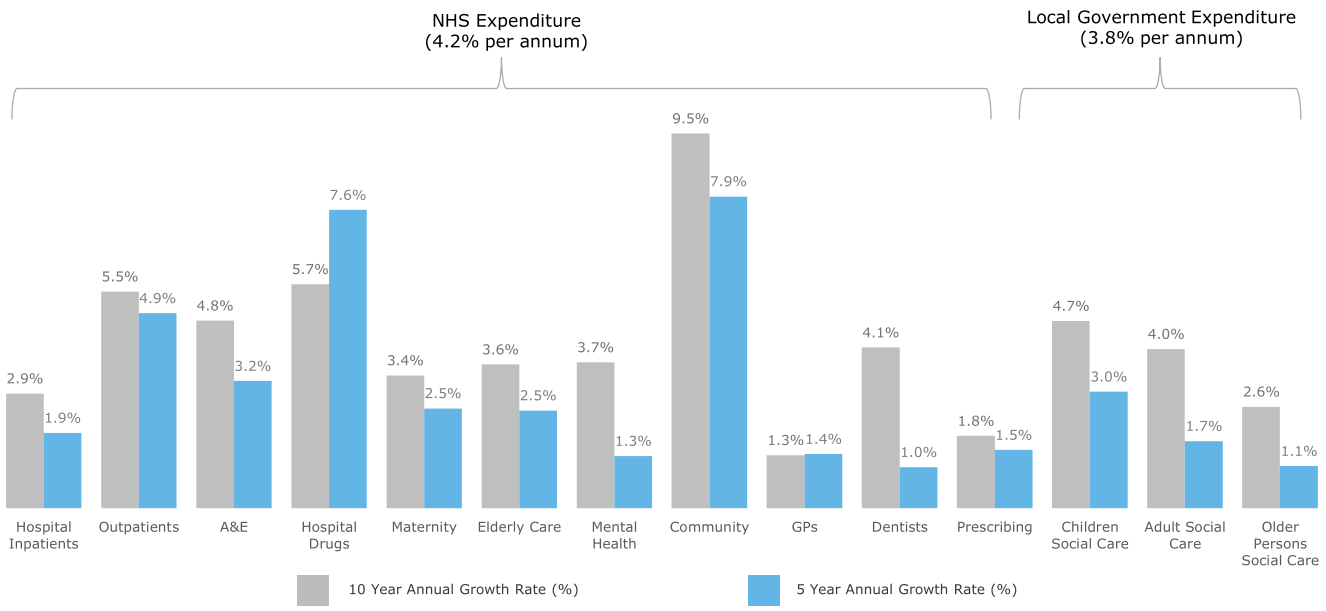
Source: ISD Scotland Cost Book 2016/17, Net Local Authority Expenditure 2016/17

Historical Expenditure Trends

One of the aims of this framework is to provide an estimate of the future resource requirements across health and social care. To provide some context, historical expenditure trends in both health and social care have been examined. NHSScotland and Local Authority expenditure data has been collected in a consistent format for over ten years, and provide some indication of long term trends.[6]

Figure 4 illustrates average annual expenditure growth rates for each major category of health and social care in Scotland from 2006/07 to 2016/17.[7] Overall, NHS expenditure has increased by 4.2%, and social care by 3.8% year on year over the past ten years. However, this rate of growth has slowed in the last five years to 3.2% and 1.8% for the NHS and social care respectively. This largely reflects the real terms reduction in the overall Scottish Government budget as a result of decisions taken by the UK Government, and specifically for Social Care, the use of eligibility criteria to manage resources.

FIGURE 4. HEALTH AND SOCIAL CARE HISTORICAL EXPENDITURE TRENDS (2006/07 – 2016/17)



Historic trends show a significant increase in the level of community health services spend over the past ten years. Specific policy decisions to invest in community services have contributed to expenditure in this area growing on average by 9.5% year on year.[8] Although we have seen growth in spending on community services, this does not yet represent a shift in the overall balance of care: expenditure on hospital services has also been growing significantly, with high rates of growth in outpatient (5.5%), Accident and Emergency (4.8%) and hospital drug expenditure (5.7%). Expenditure on hospital drugs has increased significantly in the last five years, growing at 7.6% year on year, as new and innovative drugs for cancer and other conditions become more widely available.

6 Recognising that historical expenditure trends cannot fully capture the impact of wage increases or future policy changes.

7 Mental health, maternity and elderly care includes elements of both hospital and community service provision.

8 Part of this growth can also be explained by increases in resources which are allocated to Integration Authorities to fund services provided by Local Authorities for services related to care of the elderly, Learning Disabilities and mental health and to facilitate discharge from hospitals. Total NHS Scotland expenditure on these resources was £689 million in 2016/17.

Expenditure on GP prescribing has shown a slower growth profile over the period, primarily due to a reduction in the price of certain drugs, as well as more generic drugs becoming available to the NHS.

Social care expenditure has also increased in all categories, however in the last five years adult social care spend has risen broadly in line with GDP.[9]

Historical Activity Growth and Trends in Productivity

Over the last few years, activity levels across the health and social care sector have generally increased, particularly in relation to hospital outpatient attendances and elderly care at home hours delivered (Box 1 below). The increase in care at home hours is largely as a result of the policy to keep people at home for longer.

BOX 1. ACTIVITY LEVELS ACROSS HEALTH AND SOCIAL CARE

2.1m (+10%) additional elderly care at home hours delivered from 21.6m in 2010/11 to 23.7m today

1.8m (+21%) additional hospital outpatient attendances from 8.5m per year to 10.3m

140,000 (+17%) additional hospital inpatient cases from 830,000 per year to 970,000

98,000 (+6%) additional A&E attendances from 1.6m per year to 1.7m

67,000 (+16%) additional hospital day cases from 420,000 per year to 490,000

No change in elderly residential care home places since 2010/11 remaining at 30,000 places

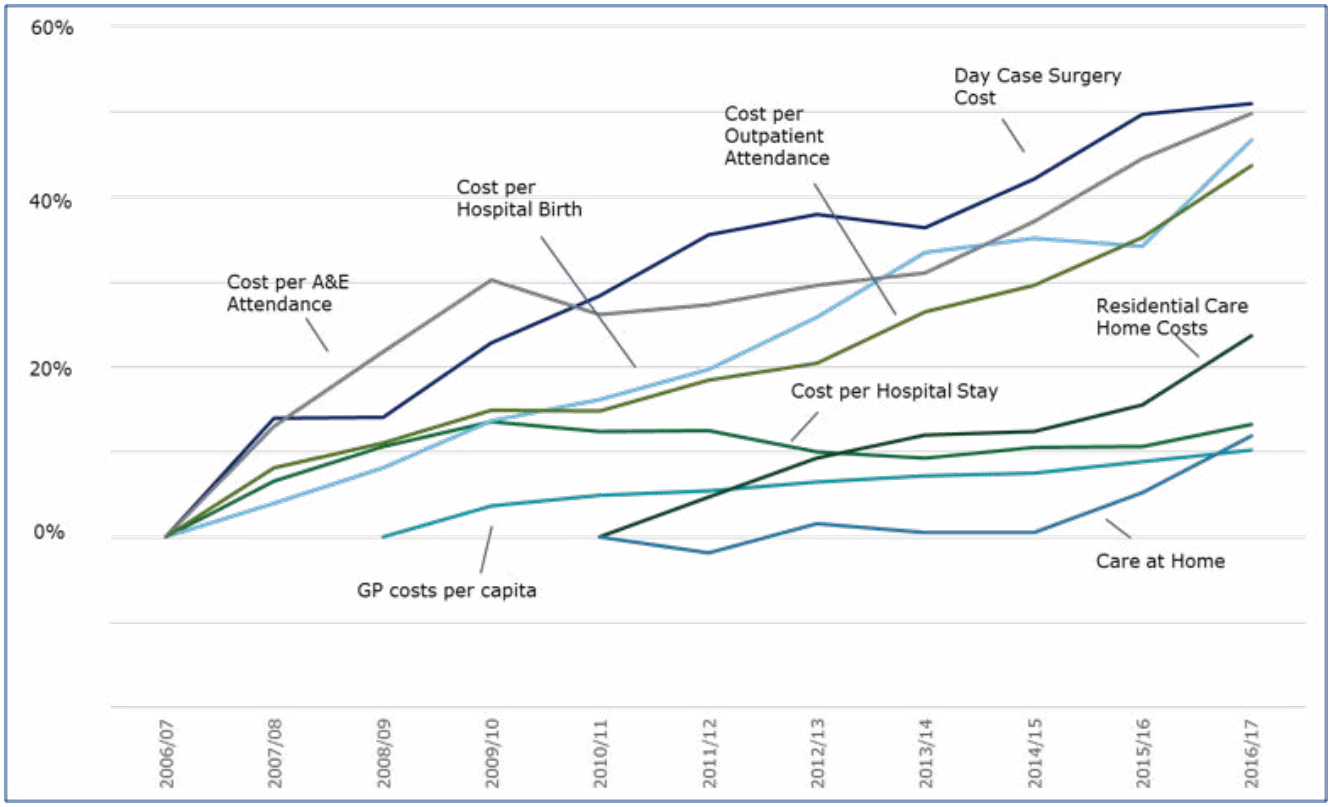
5,000 (-5%) fewer inpatient births in Scottish Hospitals from 102,000 to 97,000 episodes per year

There are now 1.8 million more outpatient attendances in Scotland compared to ten years ago whilst most other hospital activity metrics have also increased.

It is also important to consider whether health and social care services are more productive than they were ten years ago. Gains in productivity would mean that health and social care services are delivering more with the money they receive, and increasing productivity will be critical to ensuring the future sustainability of the system. Figure 5 provides an indication of how unit costs have changed over the past ten years based on a selection of available metrics for some of the largest areas of spend.

9 It should be noted that unmet need has not been quantified in any of the categories in the Figure 4 graph.

FIGURE 5 UNIT COST GROWTH (%)[10]



This illustrates that unit costs have increased by around 50% over the past ten years for certain hospital services. For example, the cost of an A&E attendance was £82 in 2006/07 and is now £123; likewise an outpatient attendance has increased from £81 to £116 over the same period. The increase in outpatient costs is partly due to the fact that more complex activity is now being done on an outpatient basis than was the case 10 years ago. The increase in A&E attendance costs is partly due to investment in emergency services to support delivery of the four hour target, with the Scottish Government providing specific investment over the last few years to improve capacity and resilience in this area. Inpatient hospital costs have not followed a similar pattern with costs per case only 13% higher over the period, as shorter lengths of stay have enabled hospitals to reduce the number of beds they have needed whilst still seeing more patients. Historically, there is less robust primary and social care data, however, work is underway to provide more of this data. Analysis illustrates that GP costs per capita and care at home unit costs have grown less significantly over the period.

Productivity is complex to assess, particularly within a health and social care context, as activity statistics on their own can often hide other benefits, such as the quality of care. The incline from 2016 in residential care and care at home partly reflects policies relating to the Living Wage.

10 Care at home costs is for people aged 65+.

Summary

Expenditure and activity are at record levels and growth trends across the developed world indicate that the level of funding will only need to increase. However, with greater pressures on the system, this will also require change in the way services are delivered. Many of these initiatives are described in the Health and Social Care Delivery Plan and are being driven forward through the integration of health and social care. Delivering improvements in productivity will also be key, ensuring that high quality services are delivered to the population of Scotland whilst managing within the available resources.

Future Demand for Health and Social Care

Drivers of Demand Growth

There are numerous studies which consider the factors driving expenditure on health and social care. Many of these studies have attempted to quantify future demand based on forward projections of need, including analysis carried out by the Health Foundation, the Fraser of Allander Institute, as well as the International Monetary Fund (IMF) and Organisation for Economic Co-operation and Development (OECD). Most of these studies conclude that the demand for health and social care will increase faster than the rate of growth of the wider economy and that over time, the share of GDP spent on these services will gradually increase. The factors for this growth can be broadly classified into three areas:

Price Effects: the general price inflation within health and social services;

Demographic Change: this includes the effect of population growth on the demand for health and social care services as well as the impact of a population living longer; and

Non Demographic Growth: this relates to demand-led growth, generated by increased public expectations and advances in new technology or service developments, for example, expenditure on new drugs.

In May 2018, the Institute for Fiscal Studies and the Health Foundation reported that UK spending on healthcare would require to increase in real terms by an average of 3.3% per year over the next 15 years in order to maintain NHS provision at current levels, and that social care funding would require to increase by 3.9% per year to meet the needs of a population living longer and an increasing number of younger adults living with disabilities.

Our analysis and assumptions are in line with these assessments and take into account the Scottish Government's twin approach of investment and reform, recognising the increasing demand and expectations placed upon our frontline services and being clear that the status quo is not an option.

Future demand forecasts therefore assume the following rates of growth and reform for health services in Scotland:

- price effects will move in line with UK Government GDP deflator projections and will reflect the impact of the NHS pay deal[11] (combined impact of 2.2-2.4% each year over the next five years);
- demographic factors will on average increase the demand for healthcare by 1% year on year;
- non-demographic growth will contribute 2-2.5% growth year on year within the healthcare sector; and
- benefits realised from savings and reform will amount to 1.3% each year and will be retained locally.

Based on these assumptions and their interaction with variable and fixed costs, future demand projections for health have been based on an annual growth rate of 3.5%

11 In terms of the GDP deflator, it is recognised that short term price pressures will also be influenced by changes in pay policy, most notably the recent lifting of the public sector pay cap.

Taking into consideration the various estimates of social care growth, pressures in the social care sector are likely to be slightly higher than in healthcare for various reasons, including pay a strong focus on the very elderly, where demographic pressures are at their greatest. For the purposes of modelling, a rate of 4.0% has been used.

Summary

National and international studies point to the fact that health and social care demand will continue to grow in Scotland, as is the case throughout the developed world. While recognising the significant additional investment planned in health and social care, if the system does not adapt or change, then there will be a net increase of £1.8 billion over the period - driven by growth in the population, public demand and price pressures. In the following sections, the policies and measures in place to address this challenge are set out, including how they will influence the future shape of health and social care expenditure.

Future Shape of Health and Social Care Expenditure

Government Spending Policy Commitments

The Scottish Government has made a number of policy commitments to be delivered in this parliament in relation to health and social care expenditure, that will influence the future shape of the budget, as well as drive reform across the system. Over the medium to long term this will influence the setting in which care is delivered, as well as redirect resources to priority areas for expenditure. The financial implications of these commitments are important to understand and plan for over the next 5-7 years and beyond.

The focus of the financial framework is on the main health and social care expenditure commitments, as set out below:

- over the course of this parliament, baseline allocations to frontline Health Boards will be maintained in real terms, with additional funding over and above inflation being allocated to support the shift in the balance of care. This means that health expenditure will be protected from the impact of rising prices and will continue to grow in excess of GDP deflator projections;
- over the course of the next five years, hospital expenditure will account for less than 50% of frontline NHS expenditure. This relates to the policy commitment to '*shift the balance of care*', with a greater proportion of care provided in a setting close to a person's home rather than in a hospital;
- funding for primary care will increase to 11% of the frontline NHS budget by 2021/22.[12] This will amount to increased spending of £500 million, and about half of this growth will be invested directly into GP services. The remainder will be invested in primary care services provided in the community; and
- the share of the frontline NHS budget dedicated to mental health, and to primary, community, and social care will increase in every year of the parliament. For adults, and in some cases for children, these services, along with unscheduled hospital care, are now managed by Integration Authorities.

The analysis below considers how these commitments will influence the future shape of health expenditure through to 2021/22 and the associated implications for future funding growth.

Future Shape of the Frontline Health Budget

Modelling was undertaken to assess what existing baseline spending for frontline Boards may look like in 2021/22, taking into account the commitments outlined above. Figure 6 illustrates the results, comparing the current position with that projected in five years' time. It illustrates that at present 50.9% of frontline health expenditure is allocated to the hospital sector, with 34.0% spent on community services, 8.1% on mental health[13] and 6.9% on GP services (funded directly by the General Medical Services contract).

In the future, it is estimated that the baseline budget for frontline Boards will be at least £1.5 billion higher at £13.1 billion. This reflects the impact of increased spending in line with inflation, supporting the shift in the balance of care, and providing additional support to improve waiting times. Within this overall position, the share of expenditure on hospital services will comprise less than half of frontline spending, with a corresponding increase in funding for community health services. In addition, there is

12 Letter to Health and Sport Committee - February 2017

13 Mental health expenditure is incorporated in both the hospital and community service expenditure lines, but is presented separately in the charts on the next page for clarity of presentation.

expected to be further funding flowing from the commitment to pass on Barnett resource consequentials in full, and this will also be prioritised towards supporting the shift in the balance of care.

FIGURE 6. FUTURE SHAPE OF FRONTLINE HEALTH EXPENDITURE

Key Policy Commitments

- Funding maintained in real terms
- Shifting the Balance of Care (<50% expenditure on hospitals)
- Expenditure on primary care will increase by £500 million by 2021/22, with half of this in direct support of GPs
- Mental Health expenditure share protected and grows in real terms each year

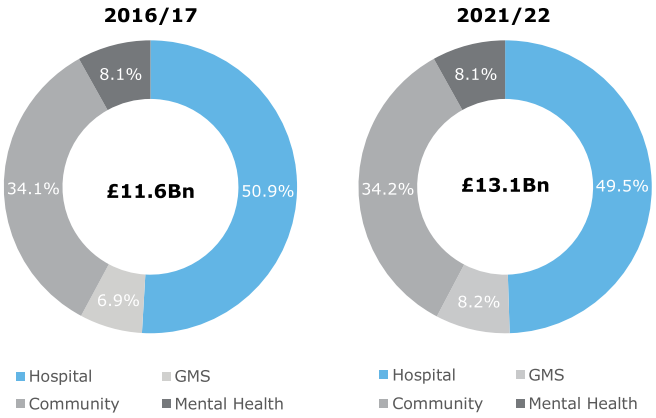
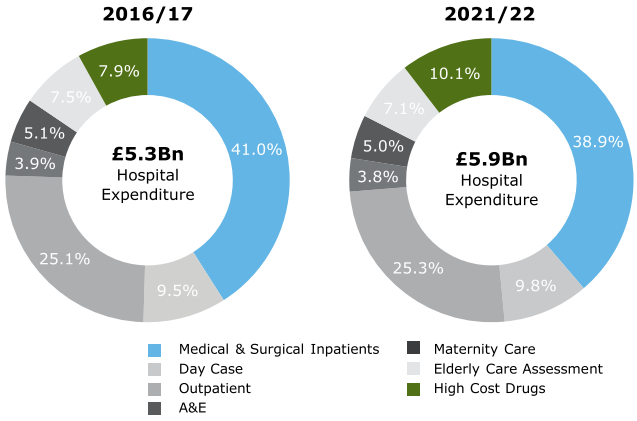


Figure 7 illustrates the main components of current hospital expenditure, with medical and surgical inpatient services accounting for the majority of expenditure (41%), followed by outpatient services (25%) and day case surgery (9.5%). In five years' time the hospital budget would be larger, standing at £5.9 billion, but the composition of spend will likely be different.

FIGURE 7. FUTURE SHAPE OF HOSPITAL EXPENDITURE



Summary

The analysis illustrates how we plan to reshape expenditure patterns across the health and social care sector, with a gradual rebalancing of expenditure towards care delivery outwith a hospital setting. There is evidence that health and social care is being reformed and that there will be significant investment to support this over the next five years. We know ultimately that the outcomes in many circumstances are better, with fewer interventions, when care is delivered in a community setting. Health and Social Care Integration focuses on delivering care in the right place, at the right time, ensuring both the quality and sustainability of care.

