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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 20 May 2019

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

The Members of the **AUDIT AND PERFORMANCE SYSTEMS COMMITTEE** are requested to meet in **Meeting Room 4 / 5, Health Village on TUESDAY, 28 MAY 2019 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

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 12 February 2019 (Pages 9 - 18)

4 Minute of Previous Meeting of 30 April 2019 (Pages 19 - 24)

5 Business Planner - for discussion (Pages 25 - 30)

STEWARDSHIP AND GOVERNANCE

6 APS Duties Report (Pages 31 - 48)

PERFORMANCE

7 Transformation Programme Monitoring (Pages 49 - 208)

AUDIT

8 External Audit Annual Report - to follow

9 Internal Audit Annual Report 2018/2019 - inc. Outstanding Recommendations (Pages 209 - 220)

10 Internal Audit Plan 2019/2020 (Pages 221 - 224)

11 ACC Internal Audit Report - Criminal Justice (Pages 225 - 228)

12 ACC Internal Audit Report - National Care Home Contract (Pages 229 - 232)

13 NHS Internal Audit Reports (Pages 233 - 292)

14 Audit Scotland - Local Government in Scotland and Safe Guarding Public Money (Pages 293 - 394)

FINANCE

15 Audited Annual Accounts - to follow

16 Financial Monitoring (Pages 395 - 416)

EXEMPT / CONFIDENTIAL BUSINESS

17 None Declared

CONFIRMATION OF ASSURANCE

18 Confirmation of Assurance

Should you require any further information about this agenda, please contact Derek Jamieson, tel 01224 523057 or email derjamieson@aberdeencity.gov.uk

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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.

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

Minute of Meeting

Tuesday, 12 February 2019
10.00 am RmTHeCR2, Marischal College

Present:	Rhona Atkinson(Chairperson); and Jonathan Passmore MBE, Cllr Gill Al-Samarai and Councillor Sarah Duncan (as substitute for Councillor Jenny Laing)
Also in attendance;	Alex Stephen (Chief Finance Officer), John Forsyth (Legal)
Apologies:	Councillor Jenny Laing

MEMBERS ARE REQUESTED TO INTIMATE ANY DECLARATIONS OF INTEREST

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

Councillor Duncan declared an interest in Item 12 on the agenda (Ethical Care & Living Wage Update Report) by virtue of her position as a paid official of Unison. Councillor Duncan intimated her intention to absent herself during that discussion.

The Committee resolved:-
To note Councillor Duncan's intimation and intention

MEMBERS ARE REQUESTED TO DETERMINE THAT ANY EXEMPT BUSINESS BE CONSIDERED WITH THE PRESS AND PUBLIC EXCLUDED

2. The Committee was asked to determine any exempt or confidential business.

The Committee resolved:-
To note that there was no exempt business to be considered.

WELCOME AND APOLOGIES

3. The Chairperson welcomed all members and attendees and extended a warm welcome to Andy Shaw (External Auditor) and David Hughes (Internal Auditor).

Apologies were noted from Councillor Laing.

The Chairperson advised that Item 8 (Transformation Programme Monitoring) would follow after Item 5 (Forward Report Planner).

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE
12 February 2019

MINUTE OF PREVIOUS MEETING OF 13 NOVEMBER 2018

4. The Committee had before it the minute of the previous meeting of 13 November 2018.

The Committee resolved:-
To approve that the minute was an accurate reflection of the meeting.

FORWARD REPORT PLANNER

5. The Committee had before it the Forward Report Planner.

The Committee resolved:-
To note its content and timelines.

TRANSFORMATION PROGRAMME MONITORING (INCLUDING PCIP)

6. The Committee had before it a report by Gail Woodcock. The report also contained an update on the PCIP.

The report recommended that the Committee:-

a) Note the information provided in this report.

The Committee heard that the report provided information on the pace of delivery together with highlights, in depth analysis and key project updates. The report had captured Lessons Learned and was broadly aligned to the developing strategic plan.

Considerable discussion continued due to the depth and quality of the report and the information it contained.

The Committee were then delivered a presentation on the PCIP by Dr Leask. This drew equal particpative discussion from the Committee.

Both authors were commended on providing a great deal of the information and assurance that the Committee sought.