Early evidence from Integration Authorities suggests that achieving this shift to primary and community care can be delivered, given the opportunities to deliver care in different settings and in different ways, however it will require appropriate investment in reform and a change in the way services are delivered across Scotland.

Through the Ministerial Strategic Group for Health and Community Care, partnerships have shared projections for their performance on the Delivery Plan objectives over the period to the end of 2018/19 and these show improvements in a number of areas. For example, for unplanned bed days, there is already an overall 7% reduction projected against the 2016/17 baseline, which is consistent with the Delivery Plan objective for a 10% reduction by end 2020. This includes a 16% reduction in days lost to delay.

Reforming Health and Social Care

Introduction

The actions required to address the challenges facing the health and social care system in Scotland are set out in the Health and Social Care Delivery Plan. The Delivery Plan brings together earlier reform programmes – such as the National Clinical Strategy, and other reform initiatives – into a framework that is designed to provide focus and acceleration for reform. Its actions are designed to set us on the right course to address the financial pressures facing the health and social care sector by reforming the way care is delivered, as well as reshaping the future balance of expenditure across care settings.

This framework has been developed to support plans at a local, regional and national level in identifying the financial impact of various policy initiatives and how they will contribute to system sustainability. The analysis provides a high level indication of the scale and type of factors that will help reform the health and social care system. Further work will be carried out at a local and regional level to develop these into more detailed delivery plans.

Reform Activities

Five specific areas of activity have been modelled as contributing to the reform of health and social care delivery across Scotland and these are summarised below:

Shifting the Balance of Care

This is one of the key policy commitments of the Health and Social Care Delivery plan and underpins our longer-standing commitment to integrating health and social care. Many activities currently undertaken in hospital could be delivered in primary, community and social care settings so a patient is seen closer to home. There is also evidence which highlights the variance in care levels across Scotland, for example, with hospital admission rates and A&E attendance rates varying widely across geographical areas.

The Financial Framework assumes potential productive opportunities through reduced variation across A&E attendance rates, outpatient follow up rates and hospital inpatient lengths of stay. These estimates are based on the health and social care system improving performance to the national average and provide a high level view of the potential scale of savings that this can deliver. Local systems will then use these high level assumptions to reflect local circumstances building on evidence about variation.

While it will be challenging given existing pressures in the system, shifting care out of a hospital setting requires investment in primary, community and social care service provision, and it is assumed that approximately 50% of savings released from the hospital sector would be redirected accordingly under the direction of Integration Authorities through their strategic commissioning plans.

Regional Working

This activity relates to better collaboration to improve services, including greater regional approaches to the planning and delivery of services. This will help drive change in how clinical networks are formed and help to reduce duplication in services and functions. The National Clinical Strategy[14] also envisages a range of reforms so that healthcare across the country can become more coherent, comprehensive and sustainable. It sets out, for example, a framework for how certain specialist acute services should be provided on a wider regional footprint.

Based on evidence from other healthcare systems it is assumed that productivity savings of just over 1% could be delivered through effective regional working.

Public Health and Prevention

Scotland, in common with many developed societies face challenges associated with lifestyle behaviours, and wider cultural factors that can prevent positive health choices being made. Addressing these requires a concerted, sustained and comprehensive approach and a number of health improvement actions have been set out in relation to smoking, exercise, diet and alcohol. These initiatives, alongside the promotion of self-care, and helping to stop people entering the health system through prevention and shared decision making (i.e. Realistic Medicine) are important themes within the Health and Social Care Delivery Plan. For example, in the East of Scotland, work is being undertaken to deliver a prevention programme to reduce the incidence or reversal of type-2 diabetes in the region dramatically. The region is taking forward a comprehensive approach to health-based interventions such as weight-loss support and advising on self-management of the condition, and more widely, the promotion of active travel and targeted interventions for children and young people. The work links into the Scottish Government's Diet and Healthy Weight Strategy.

It is not yet possible to fully quantify how these policies will ultimately impact upon the health and social care sector but it is important to capture the potential. As a result, a 1% reduction in demand is included in the financial framework from the implementation of these initiatives, starting towards the end of the five year period.

Once for Scotland

The Health and Social Care Delivery Plan also sets out how taking a 'Once for Scotland' approach can continue to deliver more effective and consistent delivery of services, building on the principles of the National Clinical Strategy. For the purposes of the financial framework a 0.25% reduction in cost is assumed, to reflect potential savings in this area. These savings estimates could increase further in the future through advances in technology.

14 A National Clinical Strategy for Scotland. 2016.

Annual Savings Plans

These relate to the operational delivery of productivity and efficiency savings that all health and social care organisations manage on an annual basis. They typically consist of a number of improvement initiatives, from reducing the reliance on bank and agency staff, to making savings on medical or surgical consumable purchases, right through to changing how services are delivered.

The financial framework has included a target of 1% year on year against these plans, although there is potential for further savings to be delivered in this way. For example, a study by NHS England estimated that historical savings in the NHS were around 0.8% year on year, but that it was considered feasible for providers to deliver efficiency savings as high as 1.5-3% year on year.[15]

15 Five Year Forward View. Health Select Committee Briefing on technical modelling and scenarios. May 2016.

Bridging the Financial Challenge

The Financial Framework provides an indication of the potential approach and type of initiatives that would create a financially balanced and sustainable health and social care system. This presents a macro level view across Scotland and within this framework, local systems will put in place local level delivery plans and developments. These plans and developments will vary in each part of the country, depending on the requirements and arrangements put in place.

Figure 8 illustrates how all of the assumptions on these reform initiatives and ongoing efficiency savings would combine to address the financial challenge over the coming years. Taking account of assumed Barnett resource consequentials through to 2023/24, total funding will be £4.1 billion higher than in 2016/17 and this is presented in figure 8. This is split between an inflationary growth in funding, and additional investment for reform. Based on this modeling there would remain a residual balance of £159 million across the health and social care system in 2023/24.[16] We would anticipate further updates to the assumptions on the reform activities mentioned above in order to address the residual balance over the period.

FIGURE 8. SYSTEM REFORM BRIDGING ANALYSIS

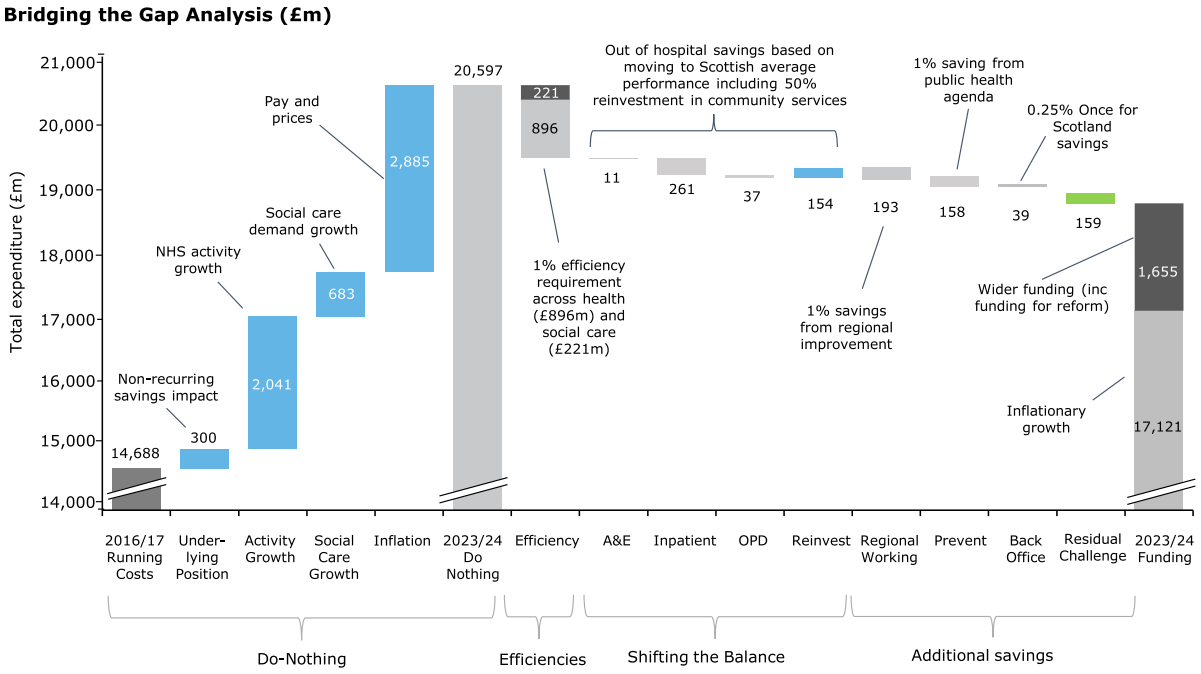


Figure 8 illustrates that from a starting point in 2016/17, with running costs of £14.7 billion, the health and social care system would require expenditure of £20.6 billion in 2023/24 if the system did nothing to change. Reform programmes have however already begun, particularly the integration of health and social care, which will help to address this 'do nothing' challenge. More progress is nonetheless needed to drive forward reform and address the residual savings balance. This will require further work across the health and care system to identify new ways to provide services to the population of Scotland.

Future iterations of the Financial Framework will include assessments of local and regional delivery plans in achieving these ambitions.

16 Presumed real terms (GDP) uplift to health and social care funding.

Summary

The Health and Social Care Delivery Plan brings together a number of policy initiatives that have been designed to reform how care is delivered to the people of Scotland. These will not only support the delivery of high quality care, but will help the system to manage the predicted growth in demand for health and social care over the next five years. There are challenges associated with this, for example, savings assumed through preventative plans may not deliver as anticipated, while the challenges are different across localities due to varying pressures.

In addition, although initial plans are in place, delivering on this agenda will require further change beyond the scope of this framework. Building on progress already underway through integration, there will need to be proportionately less care delivered in hospitals and there is an expectation that new digital technology will change care delivery models.

The System Bridging Reform Analysis does however provide a clear framework from which, regions, NHS Boards and Integration Authorities can build plans. It draws out the significant additional investment through to 2023/24, but highlights that this investment must be used to support the reform that is required across the health and social care system to ensure ongoing sustainability.

ISBN: 978-1-78851-999-1

This document is also available on The Scottish Government website:
www.gov.scot

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS431126 (10/18)

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Aberdeen City Health & Social Care Partnership
A caring partnership

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Date of Meeting	13.11.2018
Report Title	JISOP Progress Review Following a Joint Inspection
Report Number	HSCP.18.086
Lead Officer	Alex Stephen, Chief Finance Officer
Report Author Details	Alex Stephen, Chief Finance Officer
Consultation Checklist Completed	*Yes*
Appendices	a) JISOP Progress Review Following a Joint Inspection

1. Purpose of the Report

1.1. This report provides the Audit & Performance System Committee with the opportunity to discuss and comment on the Care Inspectorate's report 'Progress Review Following a Joint Inspection'.

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems Committee:

a) Reviews, discusses and comments on the report as attached at Appendix A.

3. Summary of Key Information

3.1. The Care Inspectorate and Health Improvement Scotland (HIS) carried out an inspection of ACHSCP's health and social care services for older people in Aberdeen City between November 2015 and February 2016.

3.2. Their joint inspection report was published in September 2016, after which ACHSCP drafted an action plan to address the recommendations made.

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

3.3. A progress review was undertaken over five days during June 2018 and focused on two key areas:

3.3.1. **Adult Support & Protection** – to provide assurance that issues identified the original inspection relating to adult support and protection had been fully addressed. Inspectors sampled records detailing the adult support and protection journey and met held a focus group with staff and team leaders.

3.3.2. **Other Recommendations –** to check progress with other recommendations, the inspectors met with staff and other stakeholders, including locality managers, in focus groups. The inspectors considered the ACHSCP had made good progress in relation to five of the recommendations, reasonable progress in relation to two, and limited progress in relation to one (locality management teams)

3.4. The Care Inspectorate report will also be presented to the Integration Joint Board and Clinical & Care Governance Committee at their next meetings.

3.5. The Care Inspectorate & HIS do not intend to conduct any further scrutiny in relation to the original recommendations.

3.6. The Care Inspectorate provided ACHSCP with a feedback survey to be completed by the 6th of November. Colleagues who were involved with the follow up review were asked for their views which were collated into a singular response. Key issues raised in the feedback included:

3.6.1. **Lead Inspector –** the lead inspector for the follow up review was changed mid-way through the process. This resulted in an additional work-load for ACHSCP at short notice, as the new inspector requested additional meetings and focus groups.

3.6.2. **Scope of the Follow Up Inspection –** colleagues felt that the initial meeting with the inspectors indicated that the progress review would be light-touch and focus on adult protection.

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

4. Implications for IJB

4.1. Equalities – there are no direct equalities implications arising from the recommendations of this report.

4.2. Fairer Scotland Duty - there are no direct implications for the Fairer Scotland Duty arising from the recommendations of this report.

4.3. Financial – there are no direct financial implications arising from the recommendations of this report.

4.4. Workforce – there are no direct workforce implications arising from the recommendations of this report.

4.5. Legal - there are no direct workforce implications arising from the recommendations of this report.

4.6. Other - there are no other implications arising from the recommendations of this report.

5. Links to ACHSCP Strategic Plan

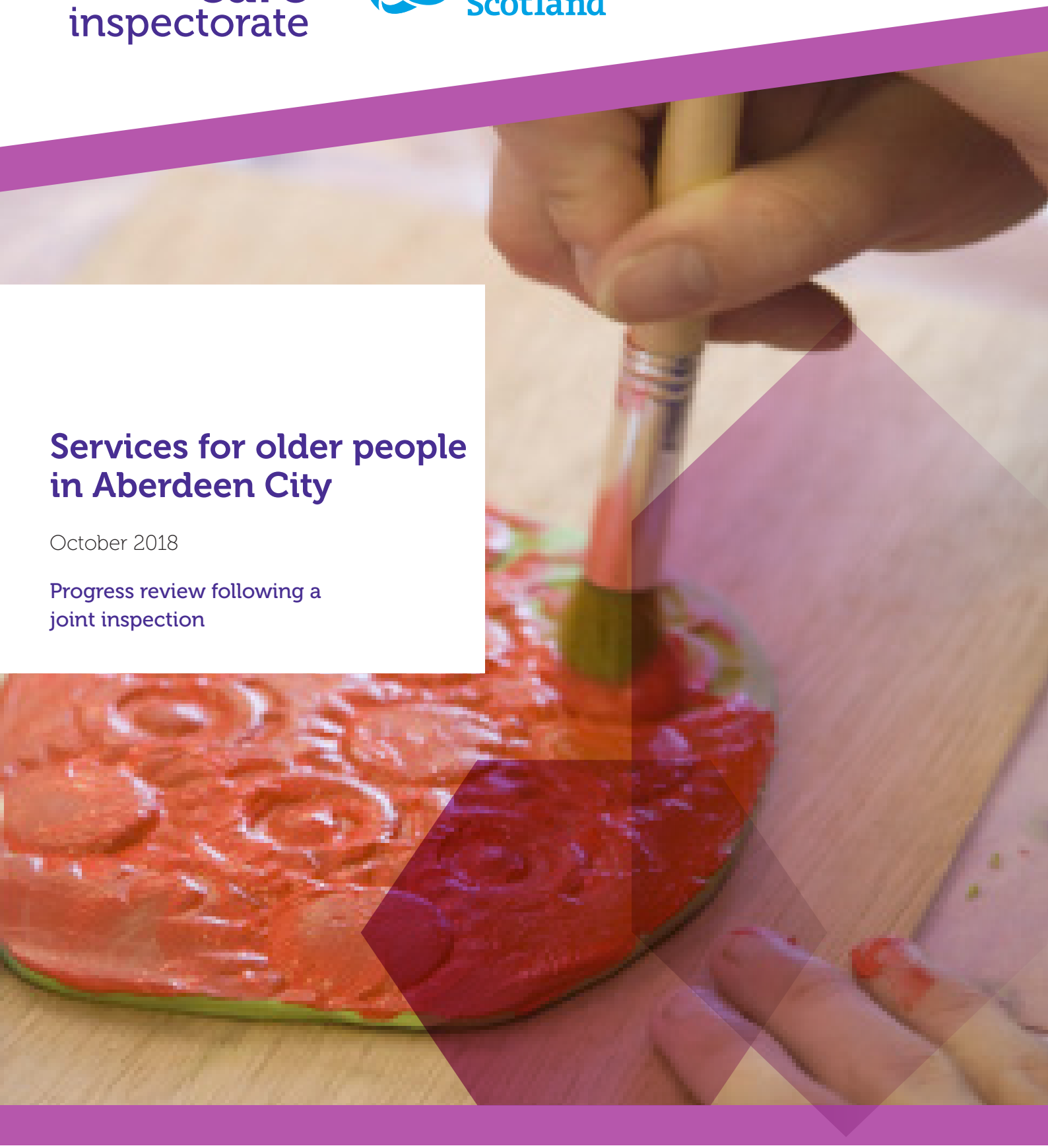
5.1. The inspections of health and social care services for older people aimed to scrutinise partnerships' preparedness and implementation for health and social care integration.

6. Management of Risk

6.1. **Identified risks(s):** There is a risk that the IJB, and the services that it directs and has operational oversight of, fail to meet both performance standards/outcomes as set by regulatory bodies and those locally-determined performance standards as set by the board itself. This may result in harm or risk of harm to people.

6.2. **Link to risks on strategic or operational risk register:** Strategic Risk Register – 5

6.3. How might the content of this report impact or mitigate these risks:
This report provides assurance that the recommendations of the original Care Inspectorate and Health Improvement Scotland Inspection have been met to a sufficient standard to allow for no further scrutiny from the inspectors.



Services for older people in Aberdeen City

October 2018

Progress review following a joint inspection

Contents

1. Background to this progress review

The Care Inspectorate, jointly with Healthcare Improvement Scotland, carried out an inspection of health and social care services for older people in the Aberdeen City between November 2015 and February 2016. We published a joint inspection report in September 2016[1], which is available on both scrutiny bodies' websites. The report highlighted some important weaknesses in the partnership's performance and, given this, we decided to carry out a review of the partnership's progress.

Following publication of the joint inspection report, the partnership drew up a detailed action plan to address the recommendations we had made. We were satisfied that the action plan had the potential to deliver the required improvements.

2. How we conducted this progress review

We undertook this progress review over five days during June 2018. Before this, we examined a range of documentation submitted by the partnership, and we also reviewed the most recent nationally reported performance data for the partnership.

We stated in our joint inspection report of September 2016 that we would revisit the partnership so that we could be assured that the significant issues in relation to adult support and protection had been fully addressed. We subsequently agreed with the partnership that we would also review progress with all of our recommendations for improvement in order to ensure a consistent approach to progress reviews.

To check progress with adult support and protection we sampled and read some records of adults at risk of harm whose adult protection journey had progressed to the investigation stage and beyond. We met with staff who carry out adult support and protection work (council officers[2]) in a focus group. We also met with team leaders who have direct responsibilities for adult support and protection.

To check progress with our other recommendations we met with health and social work staff in focus groups, including locality managers. We met with a group of unpaid carers. We met with representatives of the chief officers group and the convener of the adult protection committee.