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE
12 February 2019

The Committee resolved:-

(i) To note the information provided in this report within the context of the discussion held and the specific requests for further reports as noted
(ii) to commend officers for the quality of the process followed and the evaluation reports provided.
(iii) That officers Circulate a list of projects that were to be reallocated from the Transformation Programme
(iv) Submit the requested report(s) to the Committee Meeting of 20 August 2019

STRATEGIC RISK REGISTER REVIEW

7. The Committee had before it a report by Martin Allan (Business Manager, ACHSCP).

The report recommended that the Committee:-

a) Approve and provide comment on the revised risk register, as at Appendix A.
b) Undertake an in-depth review of 1, 2 & 3 within the strategic risk register at appendix A.
c) Approve and provide comment on the revised risk appetite statement, as at Appendix B.

The Committee heard from Sandy Reid on behalf of Martin Allan and thereafter engaged in the review sought.

The Committee resolved:-

(i) To approve and provide comment on the revised risk register, as at Appendix A
(ii) Undertake an in-depth review of 1, 2 & 3 within the strategic risk register at appendix
(iii) To provide comment on the revised risk appetite statement, as at Appendix B, and
(iv) To require the report be revised to include consideration of the comments made.

BOARD ASSURANCE & ESCALATION REVIEW

8. The Committee had before it a report by Martin Allan (Business Manager, ACHSCP).

The Committee commented that the report served as a map of governance and was a guide as to who needed to look at what and when.

The Committee resolved:-
To approve and provide comment on the Board Assurance and Escalation Framework, as at Appendix A.

PERFORMANCE MONITORING

9. The Committee had before it the report by Alison MacLeod (Lead Strategy and Performance Manager, ACHSCP).

The Committee were appreciative of the style and content of the report which assisted provide direction on reporting. The Committee commented that the report identified the distinctions between the APS and CCG Committees though clearly linked their interdependency.

The Committee resolved:-

(i) To notes the mapping of the strategic performance indicators to the strategic aims and the strategic risk register.

(ii) To approve the proposed reporting arrangements of the strategic aims to both the Clinical and Care Governance and Audit and Performance Systems Committee.

DELAYED DISCHARGES

10. The Committee had before it the report by Kenneth O'Brien (Service Manager, ACHSCP) which provided an update on current delayed discharge performance information regarding the Aberdeen City Partnership.

The Committee were appreciative of the volume and quality of the report, together with the honesty and passion presented during discussions all of which assisted the Committee provide the assurances they are required to discharge.

The Committee resolved:-
To note the performance information contained within the report

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE
12 February 2019

REVIEW ON PROGRESS WITH LOCALITY PLANNING

11. The Committee had before it the report by Anne McKenzie (Aligned Senior Manager – North Locality) which discussed the transition from 4 to 3 localilites.

The Committee commented that the report provided the position statement they were looking for.

The Committee resolved:-
To note the contents of the report

STRATEGIC COMMISSIONING IMPLEMENTATION PLAN REVIEW

12. The Committee had before it the report by Anne McKenzie (Aligned Senior Manager – North Locality).

The Committee were satisfied that the report provided confirmation that the realignment is the best way forward.

The Committee resolved:-
To note the content of the report

ETHICAL CARE CHARTER & LIVING WAGE UPDATE REPORT

13. In accordance with Item 1 – Declarations of Interest, Councillor Duncan withdrew from the meeting at this point.

The Committee had before it the report by Claire Duncan (Lead Social Work Officer, ACC).

The report recommended that the Committee:-

d) Note the implementation of the Scottish Living Wage.
e) Note the progress across the stages of the Charter
f) Note that the Charter will be included in the workstream for Care at Home commissioning.

The Committee heard that this was the first report to Committee on the topic which was aligned to Scottish Government Charter on the Living Wage for all care workers. Whilst all care providers are aware of the requirements, this cannot be mandated on all

providers albeit most have agreed. How to introduce this within ACHSCP contracts is being considered but this may also bring financial impact.

The Committee resolved:-
(i) To note the implementation of the Scottish Living Wage.
(ii) To note the progress across the stages of the Charter.
(iii) To note that the Charter will be included in the workstream for Care at Home commissioning.
(iv) To encourage that service delivery partners strive to achieve all aspects of the Charter.
(v) To re-emphasise that the Charter was endorsed and not signed.

Councillor Duncan re-joined the meeting at conclusion of this item.