3. Progress made: The partnership's approach to improvements and what we found.

Overview

We considered the partnership had made good progress in relation to five of the recommendations, reasonable progress in relation to two, and limited progress in relation to one.

[1] http://www.careinspectorate.com/images/documents/3381/Joint%20inspection%20report%20of%20services%20for%20older%20people%20in%20Aberdeen%20City.pdf

[2] These were council officers specifically trained to carry out adult support and protection work.

The partnership had worked diligently to reduce delayed discharges of older people from hospital and prevent the consequent highly negative impact on older people's health, wellbeing and quality of life.

The partnership had made good progress carrying out carers assessments for unpaid carers. It was reasonably well prepared to implement the Carers (Scotland) Act 2016, which came into force in April 2018.

The partnership had made improvements to its delivery of care at home to older people. However, its capacity to promptly deliver care at home to older people remained a persistent issue, and a significant risk to the partnership.

Due to the concerns we raised in our joint inspection, the partnership commissioned an independent review of adult support and protection. Broadly, the review's findings were congruent with our findings. The partnership had made progress implementing our recommendations on adult support and protection, and the recommendations of the independent review. It needed to deliver faster initial inquiries and investigations into adult protection concerns.

The partnership had made limited progress with the creation of locality teams. It needed to considerably step up its efforts to put locality teams in place and make them operate effectively.

Progress on recommendations for improvement

Recommendation for improvement 1

The partnership should increase the pace of its development of sustainable joint approaches that help to support improvement to deliver the Scottish Government's delayed discharge target of no delays over two weeks duration, and ensure fewer older people experience delayed discharge from hospital.

We made this recommendation because a significant number of older people in Aberdeen City were subject to delayed discharges from hospital. We identified that capacity for delivery of care at home was an important factor contributing to delayed discharges. The number of delays, the number of bed days lost standard delays and code nine delays[3] were significantly high compared to the Scottish average.

At July 2018, the Scottish Government had no specific targets for delayed discharge, other than that partnerships should continuously strive to reduce delays. The partnership had however indicated to the Scottish Government's Management Steering Group that it was working to improve delayed discharges further over 2017-18 by a further five percent.

The partnership's performance in addressing delayed discharges of older people from hospital had improved significantly. They had delayed discharges well controlled. Staff we met agreed with our analysis.

The partnership had put a number of measures in place to help reduce delayed discharges for older people. The discharge hub was fully functional at Aberdeen Royal Infirmary. Staff reported that the hub was a useful platform to support timely hospital discharge for older people. They had recruited a service manager, dedicated to reducing delayed discharge. They had increased the number of social work staff working in the hub at Aberdeen Royal Infirmary.

The discharge hub provided a robust system for monitoring capacity and flow in the acute hospital. It had team members with previous district nursing experience, which helped to build on existing relationships within the community for more effective discharge planning. Older people were able to access care packages from a range of providers quicker because of the new care portal. This care portal was an electronic application that enabled staff to source care for people from a range of providers. The partnership effectively used interim care home and nursing home beds to transfer older people from hospital when they were medically fit for discharge.

Positively, older people in Aberdeen City continued to be supported at home or in a homely setting at end of life. The partnership had developed a clearer process for accessing beds and care for older people that prevented their admission to hospital. This and the work of the care management screening team prevented unnecessary admissions of older people to hospital.

[3] [3] code nine delays are mainly due to reasons related to the Adults with Incapacity (Scotland) Act 2000

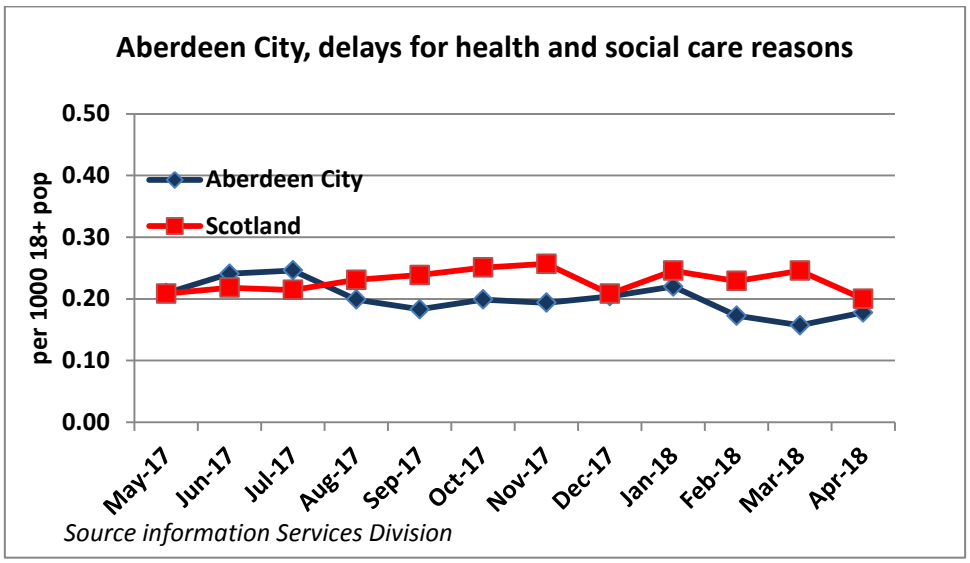


Chart 1

Chart 1 shows that the partnership had reduced its number of delayed discharges (for health and social care reasons) to below the Scotland average.

In the period July 2016 – April 2018 the partnership had an average of 8.5 code nine delays per month. These fluctuated from month to month. They had recently appointed a mental health officer tasked with reducing the number and duration of code nine delays. It was too early to tell if this was effective.

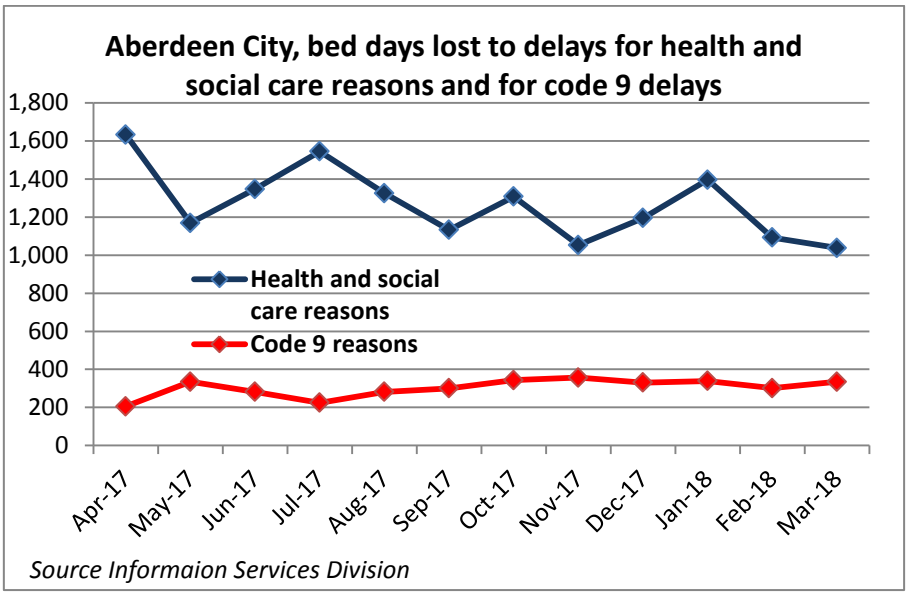


Chart 2

There was a downward trend in the number of acute beds occupied each month by delayed discharge patients. In April 2018, the partnership had 25% fewer acute beds occupied by delayed discharge patients than in April 2017.

Chart 2 shows a downward trend in the number of bed days lost to delays. This was further evidence of the partnership's progress on reducing the number of

delayed discharges. There was a rising trend in the number of bed days lost for code nine reasons (a 63% increase between April 2017 and March 2018) and this remained an area for improvement.

Senior managers, including the former chief officer, had prioritised reducing delayed discharge and this had proved effective. The integration joint board effectively supported this work.

As part of the partnership's transformational change arrangements, there were some innovations to support improvements in reducing delayed discharges and unscheduled care. These included acute care at home, which had only just recently started. The multidisciplinary health and social care team, aimed to prevent unnecessary admissions to hospital. Another initiative was Integrated Neighbourhood Care Aberdeen (INCA)[4] (see link in footnote for details of this model of health and social care). There were two pilots underway in Cove and Peterculter. These self-managing teams were made up of health and social care staff, in line with the Buurtzorg model[5]. The West Unscheduled Care Project[6] aimed to test a daytime urgent afternoon home visiting service for patients in the West Locality. An advanced nurse practitioner did these visits, which otherwise a GP would have carried out. These initiatives were in early stages of implementation and had not yet made an impact on delayed discharges.

Overall, we considered that the partnership had implemented this recommendation effectively. It had made good progress reducing the numbers of older people who could not be discharged from hospital, despite being medically fit for discharge.

Recommendation for improvement 2

The partnership should work with carers and those services that support them to ensure that:

- carers are routinely offered a carers assessment
- carers' assessments are completed for those carers who request them
- offering and completing carers' assessments is clearly documented, and
- revisions to the future format for carers assessments take into account new carers legislation.

In our joint inspection report published in September 2016, we found the partnership's delivery of support to unpaid carers was mixed and some carers we met found it easier to access services than others. The older people's records that we read in 2016 showed that half the carers were not offered a carers assessment and a third of those who had requested a carers assessment did not get one. The practice of offering carers assessments varied across the teams.

The partnership was working to address inconsistencies in practice across the teams when unpaid carers needed support to help them fulfil their caring role. Our analysis of the documentary evidence submitted for this recommendation

[4] https://www.aberdeencityhscp.scot/our-innovations/inca/
[5] A model of self-managing health and social care teams that emanates from the Netherlands.
[6] https://www.aberdeencityhscp.scot/our-innovations/west-visits/

showed there was a strong emphasis on engagement and participation of unpaid carers. This included their meaningful involvement in the planning and future design of services for carers. The implementation of the Carers (Scotland) Act 2016 in April 2018 had enhanced the partnership's focus on the needs of unpaid carers.

The carers strategy was co-ordinated by a steering group with representatives from the partnership, third and independent sectors, and carers. It was informed by various workshops, a carers' conversation programme, a citywide survey, and the work of various sub groups. Positively, the partnership received feedback from around a thousand unpaid carers at these events. Their views had strongly influenced the development of the carers strategy.

The partnership established robust eligibility criteria for unpaid carers in June 2018, in line with the requirements of the new legislation. They reviewed the carers assessment and support documentation in consultation with carer representatives. They were in the process of creating a new adult carer support plan to replace the existing carer assessment. They anticipated completing this documentation, with full implementation across the city, by the end of 2018.

The partnership undertook a review of its commissioned carer support service for adults from Voluntary Services Aberdeen (VSA), a third sector provider. The integration joint board approved a variation of the VSA contract, which commenced from November 2017. This revised contract set out arrangements for providing adult carer support plans (including emergency and future planning) for unpaid carers. Unpaid carers were referred to the VSA service when the person they cared for needed a care management assessment. Unpaid carers received support from this service if the person they cared for had their hospital discharge delayed.

We met with a number of carers who were members of a specialist Parkinson's disease carers support group and some of the people they cared for. They had mixed views about their experience of care at home services. Some said the care at home service was unable to provide the level of support that they considered was needed to support the person they cared for at home. Some carers had waited more than three months to get home support in the morning. Although end-of-life care was prioritised, access to this could vary depending on where you lived. They made positive comments about access to respite and daycare services. Some of the individuals who were cared for spoke highly about the range of support available to enable them to lead fulfilling lifestyles and participate in favourite pastimes. Carers who cared for a person with dementia said they had very good post-diagnostic support for a year. The dementia resource centre provided this support.

Frontline health and social work staff and managers we met said that good conversations had always taken place with carers. But there were inconsistencies in how this information was recorded and acted upon across the city. Staff viewed the enhanced VSA contract as a positive step to streamlining the referral process for carers in line with the newly developed eligibility criteria. Health and social work staff had attended training in preparation for the implementation of the carers legislation. Senior managers affirmed that a huge

amount of work had been done around supporting unpaid carers, and the legislation had sharpened the partnership's focus on unpaid carers.

Overall, the Aberdeen health and social care partnership and its third sector partner Voluntary Service Aberdeen completed a substantial number of carers assessments – 358 over a two-year period (2016 – 2018).

We concluded the partnership had made good progress implementing this recommendation.

Recommendation for improvement 3

The partnership should ensure that:

- pathways for accessing services are clear
- eligibility criteria are applied consistently across services, and
- waiting lists are monitored and reviewed to manage the allocation of pressurised resources equitably.

We made this recommendation because our joint inspection found that some older people had a lengthy wait to get the care and support services needed to deliver their desired personal outcomes in respect of safety, health and improvements to their quality of life and wellbeing. The partnership did not apply its eligibility criteria consistently. Older people who used services, their unpaid carers and other stakeholders were unclear about how to access health, social work and social care services.

One area where there was clear improvement was with staff recording that their conversations with older people about their self-directed support (SDS) options[7] had taken place. Staff completed a form noting that they had this conversation. The numbers of people[8] recorded to have had these conversations had risen exponentially since the start of the form system. The partnership achieved an increase for this indicator of over 1000% between June and September 2017.

The published figures from the number of direct payment recipients showed that Aberdeen City was around the Scotland average for this indicator. There was a rising trend of direct payment recipients.

Staff had to submit their recommendations for packages of care for older people to the resource allocation panel (RAP) for approval. They did not have to do this for all packages of care, and the criteria for when they did have to get approval from the RAP were somewhat complex. Some of the frontline staff we met said the arrangements for the RAP were bureaucratic and could cause delays in some instances. All self-directed option one and option two packages had to go to the RAP, while option three packages did not. Managers said that if an individual was in urgent need then care could be deployed immediately, in advance of approval by the RAP. The service managers that we met were largely positive about the RAP as a conduit to ensure:

[7] Option 1 – direct payment, option 2 – supported person chooses service and service provider, option 3 – HSCP arranges the service, option 4 – any mixture of the first three options.

[8] Older people and people with physical disabilities.

- equity of access to resources
- consistency of access to resources by people using services
- control of costs
- consistency with assessments and recommendations for people's care requirements.

The partnership referred to the number of care at home hours that they were not able to deliver as unmet need. The figure for unmet need had fallen by around half in early 2018, from around 1000 hours each month to around 450 hours each month. This showed that they were making progress.

The Scottish Government's published care at home statistics (2017) show, positively, that in 2017 the partnership increased the volume of care at home hours it delivered to older people by 11% compared to 2016. There was a marginal decrease in the number of older people who received care at home – 4% between 2016 and 2017. Overall, this data evidences the progress providing care at home to older people, with a related improvement to older people's ease of access to care at home. However, the number of care at home hours that the partnership acknowledged it could not deliver, along with the comments of the unpaid carers and the staff that we met, was evidence that this was an area for continued improvement.

Some older people still had to wait for lengthy periods for care at home. This problem could be exacerbated by people's location or if there were complexities with the aspects of the care that they required for example, double-up care at home[9] or care at very specific times.

Frontline managers reported that there were clear pathways for accessing palliative care services. We did hear some negative views about the availability of palliative care from some of the unpaid carers we met:

The partnership had made progress with the equitable allocation of day care places for older people. They had also reduced the amount of time that older people, who required a care home place, had to wait for one.

There has been progress implementing this recommendation in terms of:

- reduction in unmet need (care at home hours that could not be delivered)
- far more individuals recorded as participating in SDS "option choice" conversations
- views of some in respect of the efficacy of the RAP
- pathways to palliative care services
- access to day care places and faster access to care home places.

The partnership had made reasonable progress implementing this recommendation. It had made improvements to its timely delivery of care at home to older people. Increasing the capacity of care at home services was an area for continuous improvement.

[9] Two care at home workers are required at the same time to support the person.

Recommendation for improvement 4

The Aberdeen City adult protection committee should support improvement in adult support and protection by:

- including timescales for all partners for the completion of all stages within the adult protection processes
- providing oversight of progress of action plans completed from audits
- providing oversight and quality assurance of any action plan resulting from the commissioned review of adult support and protection.

We made this recommendation because our joint inspection found the partnership had significant deficits with its adult support and protection processes and practice. There was widespread lack of clarity about the timescales for completing adult support and protection work, particularly those for initial inquiries and investigations. There were protracted delays, sometimes of many months, in carrying out adult protection work. Some adults at risk of harm suffered adverse impact because of these delays. We intimated these findings to the partnership and it commissioned an independent review of adult support and protection. The Care Inspectorate worked alongside the independent reviewers and directly supported the reviewer's analysis of the records of adults at risk of harm.

The independent review of adult support and protection commissioned by the partnership states "The clear view from staff and frontline managers is that management systems are currently driven by scrutiny and compliance".

The culture around adult support and protection had clearly changed for the better. Staff were much more confident about their adult support and protection practice. Council officers we met said that they were well supported for their adult protection work by their team leaders and other managers. They said that the punitive climate existing at the time of our joint inspection two years ago had been replaced by a much more supportive and facilitative approach.

One of the key findings of the commissioned review of adult support and protection in Aberdeen City was "The partnership needs to address delays and confusion in key aspects of adult protection processes and look at setting clear parameters for completion".

Council officers we met all knew what the timescales were for completing adult protection initial inquiries and investigations (eight weeks for each) even though they were not formally written down anywhere. They knew the timescales from their conversations with their team leaders and from the two-weekly monitoring reports carried out on adult protection work. If there were delays in carrying out initial inquiries and investigations this was flagged up.

The partnership had not formally written down the timescales for completing adult protection initial inquiries and investigations or properly intimated the timescales to all staff. They acknowledged that this was the case. The partnership should make sure that its adult support and protection procedures are updated to include a clear written statement of the expected timescales for the completion of:

- initial adult protection inquiries

- adult protection investigations
- all other phases of the journey of the adult at risk of harm for example, timescales for convening adult protection case conferences.

The updated procedures should be made widely available in an accessible manner to all staff across the partnership. This includes third sector and independent sector partners.

The partnership had recently started a pilot initiative in the learning disabilities team. This team had a higher number of adult protection initial inquiries and investigations compared to other adult teams. The objective of this initiative was to streamline the process of carrying out initial inquiries and investigations into adult protection concerns, and to shorten the timescale for completing these activities.

The partnership's timescales for completing initial adult protection inquiries and investigations were eight weeks for each activity. Figure 1 shows the partnership's evolving position on timescales for completing adult protection initial inquiries and investigations:

- at the time of our joint inspection
- at the time of our progress review
- for the pilot in the learning disabilities team (28 days to complete both initial inquiry and investigation, which was a 75% reduction in the time allocated for completion of these activities).

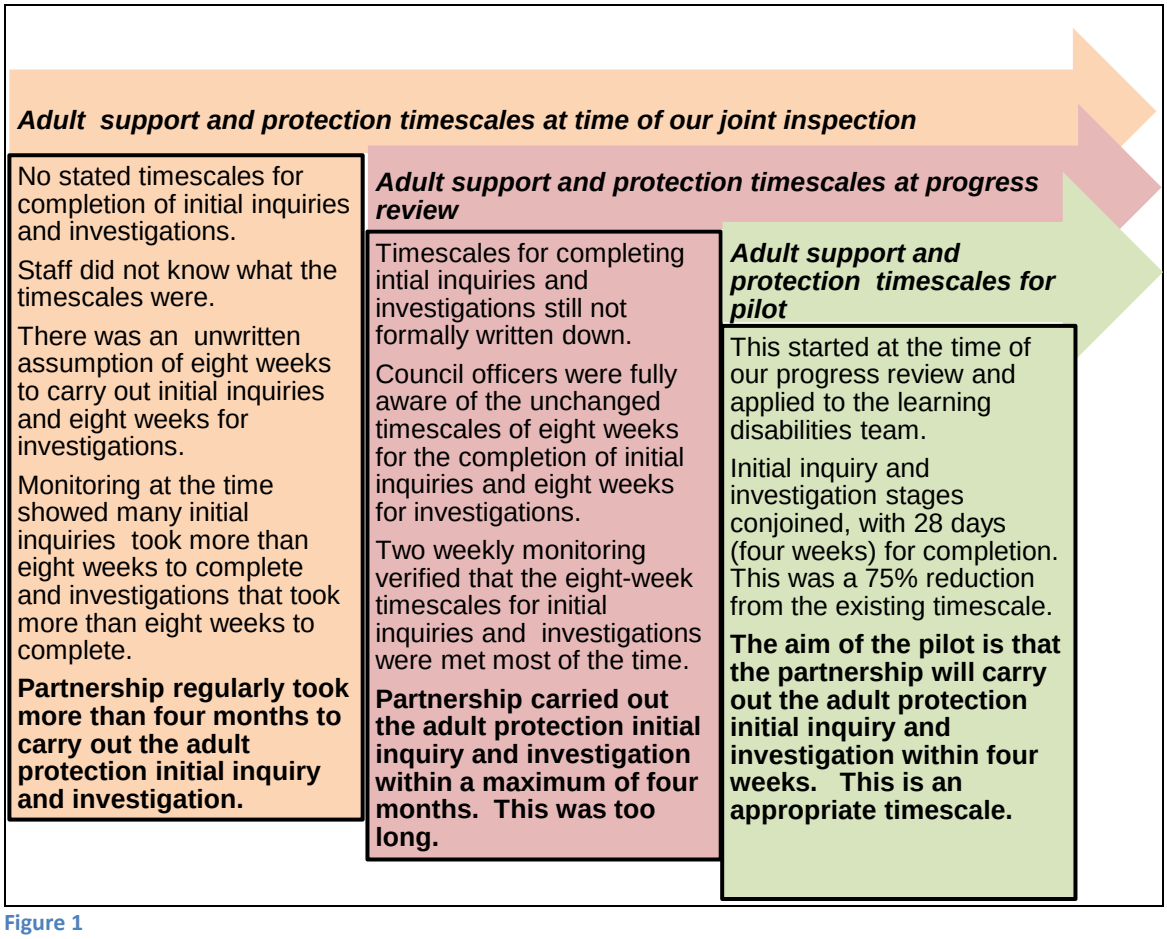


Figure 1

The council officers we met thought that the partnership's four-month timescale for completing initial inquiries and investigations into adult protection concerns was considerably too long. They said that prolonged initial inquiries and investigations could be unduly stressful for adults at risk of harm and their families. Council officers strongly supported the move towards much quicker initial inquiries and investigations into adult protection concerns.

Adult protection file reading results (see Appendix 1)

We read eight records for adults at risk of harm (all were older people) from which it was clear that adult support and protection practice was variable across the records we read. As we only read a small sample[10] of records our results are only applicable to these records and not to all adult protection records of the same type. We also read the records for two adult protection referrals and could see that these were processed effectively.

In October 2017, the adult protection committee approved the action plan for improvement activity prompted by the findings of the Review of Adult Support and Protection (June 2016). This took too long, with over a year between submission of the review report to the adult protection committee and the committee signing off the improvement plan.

The adult protection committee had made recent changes to its structure. It had put an operational subcommittee in place. A key remit of the subcommittee was to take forward action plans. It was too early to tell if this subcommittee was operating effectively. The adult protection committee should make sure that it exercises diligent leadership and governance of adult protection improvement activity.

We considered that the partnership had made good progress implementing this recommendation. It now needed to deliver and roll out its pilot initiative to dramatically reduce the time taken for adult protection initial inquiries and investigations.

Recommendation for improvement 5

The partnership should take action to ensure that frontline staff are supported to complete initial inquiries, risk assessments and risk managements plans timeously. This action should include:

- working alongside Police Scotland to set clear timescales for completing inquiries
- streamlining its risk assessment frameworks, and
- ensuring that risk assessments and risk management plans are completed and actioned.

[10] Our sample of records was too small for the results to be statistically significant, that is to enable us to infer they applied to all adult protection records of the same type. We decided to read eight records to check on adult protection key processes in practice.

We made this recommendation for the same reasons that we explain for Recommendation 4. In addition, our joint inspection found that completion of risk assessments and risk management plans for adults at risk of harm and other individuals was a critical area that required improvement.

We report on timescales for completing adult protection initial inquiries and investigations in our findings for recommendation 4.

The partnership had created new guidance and documentation on risk assessment for adult protection. Some of the staff we met were not sure when they should use the adult protection risk assessment documentation and when they should use the generic risk assessment documentation. Some of the council officers we met had never used the adult protection risk assessment documentation. We considered that the partnership should quickly issue clear guidance to all relevant staff about which risk assessment documentation they should use for adults at risk of harm subject to the adult protection procedures.

Our indicative findings on risk assessments and risk management plans from our file reading analysis were variable (see summary of our file reading findings). Our results were more positive for risk assessments than for risk management plans. The partnership acknowledged there was room for improvement on their preparation of risk management plans for adults at risk of harm. We read some very good risk assessments for adults at risk of harm that identified all the pertinent risks for the adult, set out these risks in sufficient detail, analysed the likelihood of these risks occurring, and their impact on the adult at risk of harm. The risk assessments we read that we rated worse than adequate failed to address these key elements. In six cases out of eight, a risk management plan was present. One should have been present for all eight cases. The quality of these plans was variable.

The partnership had introduced a form to give feedback to health staff who had raised an adult protection concern about an individual (made an adult protection referral). Health staff we met said that this mechanism to improve feedback was effective and helped them to feel more included and involved in adult support and protection.

The development of the police concern hub was a very positive development for adult support and protection. The hub acted as central repository for adult protection information and intelligence, and screened, and triaged this information timeously, efficiently and effectively.

We concluded that the partnership had made reasonable progress implementing this recommendation.

Recommendation for improvement 6

As part of the continued development of the new integrated arrangements, partners should develop their strategic approach to joint training and development. This should aim to:

- offer opportunities beyond mandatory training
- include the third sector to enhance a shared knowledge of roles and responsibilities, and

- achieve a cohesive approach to care delivery for older people.

Our joint inspection of 2016 concluded the partnership needed to review its strategic approach to joint training. There were a few positive examples where joint training was delivered but this needed to be strengthened to support health and social care integration.

The partnership organised a staff engagement event that brought health and social work and social care staff together. Staff we met found the messages too high-level and confirmed that to date this had not resulted in meaningful change in practice for those working at the frontline.

Senior managers in the partnership supported the adult protection committee to look at improving initiatives for shared learning and further opportunities for training. NHS Grampian had purposefully developed an adult support and protection good practice guidance document. Their evaluation of multi-agency adult support and protection events and workshops confirmed the guidance effectively supported primary care staff (including GPs). The creation of a learning and development post in health had strengthened the role of NHS staff in adult support and protection. The adult support and protection committee biennial report highlighted the positive contribution made by GPs to adult support and protection

Frontline managers said there was a big improvement in multiagency adult protection training. The partnership was piloting training of health staff to be the second person to support council officers with adult support and protection investigations.

Health staff made around 18 adult protection referrals a month. This was when health staff considered that an adult might be at risk of harm. Nationally, there are relatively few adult protection referrals from health professionals. The level of health-generated adult protection referrals a year was evidence that the partnership's joint adult protection training was effective.

Specialist training was underway to address the increase in the number of older people living at home with complex care needs. The district nursing service had started this training, with a planned roll out to other health and social care professionals.

The partnership had improved joint working arrangements with third-sector and independent-sector partners. Monthly meetings with providers were established and frontline staff and managers reported that better communication with providers and more cohesive working had emerged as a result.

Staff from both health and social care had received some training on the new carers' legislation and they demonstrated a reasonable understanding of the duties this placed on the partnership in respect of unpaid carers. Representatives from Voluntary Service Aberdeen were part of the training and partnership staff were well informed about the new contract arrangements to deliver an enhanced carer support service.

We concluded that the partnership had made good progress implementing this recommendation.

Recommendation for improvement 7

As part of the continued development of the new integrated arrangements, partners should put a formal plan in place that sets out the future allocation of the integrated care fund and set out clear criteria for how these projects would be evaluated.

We made this recommendation because our joint inspection found the partnership had not yet developed detailed plans for how it would allocate integrated care fund[11] monies and evaluate projects funded by these monies.

The partnership had a clear detailed strategy and an established approach to the use, management and review of the integrated care fund. It designed the approach to make sure that projects funded by the integrated care fund were fully compliant with the stated objectives for this fund. It could then evaluate projects using the success criteria set out in the Scottish Government guidance[12] on the use of this fund.

Staff who wanted to make a bid to the integrated care fund for funding for initiatives had to create a detailed business case. Managers said that they had found it hard to prepare business cases that led to the allocation of integrated care fund funding. Senior managers said that the partnership was developing training on how to prepare business cases that met all of the defined criteria. The integrated care fund was underspent. It also needed to make sure that the process for accessing the integrated care fund was as streamlined and user-friendly as possible. And make sure that appropriate, viable and outcome-focused initiatives received funding from the integrated care fund.

There were challenges with the Integrated Neighbourhood Care Aberdeen (INCA) team, which was funded from the integrated care fund. Senior managers said that they were reviewing this model of working. There were significant challenges associated with importing a model of care and support from the Netherlands that has a very different structure of health and social care services, and a different culture to Scotland. It may be that the learning from the INCA team experiment can be used for future service developments.

We concluded that the partnership had made good progress implementing this recommendation.

Recommendation for improvement 8

As part of the continued development of the new integrated arrangements, partners should set a clear timetable to agree and implement the structure for locality management teams.

[11] The integrated care fund is money from the Scottish Government specifically for the development and transformation of integrated health and social care.
[12] http://www.gov.scot/Resource/0046/00460952.pdf

We made this recommendation because the partnership had made very little progress with the creation of locality teams. Localities and the delivery of health, social work, and social care services based on specific locality needs was a key element of the partnership's strategic planning.

One of the challenges with the creation of locality teams was the management of the relationship between these localities and the services and teams that covered the whole of Aberdeen City. Service managers we met were conscious of the need to forge a harmonious relationship with locality teams and their managers. They considered that they should have a clear role and input into the formation of the locality teams.

Two years after we made this recommendation the partnership had made very limited progress with the development of locality teams. Locality teams were not yet in place. Four heads of locality were in post from November 2017. The partnership initially considered that each locality needed to have an operational manager as well as a locality manager. It was reconsidering this view. Senior managers we met acknowledged that the creation of locality teams was a significant challenge. We considered that significant difficulties with the creation of locality teams remained.

The partnership had made limited progress implementing this recommendation.

4. Conclusion and what happens next

Our original joint inspection identified some strengths in the delivery of services for older people in the Aberdeen City. These included a strong commitment to engaging with and involving local communities in planning how to meet the health and social care needs of the older population. However, we also identified a number of significant weaknesses and we made eight recommendations for improvement in relation to these.

The partnership had responded well to our recommendations. It had made good progress in addressing delayed discharges, carers assessments, joint training, and its process for allocating money from the integrated care fund. It had made good progress supporting the frontline staff who carried out adult support and protection work. It had made limited progress developing locality teams.

Given the findings from our review and progress made by the partnership, we do not intend to conduct any further scrutiny in relation to our original recommendations. The Care Inspectorate and Healthcare Improvement Scotland will continue to engage with the partnership and support continuous improvement.

Appendix 1 file reading results - eight adult support and protection records (these results only apply to the eight records we read)

Chronolologies	• 7 out of 8 records had a chronology • 5 chronologies were of an acceptable standard, 2 were not
Risk assessment	• All 8 records contained a risk assessment • 3 rated very good, 1 good, 2 adequate, 1 weak and 1 unsatisfactory
Risk management plan	• 6 records contained a risk management plan, 2 did not • 2 rated good, 4 rated adequate
Adult protection investigations	• All 8 records contained account of full investigation • 5 investigations effectively determined if adult was at risk of harm, 3 did not • 7 investigations completed within reasonable time, 1 was not • 2 rated very good, 2 good, 2 adequate, 1 weak and 1 unsatisfactory
Adult protection case conferences	• 6 ASP case conferences should have been convened, 5 were • 1 case conference did not invite health and police • 3 case conferences not attended by health, 2 not attended by police • No adults at risk of harm attended any of the case conferences , 2 unpaid carers did attend • 1 case conference rated very good, 2 good, 2 weak
Adult protection outcomes	• 3 adults at risk of harm better able to protect themselves • 2 clear, have someone to confide ASP concerns • 4 safe and protected • 2 living as they want • 3 ASP process delivered improved wellbeing
Financial Harm	• 4 of the 8 adults at risk of harm suffered financial harm • In 3 cases partnership acted to stop the financial harm, in 1 case it did not act • In 3 cases partership's actions stopped the financial harm • Partnership's actions to stop financial harm rated, 1 very good, 1 good, 2 weak
Involvement of adults at risk harm	• Initial inquiry stage - 6 adults at risk of harm had views taken into account by partnership, 2 did not • Investigation stage - 7 adults at risk of harm had views taken into account, 1 did not • ASP case conference - 2 adults at risk of harm had their views taken into account, 4 did not • Post case conference activity and review case conference - 2 adults at risk of harm had their views taken into account, 4 did not

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The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium are part of our organisation.

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Aberdeen City Health & Social Care Partnership
A caring partnership

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Date of Meeting	13.11.2018
Report Title	NHS in Scotland 2018 – Audit Scotland Report
Report Number	HSCP.18.085
Lead Officer	Alex Stephen, Chief Finance Officer
Report Author Details	Alex Stephen, Chief Finance Officer
Consultation Checklist Completed	*Yes*
Appendices	a) NHS in Scotland 2018 – Audit Scotland Report

1. Purpose of the Report

1.1. This report provides the Audit & Performance System Committee with the opportunity to discuss and comment on Audit Scotland's Report 'NHS in Scotland 2018' which was published on 25 October 2018.

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems Committee:

a) Reviews, discusses and comments on the report as attached at Appendix A.

3. Summary of Key Information

3.1. 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.

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Highlights from the 'NHS in Scotland 2018' Report

3.2. In 2017/18 the health budget made up 42% of the total Scottish Budget at £13.1 billion. Whilst savings of £449.1 million were made, this was largely made up of one-off savings.

3.3. In the annual review of the NHS, the Auditor General for Scotland found that "performance continued to decline in 2017/18 and the NHS is not financially sustainable in its current form". The report identifies major financial pressures which are likely to continue:

a) major workforce challenges – difficulties in recruiting and increases in sickness absence and staff turnover.

b) rising drug costs

c) a significant maintenance backlog.

3.4. Boards are also considering the potential impact of EU withdrawal on areas such as staffing, the supply and cost of drugs, and food prices.

Relevance to Integration Authorities

3.5. As well as the obvious relevance for Integration Authorities as an analysis of one of their major partner organisations, the Audit Scotland Report makes a number of recommendations which the Integration Authorities should carry out in partnership with the Scottish Government and NHS Boards.

3.6. The recommendations include:

a) working to develop a national capital investment strategy;
b) continuing to develop a comprehensive approach to workforce planning;
c) working together to develop a clearer understanding of demand, capacity and activity trends in primary and secondary care
d) publishing information on how the health funding system works
e) to put NHS staff, local communities at the heart of change

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Scottish Medium-Term Health & Social Care Financial Framework (Financial Framework)

3.7. The Audit Scotland report makes reference to the financial framework (also included on today's agenda). The Audit Scotland report emphasises that it is not yet clear how the figures presented in this framework relate to those set out in the Scottish Government's overall 5-year strategy.

4. Implications for IJB

4.1. Equalities – there are no direct equalities implications arising from the recommendations of this report.

4.2. Fairer Scotland Duty - there are no direct implications for the Fairer Scotland Duty arising from the recommendations of this report.

4.3. Financial – the financial implications are outlined throughout the Audit Scotland Report. The IJB will need to be aware of these implications as NHS Grampian is one of its partner organisations and as such any financial difficulties relating to the Health Board may impact on IJB budgets.

4.4. Workforce – the workforce implications are outlined throughout the Audit Scotland Report. The IJB will need to take consideration of these points in relation to their own workforce planning activity, for example the potential impacts of withdrawing from the European Union.

4.5. Legal - there are no direct workforce implications arising from the recommendations of this report.

4.6. Other - there are no other implications arising from the recommendations of this report.

5. Links to ACHSCP Strategic Plan

5.1. Ensuring that the APS committee has full awareness of Audit Scotland recommendations which relate to both the IJB and ACHSCP will help to ensure the IJB successfully delivers on its strategic plan.

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

6. Management of Risk

6.1. **Identified risks(s)** There is a risk of financial failure, that demand outstrips budget and IJB cannot deliver on priorities, statutory work, and projects an overspend.

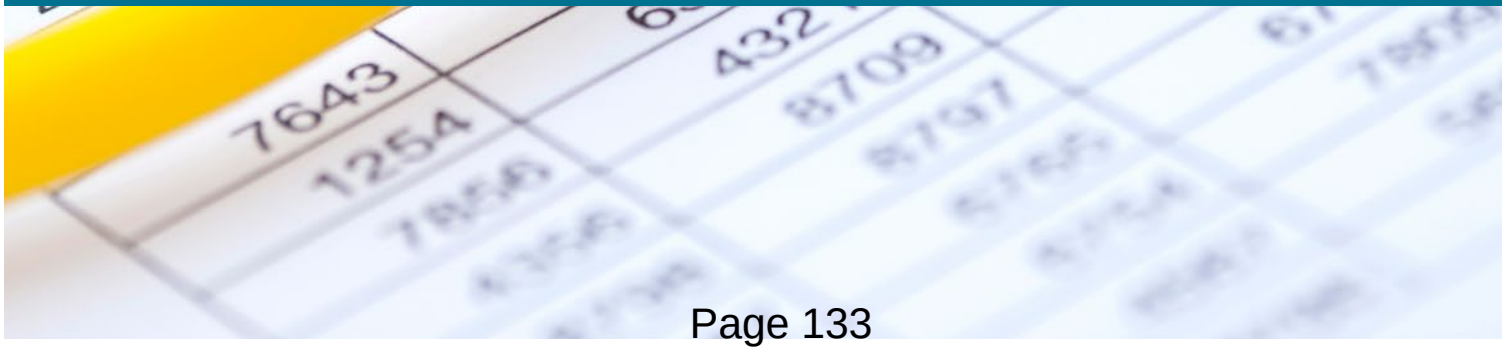
6.2. **Link to risks on strategic or operational risk register:** Strategic Risk 2

6.3. **How might the content of this report impact or mitigate these risks:** Ensuring that the IJB has an oversight of Audit Scotland reports relating to its partners will provide the IJB on the scale of the challenges faced in transforming the healthcare system in Scotland.

NHS in Scotland 2018

AUDITOR GENERAL

Prepared by Audit Scotland
October 2018



Auditor General for Scotland

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- examine how public bodies spend public money
- help them to manage their finances to the highest standards
- check whether they achieve value for money.

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- directorates of the Scottish Government
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- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Police Authority, Scottish Fire and Rescue Service.

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

Contents

Links

PDF download

Web link

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

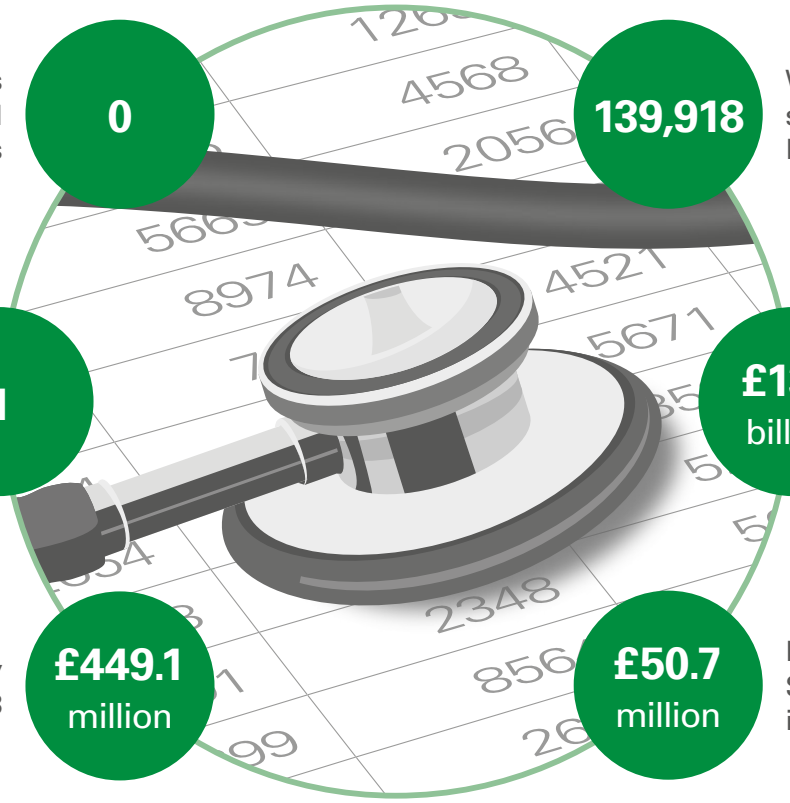
Exhibit data

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

Audit team

The core audit team consisted of: Leigh Johnston, Kirsty Whyte, Nichola Williams, Martin Allan, Agata Maslowska, and Veronica Cameron, with support from other colleagues and under the direction of Claire Sweeney.

Key facts



0
Number of boards meeting all key national performance targets

139,918
Whole time equivalent staff employed by the NHS

1
Key national performance target met

£13.1 billion
Total Scottish Government health budget in 2017/18

£449.1 million
Total savings made by NHS boards in 2017/18

£50.7 million
Brokerage provided by Scottish Government in 2017/18

Summary

Key messages

1 To meet people's health and care needs, the NHS urgently needs to move away from short-term fire-fighting to long-term fundamental change. The type of services it offers, and the demand for those services, have changed significantly over the 70 years since the NHS was created. The challenges now presented by an ageing population means further and faster change is essential to secure the future of the NHS in Scotland.

2 The NHS in Scotland is not in a financially sustainable position. NHS boards are struggling to break even, relying increasingly on Scottish Government loans and one-off savings. The Scottish Government's recent health and social care medium-term financial framework and other measures are welcome steps but more needs to be done.

3 The pressure on the NHS is increasing. Performance against the eight key national performance targets continues to decline. No board met all of the key national targets. Only three boards met the 62-day target for cancer referrals. The number of people on waiting lists also continues to increase. The only target met nationally in 2017/18 was for drug and alcohol patients to be seen within three weeks.

4 The scale of the challenges means decisive action is required, with an urgent focus on the elements critical to ensuring the NHS is fit to meet people's needs in the future. These include being clear about how the NHS is governed, multiple planning layers exist at local and national level, it is unclear how regional planning will operate in the future and health and social care integration continues to develop.

5 Ensuring effective leadership is also critical. Much more engagement and information is needed about how new forms of care will work, what they cost and the difference they make to people's lives. Without this, it will continue to be difficult to build support among the public and politicians to make the decisions needed to change how healthcare is delivered in Scotland.

decisive action is required to secure the future of the NHS in Scotland

Recommendations

The Scottish Government should:

- develop a robust and transparent financial management system for managing and monitoring NHS boards' new year-end flexibility and three-year break-even arrangement

- ensure NHS governance arrangements are clear and robust by making sure roles and responsibilities are explicit and lines of accountability are clear at each planning level

- report publicly on the progress of the Health and Social Care Delivery Plan, including measures of performance covering all parts of the healthcare system to show progress towards delivering more healthcare in the community.

The Scottish Government, in partnership with NHS boards, should:

- strengthen board-level governance arrangements, including developing an improved national approach to induction, training, and assessment for non-executive directors

- identify why NHS leadership posts are difficult to fill and develop ways to address this.

The Scottish Government, in partnership with NHS boards and integration authorities, should:

- develop a national capital investment strategy to ensure capital funding is strategically prioritised

- 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.

The Scottish Government, NHS boards and integration authorities should:

- work together to develop a clearer understanding of demand for services, and capacity and activity trends within primary and secondary care and use this to inform medium to long-term service and workforce planning

- publish clear and easy to understand information on how the health funding system works, including how much funding was provided, what it was spent on, and the impact it has on people's lives

- put NHS staff, local communities, and the public at the heart of change and involve them in planning and implementing changes to how services are accessed and delivered.

Introduction

1. The NHS is 70 years old this year and continues to provide a range of vital services to thousands of people every day across the country. In 2017/18, the NHS in Scotland:

- employed almost 140,000 (whole-time equivalent) staff across 14 mainland and island NHS boards and eight national boards
- conducted an estimated 17 million GP consultations
- carried out four million outpatient appointments
- responded to 764,201 emergencies
- spent £13.1 billion on healthcare.[1,2,3,4,5]

2. Over the years we have highlighted the growing pressures facing the NHS in our national and local audit work. These include a tight financial environment, increasing demand for services, difficulties in recruiting staff, and rising public and political expectations. In the face of these pressures, a committed workforce has continued to work to deliver high-quality care. However, the demands of a growing and ageing population on top of these pressures mean the current healthcare delivery model is not sustainable.

3. The Scottish Government set out how it wants healthcare and the health of the Scottish population to change in its 2020 Vision, published in 2011.[6] Its aim is that everyone should live longer, healthier lives at home or in a homely setting by 2020, and significant activity is under way to work towards this. However, progress is too slow and major issues still need to be addressed if the vision is to be achieved. These include ensuring the NHS is financially sustainable in the medium to longer term, recruiting the right number of skilled staff in the right places, identifying what the public wants from its healthcare system, and fully integrating health and social care services.

4. This report sets out why immediate action is needed, identifying the financial and performance position of the NHS in Scotland in 2017/18. Part 2 of the report sets out what needs to change to ensure the NHS can continue to meet the needs of the Scottish people.

Part 1

Why is immediate action needed?

Key messages

1 The overall health budget in 2017/18 was £13.1 billion, a 0.2 per cent decrease in real terms on the previous year. The NHS struggled to break even. Three boards required a loan from the Scottish Government and the majority relied on short-term measures to balance their books. NHS boards achieved unprecedented savings of £449.1 million in 2017/18 by relying heavily on one-off savings. This is not sustainable.

2 The pressures facing the NHS continue to intensify. Financial pressures such as drug costs, a backlog of maintenance, and the use of temporary staff are predicted to continue in future years. Projected funding increases are unlikely to be enough to keep pace with rising health costs and the need for investment in the NHS estate. EU withdrawal will mean additional challenges, including recruiting and retaining staff and procuring vital supplies such as drugs.

3 Performance declined against the eight key national targets between 2016/17 and 2017/18. More people waited longer for outpatient and inpatient appointments. The number of people waiting over 12 weeks for their first outpatient appointment increased by six per cent in the past year, while the number waiting over 12 weeks for an inpatient appointment increased by 26 per cent. No board met all eight targets. Only one of the eight key performance targets was met nationally– for 90 per cent of patients referred for drug and alcohol treatment to receive treatment within three weeks.

4 The NHS faces significant workforce challenges. Recruitment remained difficult in 2017/18, while sickness absence and turnover increased.

the NHS is not in a financially sustainable position and performance against national targets is declining

The NHS is not in a financially sustainable position

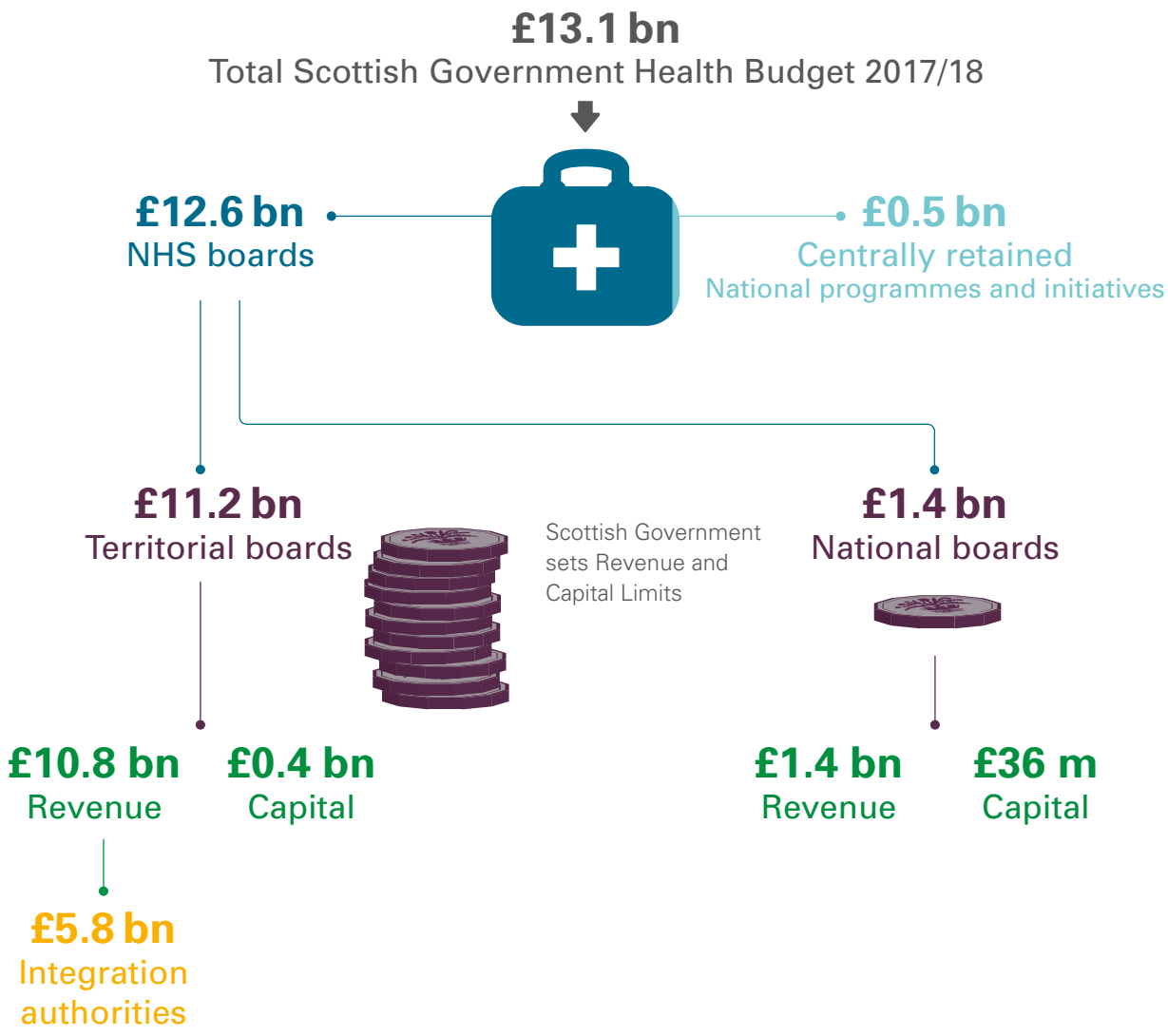
5. Financial sustainability considers whether a body is likely to be able to continue delivering services effectively or change how services are delivered in the medium to longer term with the available resources. We have looked at a number of measures which indicate risks to the sustainability of the NHS and we examine these below.

6. In 2017/18, the total Scottish Government health budget for spending on core services was £13.1 billion.[7,8] Health remains the single largest area of Scottish Government spending, accounting for 42 per cent of the total budget in 2017/18. The majority of health funding is provided to territorial boards to deliver services (Exhibit 1, page 9).

Exhibit 1

Health funding breakdown 2017/18

The majority of funding in 2017/18 was given to mainland and island NHS boards.



Source: Audit Scotland using Scottish Government draft budget 2018/19 and NHS Consolidated Accounts for financial year 2017/18

7. NHS boards delegate a significant percentage of their budget (£5.8 billion, 46 per cent in 2017/18) to integration authorities to fund health services such as primary and community care.[9] We will be publishing our second report on health and social care integration in November 2018.

8. Between 2016/17 and 2017/18, the overall health budget increased by 1.5 per cent in cash terms. Taking inflation into account, the budget decreased by 0.2 per cent:

- Revenue funding for day-to-day spending increased by 0.8 per cent in real terms (2.5 per cent in cash terms).

- Capital funding, for example for new buildings and equipment, decreased from £524.5 million to £408 million. This was a decrease of 23.5 per cent in real terms (22.2 per cent in cash terms). This was mainly due to the new Dumfries and Galloway Royal Infirmary being completed and the near completion of NHS Lothian's new Royal Hospital for Sick Children and Department of Clinical Neurosciences.

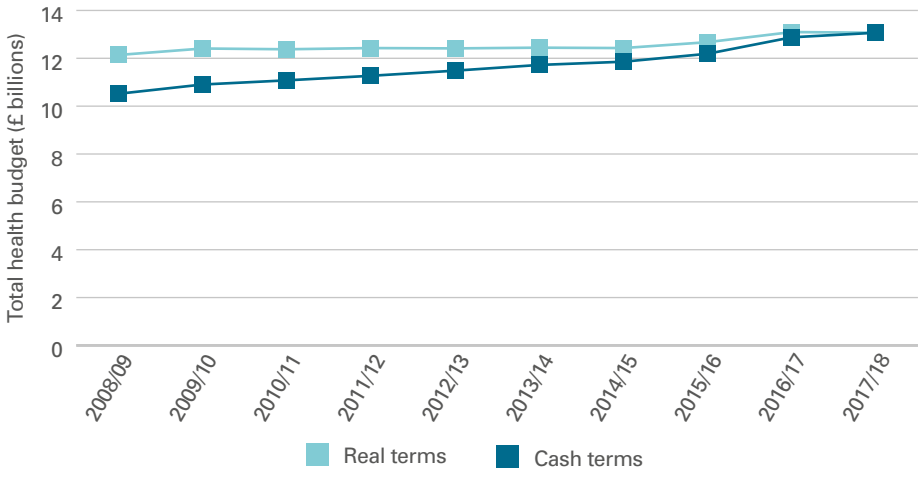
9. In 2017/18, NHS boards' budgets included £107 million ring-fenced funding for health and social care integration. NHS boards were required to pass this funding directly to integration authorities.

10. The overall health budget has increased by 7.7 per cent in real terms over the past decade (Exhibit 2). Revenue funding increased by 9.7 per cent between 2008/09 and 2017/18, while capital funding reduced by 32 per cent. This has mainly been driven by funding increases in the most recent four-year period, with the total budget increasing by five per cent since 2014/15.

Exhibit 2

Trends in the health budget in Scotland, 2008/09 to 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

11. Although health funding has increased over the past decade, funding per head of population has increased at a slower rate. In 2017/18, health funding in Scotland was £2,409 per person. This compares to £2,333 in 2008/09, a 3.3 per cent increase in real terms.[10]

The NHS met its overall financial targets in 2017/18, but boards are struggling to break even

12. NHS boards have been required by the Scottish Government to break even at the end of each financial year. This means that they must stay within the limits of their revenue and capital budgets. All NHS boards broke even in 2017/18, achieving an overall surplus of 0.07 per cent, £8.5 million.[11]

13. The majority of boards used short-term measures to break even. These included:

- Late allocations of funding from the Scottish Government. NHS Greater Glasgow and Clyde received a late allocation of £8 million for winter beds and acute strategy in February 2018 which allowed them to break even at year-end (31 March 2018).
- Reallocating capital funding to revenue funding to cover operating costs–for example, in NHS Borders, Forth Valley, Greater Glasgow and Clyde, and Tayside.
- Postponing new investments and using slippage on funding–for example, in NHS Borders, NHS Grampian and NHS National Services Scotland.
- One-off gains, including writing off accruals and lower than budgeted medical negligence payments. This was the case in NHS Greater Glasgow and Clyde and NHS Lanarkshire.

More boards are predicting year-end deficits

14. In 2015/16, all territorial NHS boards predicted at the start of the year that they would break even or record a surplus. In 2016/17, three boards predicted they would be in deficit at the end of the year. This increased to seven in 2017/18. In 2018/19, eight boards predicted at the start of the year that they would be in deficit at the end of the year.[12]

15. The size of the predicted deficits is also growing. In 2015/16, territorial boards predicted at the start of the year they would achieve an overall surplus of £0.5 million at year-end. In 2016/17, this moved to a predicted deficit of £34.1 million. A year later, this figure had almost tripled with boards predicting a deficit of £99.3 million by the end of financial year 2017/18.[13]

16. In the 2017/18 annual audit reports, auditors highlighted significant levels of risk around boards' ability to break even in 2018/19. At May 2018, NHS boards were predicting a deficit of £131.5 million in 2018/19.[14]

The amount of loans provided by the Scottish Government to enable boards to break even is increasing

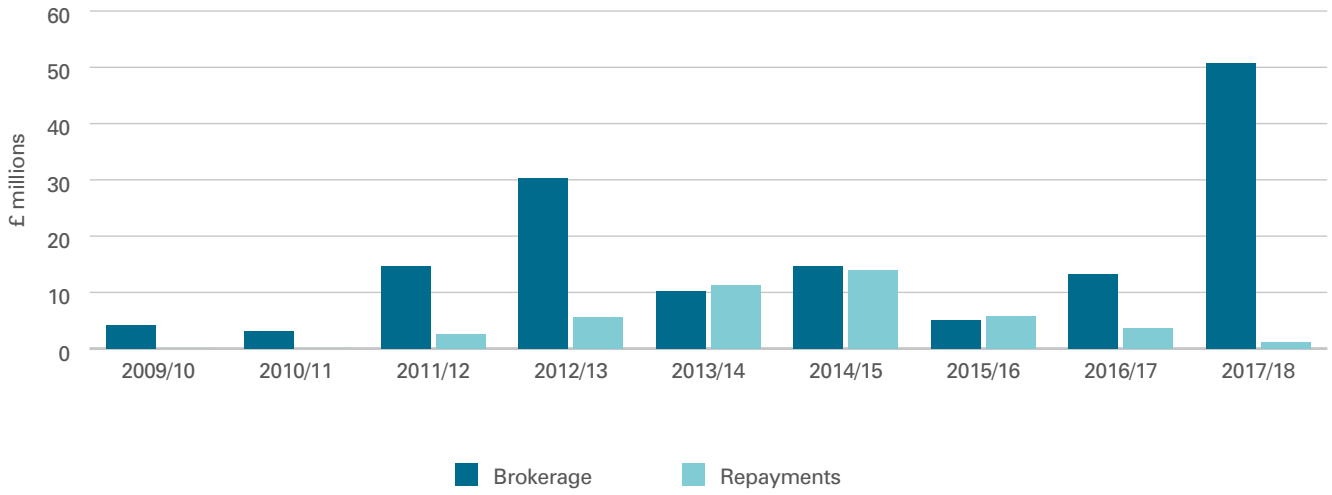
17. In 2017/18, the Scottish Government provided loans totalling £50.7 million to NHS Ayrshire and Arran, Highland, and Tayside. This allowed them to break even. This is significantly more than in 2016/17 and in previous years (Exhibit 3, page 12). The total amount of outstanding loans across all NHS boards at the end of 2017/18 was £102 million. Four boards (NHS Ayrshire and Arran, Borders, Highland and Tayside) have predicted they will need loans totalling £70.9 million in 2018/19. This has implications for other NHS boards since loans must be financed from the existing overall budget.

18. In October 2018, the Cabinet Secretary for Health and Sport announced that all territorial boards' outstanding loans will be written-off at the end of the 2018/19 financial year. We are carrying out further work to understand the implications of the recent announcement.

Exhibit 3

Scottish Government loans provided to NHS boards, 2009/10 to 2017/18 and repayments made by NHS boards

Loans paid out are greater than the amount repaid.



Note: In 2011/12, NHS Forth Valley received brokerage of £11 million, of which £1 million did not need to be repaid.

Source: Audit Scotland

NHS boards made unprecedented savings in 2017/18, but this was only achieved through one-off measures

19. NHS boards need to make savings to break even at the end of the financial year, to close the gap between the funding they receive and how much it costs to deliver services.

20. In 2016/17, NHS boards made overall savings of £387.4 million, which at the time was unprecedented. In 2017/18, the figure rose to £449.1 million. This represents 3.6 per cent of total revenue allocations to NHS boards. Despite this, the NHS did not meet its overall savings target of £480.8 million in 2017/18, falling short by seven per cent, £31.7 million.

Boards relied heavily on one-off savings in 2017/18

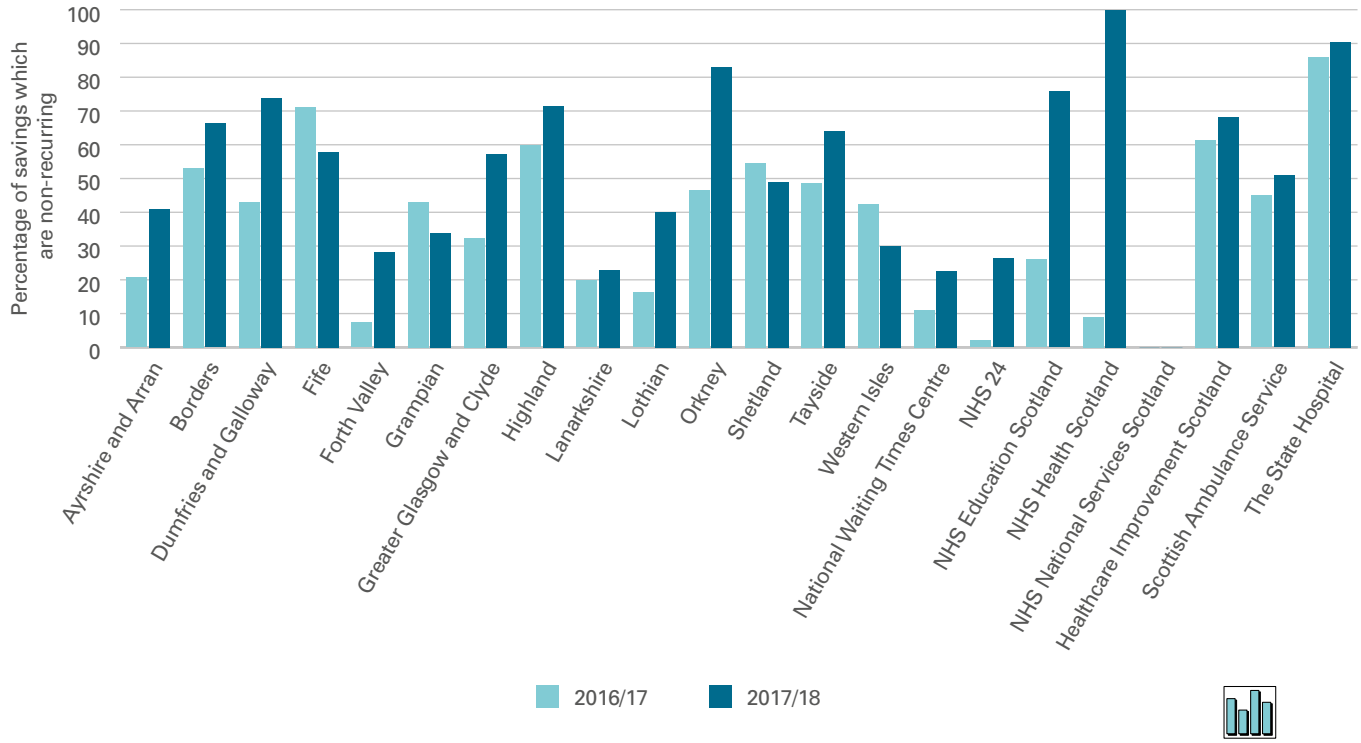
21. In 2017/18, 50 per cent of all savings were one-off (non-recurring), up from 35 per cent in 2016/17, and 20 per cent in 2013/14.[15] Savings reduce expenditure and contribute to achieving financial targets, but they do not necessarily mean increased efficiency or effectiveness.

22. Savings are classed as either recurring or non-recurring. The former recur in future years, for example as a result of providing services in a different way. Non-recurring savings do not result in ongoing savings, for example selling a building or delaying filling a vacant post. The reliance on one-off savings varied widely, from 23 per cent in NHS Lanarkshire to 83 per cent in NHS Orkney among the territorial boards. In the national boards, the range was from 0 per cent at NHS National Services Scotland to 100 per cent at NHS Health Scotland (Exhibit 4, page 13).

Exhibit 4

Percentage of total savings that were non-recurring by NHS board, 2016/17 to 2017/18

The use of non-recurring savings increased significantly in 2017/18.



Source: NHS board annual audit reports 2017 and 2018

23. Relying on one-off savings is not sustainable:

- It is becoming more and more difficult to identify areas in which NHS boards can make one-off savings.
- NHS boards that make high levels of one-off savings have to find more savings in future years.
- Non-recurring savings don't address the need to change the way NHS boards provide services.

Boards increasingly don't know where future savings will come from

24. At the start of the 2017/18 financial year, NHS boards were unable to identify where 28 per cent of all planned savings would come from, up from 17 per cent the previous year, and three per cent five years ago.[16]

Projected future health funding increases are unlikely to be enough to keep pace with rising costs

Cost pressures continue to intensify

25. NHS boards' costs are of two main types:

- Fixed–these are costs that boards have limited room to change in the short term. They make up significant parts of their budgets. The largest area is staff costs, which accounted for £6.6 billion (54 per cent) of total revenue spending in 2017/18. Other fixed costs include annual repayments on hospitals funded through private finance initiative (PFI) arrangements. These are fixed annual amounts which boards have to manage as part of their overall budget.

- Discretionary–these are costs that boards can influence to differing extents. Examples include:
  - prescribing or temporary staffing. For example, boards can reduce the volume of drugs dispensed, prescribe cheaper alternatives, or use less temporary staff from agencies to reduce costs
  - areas where boards can influence their costs by deciding, for example, how they provide services in their area.

26. In 2017/18, costs continued to increase in several key areas (Exhibit 5, page 15).

Health is projected to remain the single largest area of Scottish Government expenditure in future years

27. Health is one of the Scottish Government's six key policy priorities, alongside social security, police, early learning and childcare, higher education, and pupil attainment.[17] The share of the overall Scottish Government resource budget taken up by these six priorities is projected to increase from 56 per cent in 2019/20 to 64 per cent in 2022/23, with overall health spending accounting for the majority of this.[18] The Scottish Government's five-year financial strategy states that all other funding commitments will need to be met from the remainder of the budget.

Increases in health costs are likely to outstrip funding increases

28. Between 2008/09 and 2017/18, increases in health funding have averaged 0.8 per cent per year in real terms. The Scottish Government's five-year financial strategy, published in May 2018, sets out a potential annual real terms health funding increase of 1.1 per cent between 2018/19 and 2022/23.[19]

29. At the same time, health costs are projected to increase more quickly. Scotland's ageing population means that more people will be living longer with multiple long-term conditions, leading to greater costs for the NHS. Other cost pressures, such as increases in drug spending, are also projected to intensify. The Fraser of Allander Institute has predicted that the health resource budget is likely to have to increase by around two per cent per year in real terms to 2030 just to stand still.[20]

30. In October 2018, the Scottish Government published its *Medium Term Health and Social Care Financial Framework*.[21] We discuss the framework in more detail in Part 2. The framework sets out a total projected funding increase to 2023/24 although it is not yet clear how the figures relate to those set out in the Scottish Government's overall five-year financial strategy in May 2018.

Exhibit 5
Cost pressures in 2017/18

Most NHS boards overspent on their pay budget and agency costs remain high

£6.6 billion was spent by NHS boards on staff in 2017/18 (54 per cent of revenue expenditure) and the majority of NHS boards overspent on their pay budget.[1]

£165.9m
Amount spent on agency staff in 2017/18.

5% decrease in real terms on the previous year.

38% increase over the past five years.[2]

£100m
Amount spent on agency medical locums in 2017/18.

10% decrease in real terms on the previous year.

40% increase over the past five years.[3]

£152m
Amount spent on bank nurses in 2017/18.

5% increase in real terms on the previous year.

21% increase over the past five years.[4]

Backlog maintenance has increased

£448.9m
Amount NHS boards spent on capital projects in 2017/18.

£417.2m
The amount funded by the Scottish Government. The rest was funded by selling assets such as land and buildings, and donations.

72%
NHS estate rated in good physical condition in 2017/18.

increase from **70%** in 2016/17.
The figures vary widely across territorial boards, from **25%** of the estate rated good in NHS Orkney to **98%** in NHS Borders.

£899m
Total maintenance backlog in 2017/18.

increase from **£887m** in 2016/17.
45% of all backlog maintenance is classed as significant or high risk, a **2%** reduction since 2016/17. The figures vary widely across territorial boards, from **12%** of all backlog maintenance rated significant or high risk in NHS Western Isles, to **74%** in NHS Tayside. Over half, **56%**, of all backlog maintenance was accounted for by three boards, NHS Greater Glasgow and Clyde, Grampian, and Tayside.

Spending on drugs continues to rise

£1.7bn
Amount spent on drugs in 2016/17.

1.5% increase in real terms from 2015/16.

19.4% increase over the past five years.

£1.3bn
spend in community.

£0.4bn
spend in hospitals.

2.2% increase in real terms spending on drugs in the community between 2015/16 and 2016/17.

0.7% decrease in real terms spending on drugs in hospitals.[5]

Cont.

Exhibit 5 (continued)

Spending on drugs continues to rise (continued)

103 million items. Number of items dispensed in the community.

0.1% decrease
Volume of drugs dispensed in the community between 2016/17 and 2017/18.[6]

Clinical negligence costs continued to increase

£643m
Amount set aside to manage potential future clinical negligence payments in 2017/18.

9% increase
in real terms since 2016/17.[7]

Notes:
1. *Financial Performance Returns,* Scottish Government. *NHS Consolidated Accounts*, Scottish Government, July 2018.
2. *NHS Consolidated Accounts*, Scottish Government, July 2018.
3. *NHS Scotland Workforce*, ISD Scotland, June 2018.
4. Bank and agency nursing and midwifery comparison (capacity), ISD Scotland, June 2018.
5. R600 pharmacy drugs expenditure, ISD Scotland cost book data, November 2017. 2016/17 is the latest cost book data available.
6. *Volume and Cost (NHS Scotland)*, ISD Scotland, July 2018. This only includes items dispensed in the community.
7. *NHS Consolidated Accounts,* Scottish Government, July 2018.

Source: Audit Scotland

The NHS estate will need more investment than is likely to be available in future years

31. The NHS capital budget fluctuates over time. In recent years, new hospitals have been built in Dumfries, Edinburgh, and Glasgow. In general, however, the budget has been declining over the past ten years. Backlog maintenance remains significant across the whole estate at £899 million in 2017/18 and a number of hospitals and other health facilities will require significant investment to ensure they remain fit for purpose. Capital funding will also be required for other purposes, such as replacing significant amounts of medical equipment in the short to medium term.

32. The Scottish Government's five-year financial strategy projects the overall capital budget to remain relatively static between 2018/19 and 2022/23.[22] There is no breakdown by policy area but health will be competing with other policy areas for capital funding.

33. As the way healthcare is delivered changes, the existing NHS estate will need to adapt to reflect this. The Scottish Government has not planned what investment will be needed.

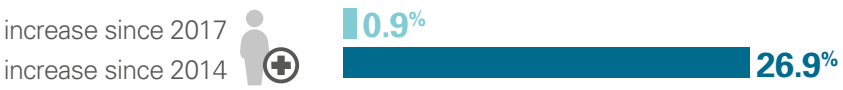
The number of patients on waiting lists continues to rise and performance against targets is declining

34. The number of people waiting for first outpatient and inpatient appointments continued to increase in the past year while elective and emergency admissions declined. Exhibit 6 (page 17) shows trends across indicators of demand and activity for acute services.

Exhibit 6
Indicators of demand and activity for acute services in 2017/18

Demand for secondary care services

305,754 patients waiting for first **outpatient** appointment in March 2018

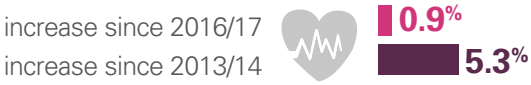


72,837 patients waiting for first **inpatient** appointment in March 2018

Activity

149,424 elective admissions in 2017/18

593,531 emergency admissions in 2017/18



1,418,667 new outpatient apppointments in 2017/18

2,814,883 return outpatient apppointments in 2017/18

1,434,118 procedures in 2017/18

453,731 daycase patients in 2017/18

6.2 days average length of hospital stay in 2017/18

Source: Annual Acute Hospital Activity and Hospital Beds - Year ending March 2018, ISD Scotland, 25 September 2018; New Outpatient Appointment: Waiting Times for Patients waiting at Month end, Census date at 31 March 2018, August 2018; Inpatient or day case admission: waiting times for patients seen, Quarter ending March 2018; ISD Scotland, September 2018.

Trends in demand and activity need to be better understood

35. The Scottish Government and NHS need to better understand these patterns of demand and activity. For example, the overall number of people waiting for their first outpatient appointment continued to increase in 2017/18, but the number of new and return outpatient appointments NHS boards carried out declined over the same period.[23,24] It is not possible from national published data to tell whether the increase in the number of people waiting is:

- an actual rise in demand
- being caused by reductions in capacity, with boards seeing fewer patients than previously
- a combination of both these factors.

Similarly, the number of elective admissions declined by 9.7 per cent between 2016/17 and 2017/18.[25] It is difficult to tell if this is due to reduced demand or because NHS boards lack the capacity to undertake as many procedures. There is also wide variation across NHS boards.

36. Changes in demand and activity can be caused by a variety of factors. These include public expectations, levels of referrals from GPs and other healthcare professionals, availability of staffing, and winter pressures such as flu and adverse weather. It is important that NHS boards and integration authorities fully understand the reasons behind changes in demand and activity to plan services effectively both in the short term and in the longer term.

37. There continues to be a lack of public data on important areas of the healthcare system. The focus remains on acute hospitals and there is limited public data on primary care, for example the number of people seeking GP consultations, and the reasons for referrals on to secondary care. This makes it difficult to assess overall demand or better understand changes in demand and plan how to meet it.

Declining performance against national standards indicates the stress NHS boards are under

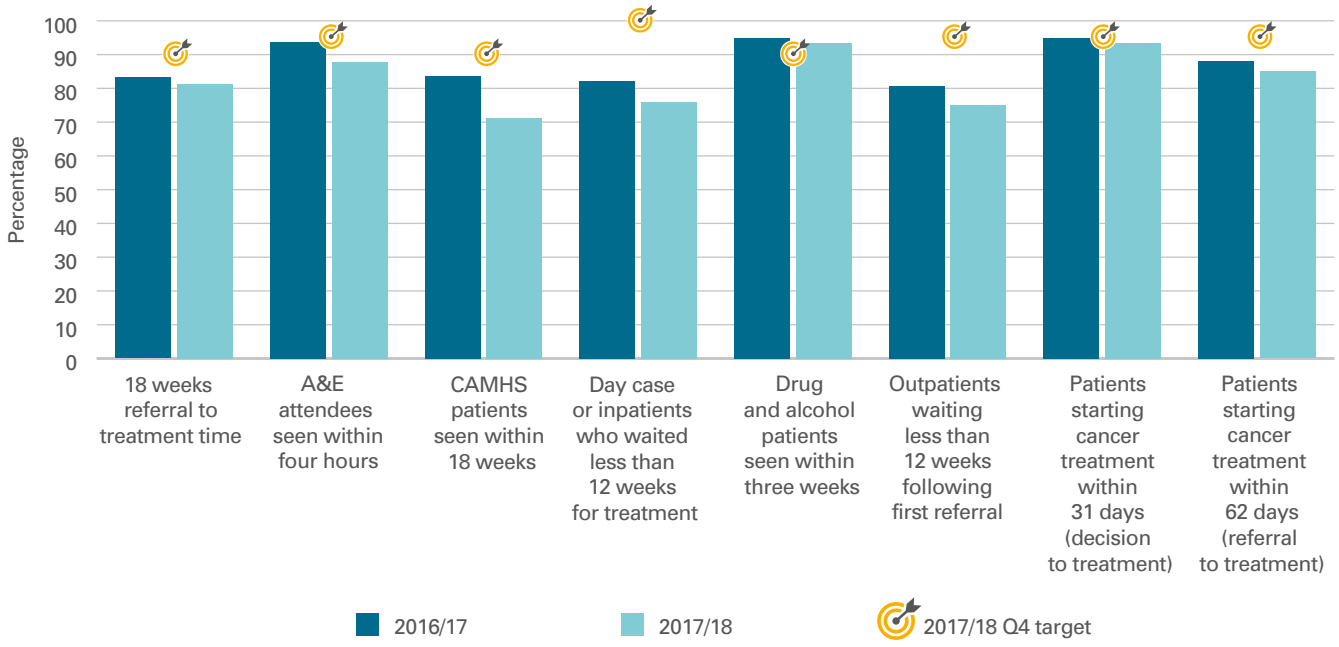
38. The NHS met only one of eight key national performance targets in 2017/18, for 90 per cent of patients referred for drug and alcohol treatment to receive treatment within 21 days (Exhibit 7, page 19). Nationally, the target of 95 per cent of patients starting cancer treatment within 31 days was missed by one and a half percentage points. No boards met all eight targets. NHS Western Isles met six indicators, while NHS Lothian did not meet any targets. NHS Grampian, Greater Glasgow and Clyde, Highland, and Tayside each met one target. Appendix 3 shows performance against the national standards by NHS board.

39. Performance declined against all eight key national targets between 2016/17 and 2017/18. The greatest reduction was in performance against Children and Adolescent Mental Health Services' (CAMHS) patients seen within 18 weeks, where performance dropped by 12.4 percentage points, from 83.6 per cent in 2016/17 to 71.2 per cent in 2017/18. We published our report examining CAMHS in Scotland in September 2018.

Exhibit 7

NHS Scotland performance against key national performance standards 2016/17 to 2017/18

NHS Scotland met one key performance standard in 2017/18.



Notes:
1. CAMHS is Children and Adolescent Mental Health Services.
2. Figures are for month/quarter/census point ended March 2018 (Appendix 3).

Source: See Appendix 3 for sources

40. The number of people waiting over 12 weeks for their first outpatient appointment or planned inpatient procedure continued to increase in 2017/18:

- In the final quarter of 2017/18, 93,107 people waited more than 12 weeks for their first outpatient appointment, an increase of six per cent on the previous year. The number of people who waited more than 12 weeks has increased by 215 per cent in the last five years. People waiting more than 16 weeks increased by 13 per cent between 2016/17 and 2017/18, and by 558 per cent over the last five years.

- People waiting more than 12 weeks for an inpatient or day case procedure increased by 26 per cent between 2016/17 and 2017/18 to 16,772 people, and by 544 per cent over the last five years.[26]

41. NHS boards are working with the Scottish Government to implement a range of initiatives aimed at improving access and waiting times, such as the Scottish Access Collaborative. This was set up by the Scottish Government in October 2017 to improve waiting times for patients waiting for non-emergency procedures. However, 2017/18 annual audit reports of NHS boards indicated that financial pressures will continue to have a detrimental impact on performance. NHS boards need to balance quality of care, performance targets, and financial targets. A continuing focus on meeting targets in the acute sector makes it harder to achieve the longer-term aim of moving more funding and services into the community.

The NHS is managing to maintain the overall quality of care, but it is coming under increasing pressure

42. The Scottish Government has three Quality Ambitions for the NHS in Scotland–that the NHS is safe, person-centred, and effective. It does not comprehensively assess and report on these ambitions. Healthcare Improvement Scotland (HIS) is currently rolling out a new Quality of Care approach which involves a more comprehensive assessment of quality.[27]

43. Analysis of a range of measures indicates there are positive examples, including:

- Ninety per cent of patients responding to the 2018 inpatient survey rated their care and treatment as good or excellent, similar to the 2016 survey. Ninety-one per cent of people were positive about their experience of hospital staff, a slight increase since 2016.[28]

- some patient safety indicators improved: the hospital standardised mortality rate decreased by 9.2 per cent between 2013/14 and 2017/18, and C-Diff Infection rate decreased by 0.1 to 0.27 infections per 1,000 occupied bed days between 2016/17 and 2017/18.[29,30]

44. We reported last year that the wide range of pressures facing the NHS may be beginning to affect the quality of care staff are able to provide. This concern remains in 2017/18. For example:

- the percentage of patients rating the quality of care provided by their GP practice as positive has declined from 90 per cent in 2009/10 to 83 per cent in 2017/18. Only 58 per cent of respondents who received treatment in the last 12 months felt they were given the opportunity to involve the people that mattered to them.[31]

- SAB infections, including MRSA, remained relatively static between 2017 and 2018 but remain above the national standard.[32]

- there have been specific concerns about some services. For example, a 2017 HIS inspection of adult health and social care services in Edinburgh rated a majority of quality indicators as weak or unsatisfactory; and an independent inquiry into mental health services in NHS Tayside is under way.[33,34]

45. A key indicator of the quality of care is the extent of serious adverse events happening in hospitals and other healthcare settings. As part of its review of NHS governance in 2017/18, the Scottish Parliament's Health and Sport Committee identified that there was no common definition of a serious adverse event and that there is no national reporting of the frequency of, and learning from, these events. The Committee recommended that a standard definition and national reporting be developed.[35] HIS published a revised national framework in July 2018 to improve consistency in this area.[36]

The NHS workforce is crucial to the future of the NHS but faces significant challenges

46. The NHS depends on having the appropriate number of staff, in the right place, with the appropriate skills. Overall staff levels in the NHS in Scotland are at their highest level ever, with 139,918 whole-time equivalent (WTE) staff employed as at March 2018. This is a 0.3 per cent increase on the previous year. But NHS boards continue to face major workforce challenges (Exhibit 8, page 22).

Withdrawing from the European Union will create additional challenges

47. EU withdrawal has the potential to significantly affect the NHS. It has been difficult to assess the scale of the risk, particularly in terms of workforce as data on the nationality of employees is not routinely collected, and there is still significant uncertainty about what form EU withdrawal will take. Some figures are available:

- General Medical Council data shows that 5.9 per cent (1,177 people) of doctors working in Scotland obtained their primary medical qualification in a non-UK European Economic Area (EEA) country.[37]

- The Scottish Government has estimated that there are 17,000 non-UK EU nationals working in health and social care in Scotland (4.4 per cent of the total health and social care workforce).[38]

NHS boards are working with the Scottish Government to identify how many of their current workforce are non-UK EU citizens.

48. The NHS is already experiencing an impact on recruitment:

- A 2018 British Medical Association (BMA) survey of members across the UK found that 57 per cent of respondents reported a decline in applications for positions in their departments from non-UK nationals since the 2016 vote to leave the European Union.[39]

- The Nursing and Midwifery Council reported that during 2017/18, there was an 87 per cent decrease in the number of nurses and midwives from non-UK EEA registering to work in the UK compared to the previous year.[40]

- In addition, if there is a loss of mutual recognition of professional qualifications between the EU and the UK, it will be more difficult for qualified staff from the EU to work in Scotland.

49. Changes to rules and regulations may also have a significant effect on the NHS. For example, medicine and medical equipment may be more expensive and it may take longer to access essential medical supplies. This includes imported products with limited lifespans, such as radioisotopes that are used to treat cancer. Increases in the price of food due to trade tariffs or additional custom checks will also have an impact on the NHS. Our briefing *Withdrawal from the European Union: Key audit issues for the Scottish public sector* sets out key questions that all public bodies should be asking themselves in the five months to EU withdrawal.

Exhibit 8
Workforce pressures in the NHS

Vacancy rates

Consultants
2013/14 6.5% → 2017/18 7.5%

Allied health professionals
2013/14 3.9% → 2017/18 4.4%

Nursing and midwifery
2013/14 2.7% → 2017/18 4.5%

GPs
2015 22% → 2017 24% (number of practices reporting a vacancy)

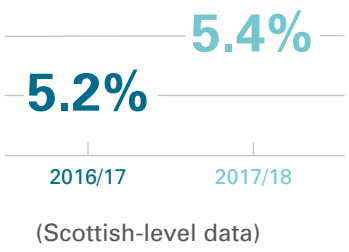
Percentage of vacancies open long term

60% of consultant vacancies open at least six months

30% of nursing and midwifery and AHP vacancies open three months or more

27% of filled GP vacancies took more than six months to fill

Sickness absence

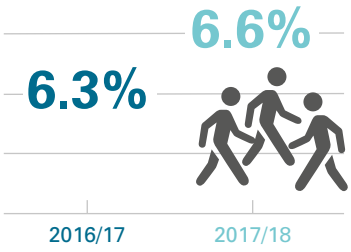


(Scottish-level data)

4% NHS Shetland was the only territorial board to meet the national target

5.8% NHS Fife had the highest sickness absence rate among the territorial boards

Staff turnover



2017 staff survey

46% responded that they could meet all conflicting demands on their time at work

34% responded that there are enough staff to do their job properly

65% believed it is safe to speak up and challenge the way things are done if they have concerns about the quality, negligence or wrongdoing by staff

29% have experienced emotional or verbal abuse from a patient or the public

Note: The 2017 staff survey included some social care staff, who made up a small proportion of the overall total.

Sources: Audit Scotland using ISD Scotland workforce data, June 2018 and *Health and social care staff report 2017*, Scottish Government, March 2018. *Primary Care Workforce Survey Scotland 2017*, Scottish Government, March 2018

Part 2

What needs to change?

Key messages

1. Changing how healthcare services are accessed and delivered is a long-term, complex undertaking. Successfully achieving it will bring real benefits to patients, NHS staff, and the wider public. A number of key elements are critical to success, including clarity about the scale of the challenge, effective leadership, involving stakeholders in planning and decisions, and clear governance.

2. Leaders play a crucial role in developing and delivering change. There is evidence that the NHS is struggling to recruit and retain the right people, and ensure they have the time and support they need.

3. The healthcare system needs to become more open. People need to be able to take part in an honest debate about the future of the NHS. There is a lack of information on:

    - how the NHS is performing and the difference it is making to people's lives
    - how health funding is used and the impact it has on people
    - how much health funding is likely to be required, and available, over the medium to longer term
    - the progress being made towards achieving the Scottish Government's 2020 Vision.

4. The overall governance of the NHS needs to be clarified for NHS staff as well as the public. Roles and responsibilities for each planning level need to be explicit and lines of accountability well defined. NHS boards need better support to govern and challenge effectively.

an urgent focus on the elements critical to success is needed

50. There are many reasons why the way in which health services are accessed and delivered in Scotland needs to change. The significant financial, workforce, and demographic pressures facing the NHS, as set out in Part 1, are undoubtedly key drivers, but there are also many positive reasons for change. The Scottish Government's vision for healthcare sets out multiple benefits:

- the Scottish public will benefit from services that are more joined up, tailored, and delivered closer to home. For more complex care needed at hospitals, there will be quicker access and shorter stays

- healthcare staff will have more time to provide high-quality, personalised care
- the wider public sector will benefit from a population that is healthier and takes more responsibility for their own health
- as a result of all of the above, the healthcare system should also become more efficient by reducing the costs of delivering services and improving processes.

51. Achieving these benefits, however, is incredibly challenging. These changes need to happen at the same time, while also continuing to deliver high-quality services on a day-to-day basis. It involves:

- significant organisational and cultural change
- developing and then introducing new ways of working
- designing, delivering, and using new digital technology.

52. It is therefore essential that all the elements needed for successful change are in place. This chapter focuses on the key elements that need addressed if the Scottish Government is to achieve its 2020 Vision.

A clear understanding is needed of the scale of the challenges facing the NHS and the options for addressing them

53. Transforming how health services are delivered and achieving the Scottish Government's vision of delivering more care in the community are long-term projects. They require planning over the short, medium and longer term. An essential part of this is to understand:

- how much funding is likely to be required in the medium to long term
- what funding is likely to be available over the same period.

Where there is a mismatch between what is available and what is required, then options can be developed involving NHS staff, the public and politicians.

54. In October 2018, the Scottish Government published its *Medium Term Health and Social Care Financial Framework* ('the framework'). This is an important step in enabling an open debate about the scale of the financial challenges ahead and the potential options for dealing with the impact this will have on delivering services.

55. The framework covers the period 2016/17 to 2023/24 and has four main sections:

- health and social care expenditure–setting out current expenditure and historical expenditure trends in health and social care, and historical activity growth and trends in productivity
- future demand for health and social care–including drivers of demand growth and an estimate of the future increases in health spending required
- future shape of health and social care expenditure–setting out how shares of health funding will be re-distributed across different parts of the system in future years

- reforming health and social care–identifies five specific areas of activity (shifting the balance of care, regional working, public health and prevention, Once for Scotland, and annual savings plans) that will contribute to the reform of health and social care delivery.

56. The financial framework focuses on 'frontline' NHS board expenditure, comprising the 14 territorial NHS boards and four of the national boards (NHS 24, Golden Jubilee Hospital, State Hospital and the Scottish Ambulance Service), and local government net expenditure on social care. The framework sets out a 'do nothing' position. This takes into account estimated expenditure growth caused by factors such as demand and pay and prices and sets out that health and social care resource expenditure in 2023/24 would need to be £20.6 billion. This is more than the projected resource funding availability of £18.8 billion over the same time period. The framework sets out the three main ways in which the Scottish Government plans to bridge the gap:

- efficiency savings–a one per cent efficiency requirement across health and social care
- savings arising from shifting the balance of care–this includes A&E, inpatients and outpatients
- additional savings–from regional working, public health prevention, and back office efficiencies.

A remaining gap of £159 million is identified which is expected to be addressed over the period to 2023/24.

57. The projected funding figures set out in the framework are based on the Scottish Government receiving additional funding from the UK Government of £3.3 billion due to increased funding for the NHS in England (known as Barnett resource consequentials). It is not yet known how the UK Government plans to fund increases in English health expenditure and the options chosen may affect the amount available to the Scottish Government.

58. Alongside the publication of the health and social care financial framework, the Cabinet Secretary announced recently that NHS territorial boards will no longer be required to break even at the end of each financial year. Instead, they will be required to break even every three years. This should provide NHS boards and integration authorities with greater flexibility in planning and investing over the medium to longer term to achieve the aim of delivering more community-based care. It also makes it even more important that NHS boards plan their finances over a medium to longer-term period. Traditionally, NHS boards have taken a short-term approach to financial planning with most of their financial plans covering three years or less. This continued to be the case in 2017/18. The main reasons given by NHS boards for this are the current uncertainties around the implications of regional planning and the national health financial framework. The Scottish Parliament's Health and Sport Committee reported in 2018 that it 'did not accept an inability to undertake longer-term financial planning exists'.[41]

59. As we showed in Part 1, the NHS estate is likely to require more investment than is likely to be available. This makes it more urgent to identify how the type, location, and size of healthcare facilities need to change as more services are delivered in the community. We recommended in our *NHS in Scotland 2017*

report that the Scottish Government, in partnership with NHS boards and integration authorities, should develop a capital investment strategy to ensure the NHS Scotland estate is appropriate for delivering more regional and community-based services.[42] This will help the Scottish Government and NHS boards engage and involve the public in agreeing how the NHS estate will develop. The Scottish Government is developing a national health capital investment plan, scheduled for completion by the end of the financial year 2018/19.

There is a need to ensure effective leadership is in place with the time and support to deliver change

60. Effective leadership is critical to achieving successful change. Leaders need to drive change and improvement, involve staff and the public in developing a common vision and work with partners to deliver it. But they also require a skilled and cohesive team to support them and strong sponsorship from the top. Health and social care integration has changed the context in which NHS boards operate and has also increased the number of effective leaders required across Scotland.

61. The Scottish Government has recently developed a new approach to leadership and succession planning. This includes developing a talent management scheme to identify future leaders and introducing values-based recruitment to ensure new appointments share the values of the organisation, in addition to skills and experience.

62. There are indications that finding effective leaders and support teams is becoming more difficult:

- The NHS Greater Glasgow and Clyde chief executive position required two recruitment rounds to fill.
- The Scottish Borders Integration Joint Board chief finance officer role was vacant from October 2017 until recently. This has now been filled through a one-year secondment from NHS Lothian.
- The chief executive position in NHS Orkney has been an interim appointment since January 2018 and a recruitment exercise has only recently taken place.
- NHS Highland has experienced significant turnover in non-executive members, with six new members in 2017/18. This has led to challenges in ensuring members have the skills, experience and training required to fulfil their role.
- There is an increasing number of joint posts across NHS boards. For example:
  - The chief executive and director of finance in NHS Grampian are now also the chief executive and director of finance in NHS Tayside
  - The director of finance for the Golden Jubilee National Hospital is also the interim director of finance for the Scottish Ambulance Service.
- Increasing regional planning has created additional responsibilities for senior leadership teams.
- Key support functions such as finance and human resources are also experiencing vacancies in many boards. Twelve boards reported vacancies in their finance team and 11 boards reported vacancies in their HR team.

- The NHS workforce is ageing, and chief executive positions at NHS Grampian, Highland, and Tayside will become vacant due to retirement. The chief executive at NHS Borders is also due to retire at the end of April 2019.

- Only 62 per cent of respondents to the 2017 national health and social care staff survey felt that the senior managers responsible for the wider organisation were sufficiently visible. 64 per cent of respondents had confidence and trust in the senior managers responsible for their wider organisation.[43]

63. NHS board chief executives and senior teams are responsible for the delivery of critical day-to-day services as well as leading the changes to how services are accessed and delivered in their boards. This places significant demands on senior leadership teams. To successfully plan and deliver the whole-scale changes that are required takes time and capacity.

NHS governance arrangements are confusing and non-executive directors need more support

The overall governance of the NHS needs to be clarified

64. The arrangements for NHS planning are complex. There are now multiple planning levels from small localities through to national planning (Exhibit 2 in our report *NHS in Scotland 2017* describes these). Last year we said that it was not yet clear how planning at each of the different levels would work together in practice. This remains the case:

- Lines of accountability for health and social care integration are still not universally clear. Auditors highlighted issues in some areas in 2017/18 relating to the need for greater clarity to avoid duplicating governance arrangements, managing overspends in integration authorities, and ownership of performance management.

- Regional plans have not yet been published so it is not clear how roles and responsibilities between NHS boards will work within the regions or where accountability and decision making will lie for service planning, delivery, and performance.

- There is no public information on the progress of national planning initiatives, such as Once for Scotland (delivering services and functions more efficiently at a national level).

- It is not clear to what extent the public, staff, and NHS boards have been involved in some decisions to change how services are accessed and delivered. For example, the Scottish Government has decided to develop regional elective centres across Scotland to carry out procedures such as knee and hip replacements. This will change how people access services, but the decision was taken before regional plans were developed.

65. As new planning layers have been created, none have been removed. This multiplicity of levels and lack of clarity over their roles means NHS governance is confusing. If the different planning levels are to work together effectively and the public is to easily understand what each part of the system is intended to do, governance arrangements must be clear and robust. This means that roles and responsibilities are explicit, and lines of accountability are well defined. For example, the roles and responsibilities of NHS boards have changed with the

introduction of Integration Authorities and will continue to change as regional and national planning develops further. It is important to ensure that the roles and responsibilities of NHS boards in this new context are clear.

66. The Scottish Government, working with NHS boards and integration authorities, should clearly set out the key decisions that need to be made in planning how to deliver services and why. This would help ensure:

- decisions are made at the right level, are coherent and fit with existing policies and plans
- there is clear accountability for delivering outcomes
- NHS staff and the public have the opportunity to make their voice heard.

67. To ensure the multiple planning levels can operate effectively, it is also essential that lines of accountability and levels of scrutiny within the Scottish Government's Health and Social Care Directorate are clear and robust. There is scope to improve these. The directorate is led by the Director General of Health and Social Care, who is also the Chief Executive of NHS Scotland. The Chief Executive is responsible for the day-to-day performance of the NHS and for implementing Scottish Government health policies. The Director General is responsible for holding the NHS to account for its performance and how well it has implemented Scottish Government policies. The Director General is also the chair of the directorate's Assurance Board which holds the directorate to account for its performance. The challenges facing the health and care system make this dual role ever harder.

68. There is also scope to increase independent scrutiny of the directorate. In the Auditor General for Scotland's report *The 2017/18 audit of the Scottish Government Consolidated Accounts*, the Auditor General highlighted the important role of non-executive directors in ensuring effective scrutiny and challenge within the Scottish Government.[44] The report found that, across the Scottish Government, scrutiny and challenge was not as effective as it needed to be. Within the Health and Social Care Directorate, only one non-executive director provided independent challenge in 2017/18 as a member of the directorate's Assurance Board.

Boards need better support to challenge and govern effectively

69. Each NHS board is responsible for ensuring that health services are delivered safely, efficiently and effectively, and to give the public confidence in the NHS. There is evidence that not all boards are operating effectively. Our forthcoming report, *Health and Social Care Integration: Update on progress,* will examine the effectiveness of governance arrangements in integration authorities.

70. Boards are made up of executive members, including the chief executive and other senior managers, and non-executive members. These include staff representatives and members of the public appointed through a competitive recruitment process. The board is responsible for:

- ensuring the organisation delivers its functions in accordance with the Scottish ministers' policies
- the strategic and financial leadership of the organisation

- holding the chief executive and senior management to account.

71. Board members need to have an appropriate level of knowledge, skills, and expertise to do their role effectively. But there is no consistent approach across the NHS to ensuring this. For example:

- Skills gap analysis–not all NHS boards have identified the range of skills and expertise among board members and areas where training or additional expertise may be needed.

- New member induction–in a 2018 survey of board members by the Scottish Parliament's Health and Sport Committee, only 61 per cent of respondents agreed there is adequate induction for board members.[45]

- Training and development–most NHS boards have training and development programmes for board members, but these are often ad-hoc. Less than half (48 per cent) of board members surveyed by the Scottish Parliament's Health and Sport Committee agreed there was adequate training.[46]

- Performance assessment–not all NHS boards do one-to-one annual appraisals. If these do take place, it is not always clear how formal these are, for example, if it is an informal discussion or a structured appraisal. There is no standard approach across the NHS to assessing the performance of board members.

72. The majority (63 per cent) of board members surveyed by the Scottish Parliament's Health and Sport Committee in 2018 thought their board had the right skills, knowledge and expertise. However, a third thought their board only partly had the right skills, knowledge and expertise.[47] NHS boards are complex organisations in a continually changing environment and without appropriate support, boards cannot fulfil their role effectively.

Scrutiny arrangements need to be improved across the NHS

73. Through our audit work we have identified areas for improvement:

- Financial and performance reporting–there are examples of financial reporting to boards that was too lengthy or not easily understandable, or too high-level and did not provide enough information for board members to be able to scrutinise. Performance reporting did not always provide appropriate detail on the reasons for performance or planned actions to improve targets.

- Accessibility and transparency–the language used in reports can often contain acronyms and technical information that is not explained and can be difficult for lay people to fully understand. Agenda items are often for noting with no discussion required and board minutes do not always provide a clear picture of the level of scrutiny that took place in meetings. Board papers are not always easy to find on board websites.

74. The majority of board members who responded to the 2018 survey (87 per cent), felt that members of their board always or mostly challenged advice, opinions and information presented. However, 13 per cent disagreed. Almost one in five (17 per cent), reported that their board only sometimes or hardly ever sufficiently holds the chief executive and senior management team to account for the operational management of the organisation and the delivery of agreed plans to time and budget.[48]

75. The Scottish Government is carrying out a range of work aimed at strengthening governance arrangements in NHS boards. This includes piloting a standardised review of corporate governance. Case study 1 sets out the scope and key findings from the pilot in NHS Highland.

Case study 1

Scottish Government corporate governance review of NHS Highland

A review team was set up which included the chair of NHS Greater Glasgow and Clyde and a non-executive director from Healthcare Improvement Scotland. The team developed a framework for assessing governance based on sources of evidence that included codes of conduct from other bodies, academic literature, and lessons learned from successes and failures from across the UK public sector. The review included desk research, face to face interviews with current and previous, board members and other stakeholders, and observation of board meetings.

The review made a number of recommendations to the board, including the need to:

- develop a clear strategic plan for the board, and a planning cycle
- make sure appropriate reporting methods are in place
- agree shared expectations of the roles and responsibilities of board members and clarify the relationship between the board and the Executive Team. Develop an induction programme and map existing board member skills against the future requirements
- develop a governance map, setting out remits of committees and how they relate to one another. Develop guidance on writing board papers, including protocol for ensuring confidentiality and making sure papers are circulated five days ahead of meetings. Minutes should include an action plan
- make sure there is a shared understanding of best practice in assessing and managing risk, and the operation of the finance and audit committees. The chair and chief executive should attend the Audit Committee and there should be an external review of the existing internal audit services
- develop an engagement strategy, including clearly defining the roles and responsibilities of board members in supporting this
- consider external support to help resolve recent issues. Develop protocols for board members to raise concerns. Reconsider having board members sitting on operational groups.

Source: Audit Scotland using Corporate Governance in NHS Highland report, Scottish Government, May 2018

The Scottish Government and the NHS need to become more open

76. If efforts to transform the NHS are to be successful there must be a shared understanding of why change is needed. There must also be broad agreement between the public, politicians, NHS staff, NHS boards, integration authorities, and the Scottish Government about:

- the scale of the challenge
- the options for what needs to happen
- how changes will be implemented.

There is currently no common agreement on these areas. If health and care services are to change to meet the needs of Scotland's people, then the NHS and the Scottish Government must become more open. People need access to information if they are to have an honest debate about the future of the NHS and get involved in designing services to meet their needs.

77. In our report, *NHS in Scotland 2017*, we stated that 'open and regular involvement with local communities about the NHS is needed to develop options for delivering services differently.'[49] People are closely invested in their local health services, and there continue to be many examples of public and political opposition to attempts by NHS boards to change how services are delivered. This suggests that local communities are still not being involved appropriately in planning changes to services.

There is still no overall picture of how the NHS is performing and the difference the NHS is making to people's lives

78. In previous years we have commented that existing national NHS performance measures do not measure the quality of care across the whole healthcare system, focusing mainly on access to the acute sector. It is important that wider performance measures are developed to provide a clear picture of how the system as a whole is working.

79. The Scottish Government commissioned an independent review of targets and indicators in health and social care in Scotland. This reported in November 2017 and recommended that the Scottish Government move to a system of indicators and targets which allow improvements across a whole system of care to be tracked.[50] The Scottish Government has not yet made progress on the recommendations.

80. The availability of public information on performance has improved with the introduction of the NHS Performs website, which shows information on indicators such as A&E performance and hospital deaths, at hospital, NHS board, and national-level.[51] However, the range of data is limited and focuses on the acute sector. Another positive development is the uptake in the use of Care Opinion, an independent website which allows patients and the public to publicly share their stories and experiences of health services across Scotland. All NHS boards in Scotland are now using Care Opinion and NHS staff are able to view stories and respond.

Better information is needed on how the NHS uses funding to support change

81. Health funding in Scotland is the single largest area of Scottish Government expenditure. The Scottish public need to know what this funding is being used for and what it is achieving.

82. There is no easy-to-understand, summarised public information available on health funding and what it is spent on. There is information on parts of the system, but they do not provide a comprehensive picture or provide information that is easy to access.

83. There is also no public information on how the health funding system works, for example:

- How much funding, and the type of funding, the Scottish Government allocates to NHS boards throughout the year, and how NHS boards then allocate this to integration authorities.
- What the Scottish Government expects NHS boards to spend funding on and how NHS boards prioritise expenditure.
- How the Scottish Government monitors how NHS boards use funding and whether they are achieving the outcomes the Scottish Government wants.

84. Since June 2018, the Scottish Parliament has received a monthly update on boards' financial position. This includes their year-to-date position against budget and the expected outturn at year-end.[52] The reports also indicate which NHS boards may require brokerage to break even at the financial year-end. This is a helpful step forward in providing information that the public and MSPs can use to scrutinise financial performance. There is, however, room for improvement to make the information more helpful. For example, in the June 2018 report, eight NHS boards were projecting that they would not break even at year-end, but only four boards indicated that they might require brokerage.[53] It is not clear from the information presented why the remaining four boards do not expect to require brokerage or why the boards indicating they may need brokerage do not expect to identify additional savings.

The Scottish Government is making progress with the Health and Social Care Delivery Plan but public reporting is needed

85. The Health and Social Care Delivery Plan sets out an ambitious set of actions to achieve the 2020 Vision. A number of key actions have been achieved, including putting in place a new national GP contract in April 2018 and publishing national public health priorities in June 2018. Work is also under way across a range of other areas, including increasing paramedic and health visitor numbers, developing new elective centres, and establishing a new national public health body.

86. Significant progress still needs to be made, however, to achieve the 2020 Vision. In a number of areas, including those where actions have been achieved, implementation and embedding is likely to take a number of years and progress is often dependent on other actions being achieved. For example, the success of the new GP contract is dependent on resolving issues such as premises costs and increasing the number of GPs and others, such as pharmacists and paramedics, to develop multidisciplinary teams. Progress has also been slower than planned in some areas; for example the publication of the national public health priorities were over a year later than the target date. This is partly due to

the complexity and scale of the changes. Successfully achieving the actions in the Delivery Plan will require staff, public, and political buy-in and involvement.

Detailed workforce planning is overdue

87. All three parts of the Health and Social Care National Workforce plan have now been published, with the final part on the primary care workforce published in April 2018.[54] As with part one, parts two and three largely focus on what needs to be done to plan for the future, rather than on setting out what the medium to longer-term workforce will look like. In our 2017 report, *NHS workforce planning*, we recommended that there is a need to better understand future demand and to provide a breakdown of the cost of meeting this demand.[55] The National Workforce Plan does not provide this information. We will be undertaking an audit of primary care workforce planning in 2018/19.

Reporting on progress towards the Scottish Government's 2020 Vision needs to be made public

88. Progress towards achieving the Delivery Plan is reported to the Scottish Government's Health and Social Care Delivery Plan Programme Board every six weeks. This board is responsible for the strategic oversight and operational assurance of the delivery of the Delivery Plan. There is scope to improve the monitoring and reporting of progress:

- There is no public reporting of progress. Programme Board minutes are made public but agendas and papers, including progress updates, are not published.
- An integrated performance framework covering all elements of the Delivery Plan has not yet been developed. The Delivery Plan states that this would be produced by early 2017. As we reported in our *NHS in Scotland 2017* report, the Delivery Plan does not set out in detail how the changes described in it will be achieved and many of the actions in it are statements of intent rather than actions.[56] It remains important that the performance framework sets out clearly what work is being done and how progress will be measured.
- In the overall progress reports provided to the Programme Board it is not always clear whether current progress is as expected, or why expected progress has not been made. Where completion dates have been delayed, these are not always clearly labelled as delayed, despite some activities slipping by more than a year from the planned target date.
- The public and politicians cannot fully hold the Scottish Government to account or get involved in changing how health care services are accessed and delivered if they do not know what:
  - activities are being undertaken
  - progress is being made towards achieving these
  - challenges are being faced in achieving the Delivery Plan actions.

Endnotes

1 *NHS Scotland Workforce Information - Overall trend*, ISD Scotland, June 2018.

2 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.

3 *Acute Hospital Activity and NHS Beds Data Release*, ISD Scotland, June 2018.

4 *Annual Report and Accounts for year ended March 2018,* Scottish Ambulance Service.

5 *Draft budget 2018/19*, Scottish Government, December 2017.

6 *2020 Vision: Strategic Narrative,* Scottish Government, September 2011.

7 *Draft budget 2018/19*, Scottish Government, December 2017.

8 This was the Departmental Expenditure Limit (DEL).

9 *NHS Consolidated Accounts for financial year 2017/1*8, Scottish Government, 2018.

10 Audit Scotland using *Draft budget 2018/19*, Scottish Government and *Mid-year population estimates*, National Records of Scotland, April 2018.

11 *NHS Consolidated Accounts for financial year 2017/18*, Scottish Government, 2018.

12 *NHS board Local Delivery Plans 2015/16-2017/18* and *NHS Scotland 2018-19 Consolidated Summary Financial Report*, June 2018.

13 *NHS board Local Delivery Plans 2015/16-2017/18.*

14 *NHS Consolidated Summary Financial Report*, June 2018.

15 *NHS board annual audit reports 2017/18.*

16 *NHS board Local Delivery Plans 2013/14-2017/18.*

17 *Scotland's Fiscal Outlook: The Scottish Government's Five-Year Financial Strategy*, Scottish Government, May 2018.

18 Ibid.

19 Ibid.

20 *Scotland's Budget Report 2017,* Fraser of Allander Institute, September 2017.

21 *Medium Term Health and Social Care Financial Framework*, Scottish Government, October 2018.

22 *Scotland's Fiscal Outlook: The Scottish Government's Five-Year Financial Strategy*, Scottish Government, May 2018.

23 *New Outpatient appointment: waiting times and activity,* ISD Scotland, September 2018.

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25 Ibid.

26 *Inpatient, Day Case and Outpatient Waiting Times,* ISD Scotland, June 2018.

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33 *Services for older people in Edinburgh - joint inspection of adult health and social care services,* Healthcare Improvement Scotland, May 2017.

34 *Carseview Centre: Tayside leadership team commissions independent assurance on mental health services*, NHS Tayside press release, May 2018.

35 *The Governance of the NHS in Scotland - ensuring delivery of the best healthcare for Scotland,* Health and Sport Committee, July 2018.

36 *Learning from adverse events through reporting and review,* Healthcare Improvement Scotland, July 2018.

37 General Medical Council submission to Health and Sport Committee inquiry into the impact of leaving the EU on health and social care in Scotland, General Medical Council, January 2018.

38 *Non-UK nationals in Scotland's workforce*, Statistics from the Annual Population Survey 2017, 13 June 2018.

39 *Quarterly survey*, Q2, British Medical Association, 2018.

40 *The Nursing and Midwifery Council register*, Nursing and Midwifery Council, March 2018.

41 *The Governance of the NHS in Scotland - ensuring delivery of the best healthcare for Scotland,* Health and Sport Committee, July 2018.

42 *NHS in Scotland 2017*, Audit Scotland, October 2017.

43 *Health and Social Care Staff Experience Report 2017,* Scottish Government, March 2018.

44 *The 2017/18 audit of the Scottish Government Consolidated Accounts*, Auditor General for Scotland, September 2018.

45 *NHS Corporate Governance - Survey Analysis Report,* Scottish Parliament Information Centre, February 2018.

46 Ibid.

47 Ibid.

48 Ibid.

49 *NHS in Scotland 2017*, Audit Scotland, October 2017.

50 *Review of Targets and Indicators for Health and Social Care in Scotland,* Scottish Government, November 2017.

51 https://www.nhsperforms.scot/.

52 *NHS Scotland 2018-19 Consolidated Financial Reporting.*

53 Ibid.

54 *National Health and Social Care Workforce Plan Part 3 - improving workforce planning for primary care in Scotland,* Scottish Government, April 2018.

55 *NHS workforce planning*, Audit Scotland, July 2017.

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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 2017/18 and why immediate action is needed.

Our findings are based on evidence from sources that include:

- the audited annual accounts and auditors' reports on the 2017/18 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 and a range of other key stakeholders.

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 37).

Appendix 2

Financial performance 2017/18 by NHS board

Board	Core revenue outturn (£m)	Total savings made Annual Audit Report (£m)	Non-recurring savings in Annual Audit Report	NRAC: distance from parity
Ayrshire and Arran	779.5	24.8	41%	-1.0%
Borders	223.9	8.3	66%	1.3%
Dumfries and Galloway	327.5	22.6	74%	2.8%
Fife	683.6	22.5	58%	-1.0%
Forth Valley	547.1	24	28%	-1.0%
Grampian	1,003.6	27.7	34%	-0.9%
Greater Glasgow and Clyde	2,349.2	122.4	57%	1.8%
Highland	693.2	35	71%	-0.7%
Lanarkshire	1,239.4	36.1	23%	-1.0%
Lothian	1,512.2	23.5	40%	-0.9%
Orkney	55.6	1.3	83%	5.1%
Shetland	56.8	4.7	49%	3.0%
Tayside	820.6	46.8	64%	-1.0%
Western Isles	82.1	3.5	30%	15.1%
Healthcare Improvement Scotland	28.2	2	68%	
National Services Scotland	416.6	18.2	0%[1]	
National Waiting Times Centre	66.2	4.5	23%	
NHS 24	71.7	2.4	26%	
NHS Education for Scotland	444.4	8	76%[1]	
NHS Health Scotland	19.4	0.3	100%	
Scottish Ambulance Service	235.4	8.7	51%	
State Hospital	32	1.8	90%	

Notes: 1. These figures are from Month 13 Financial Reporting Return to the Scottish Government. 2. NRAC is the NHS Scotland Resource Allocation Committee.

Appendix 3

NHS performance against key LDP standards in 2017/18

Measure	18 weeks referral to treatment time	A&E attendees seen within four hours	CAMHs patients seen within 18 weeks	Day case or inpatients who waited less than 12 weeks for treatment
	standard = 90%	standard = 95%	standard = 90%	standard = 100%
Ayrshire and Arran	78.6	90.8	98.2	85.2
Borders	86.7	89.5	48.2	84.5
Dumfries and Galloway	84.0	90.3	89.9	77.7
Fife	79.1	94.6	67.7	87.6
Forth Valley	83.4	83.4	48.0	56.1
Grampian	65.5	94.1	48.7	64.0
Greater Glasgow and Clyde	89.3	86.7	88.7	78.7
Highland	81.7	96.0	82.9	65.0
Lanarkshire	82.1	90.0	71.4	62.6
Lothian	74.6	75.4	65.1	79.3
Orkney	98.9	95.9	94.7	95.9
Shetland	81.8	94.4	94.7	94.2
Tayside	71.9	98.0	40.7	73.6
Western Isles	91.7	97.7	94.7	100.0
National total	**81.2**	**87.9**	**71.2**	**75.9**

Key Green = Standard met
Red = Standard missed

Measure	Drug and alcohol patients seen within three weeks	Outpatients waiting less than 12 weeks following first referral	Patients starting cancer treatment within 62 days (referral to treatment)	Patients starting cancer treatment within 31 days (decision to treatment)
	standard = 90%	standard = 95%	standard = 95%	standard = 95%
Ayrshire and Arran	98.6	85.0	87.3	97.4
Borders	89.3	91.7	95.7	100.0
Dumfries and Galloway	95.6	90.4	94.9	96.6
Fife	95.9	93.6	86.2	97.4
Forth Valley	98.4	84.6	79.7	97.0
Grampian	91.0	63.4	76.7	87.2
Greater Glasgow and Clyde	94.5	74.5	81.3	92.7
Highland	86.8	80.7	81.4	93.2
Lanarkshire	99.4	84.8	96.5	99.2
Lothian	79.9	66.2	87.2	91.1
Orkney	100.0	62.5	91.7	100.0
Shetland	100.0	80.7	100.0	100.0
Tayside	87.3	70.7	86.5	92.5
Western Isles	91.7	88.9	88.9	100.0
National total	**93.5**	**75.1**	**85.0**	**93.5**

Sources:

Child and Adolescent Mental Health Services: Waiting Times, Workforce and Service Demand: Quarter ending 31 March 2018, ISD Scotland, June 2018

National Drug and Alcohol Treatment Waiting Times Report - January-March 2018, ISD Scotland, June 2018

18 weeks referral to treatment (RTT), Month ending March 2018; ISD Scotland, May 2018

New Outpatient Appointment: Waiting Times for Patients waiting at Month end, Census date at 31 March 2018, June 2018

Inpatient or day case admission: waiting times for patients seen, Quarter ending March 2018; ISD Scotland, June 2018

Accident and Emergency: attendances and time in department by NHS board and month, Month ending March 2018; ISD Scotland, June 2018

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 2018; ISD Scotland, June 2018

Performance against the 31 day standard from date decision to treat to first cancer treatment by NHS board, Quarter to March 2018, ISD Scotland, June 2018.

NHS in Scotland 2018

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ISBN 978 1 911494 75 1 AGS/2018/8