FINANCIAL MONITORING

14. The Committee had before it the report By Alex Stephen (Chief Financial Officer, ACHSCP).

A minor typo at 3.2 saw a change to the date of 31.12.2018. The Committee entered into discussions regarding the report and commented on the continuing financial challenges which would require strategy in some areas to assist. The report also highlighted some areas worthy of future development and consideration.

1.1. The report recommended that the Audit & Performance Systems Committee:
g) Notes this report in relation to the IJB budget and the information on areas of risk and management action that are contained herein.
h) Notes the budget virements indicated in Appendix E.

The Committee resolved:-
(i) To note this report in relation to the IJB budget and the information on areas of risk and management action that are contained herein.
(ii) To note the budget virements indicated in Appendix E.
(iii) To recognise the astute financial management exercised.

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE
12 February 2019

EXTERNAL AUDIT PLAN

15. The Committee had before it the report by Andy Shaw, Director (Assurance, KPMG), the external auditor to the IJB.

The Committee heard an overview of the document which included the methodology used. This included reference to Audit Scotland requirements in respect of risk.

The Committee resolved:-
To approves the approach to external audit, as outlined in Appendix A.

INTERNAL AUDIT - BUDGET SETTING, MONITORING AND FINANCIAL PERFORMANCE

16. The Committee had before it the report by David Hughes, (Chief Internal Auditor, Aberdeenshire Council).

The Committee were assured by the report and discussion.

The Committee resolved:-
To review, discuss and comment on the issues raised within the report

LOCAL GOVERNMENT FINANCE - AUDIT SCOTLAND

17. The Committee had before it the report by Alex Stephen, Chief Finance Officer.

The report provided additional information what

The Committee resolved:-

(i) To reviews, discuss and comment on the report as attached at Appendix A.

(ii) To instructs the Chief Finance Officer to bring the report, *Local government in Scotland: Challenges and performance*, to be published by the Accounts Commission in March 2019, which comments on the wider challenges and performance of councils, to the Committee at its meeting in May 2019.

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE
12 February 2019

CONFIRMATION OF ASSURANCE

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

The Committee resolved:-
That they were satisfied that they had been able to discharge their duties of assurance.

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE
12 February 2019

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

Minute of Meeting

Tuesday, 30 April 2019
10.00 am Health Village Room 5

Present:	Luan Grugeon (Chairperson) ; and Councillors Gill Al-Samarai and Philip Bell
Also in attendance;	Alex Stephen (Chief Finance Officer, ACHSCP), Councillor Sarah Duncan, Derek Jamieson (Governance, ACC)
Apologies:	None

DECLARATIONS OF INTEREST

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

The Committee resolved:-
to note that there were no declarations of interest.

DETERMINE EXEMPT BUSINESS

2. The Committee were asked to determine any exempt or confidential business.

The Committee resolved:-
to note that there were no items of exempt or confidential business on the agenda.

MINUTE OF PREVIOUS MEETING OF 12 FEBRUARY 2019

3. The Committee had before it the minute of the previous meeting of 12 February 2019.

As this meeting was called as Urgent to deal with Unaudited Accounts, there was agreement that Standing Items should be deferred until a regular meeting.

The Committee resolved:-
To defer this item to the meeting of 23 May 2019

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE
30 April 2019

BUSINESS STATEMENT - FOR DISCUSSION AND UPDATE

4. The Committee had before it the Business Statement.

As this meeting was called as Urgent to deal with Unaudited Accounts, there was agreement that Standing Items should be deferred until a regular meeting.

The Committee resolved:-
To defer this item to the meeting of 23 May 2019

LOCAL CODE OF GOVERNANCE

5. The Committee had before it the report by Alex Stephen (Chief Finance Officer) on Local Code of Corporate Governance.

The Committee heard that this was an important part of the governance arrangements which were subject to annual review. The attached Appendix provided the sources of assurance which indicated the volume of work of the revised documents subjected to the review.

The Committee indicated that whilst content with the very detailed and necessarily lengthy documents, as a living document, they were keen to revisit these at some future point as they change and evolve. There were keen that cross Grampian IJB working also be considered.

The Chief Finance Officer undertook to consider how best to action such revisits and considerations.

The Committee resolved:-
To Approve the changes to the sources of assurance, as highlighted in appendix A

REVIEW OF FINANCIAL GOVERNANCE ARRANGEMENTS

6. The Committee had before it the report by Alex Stephen on the Review of Financial Governance Arrangements. The Committee were provided with an overview summary of the report and heard that this was a living document subject to regular update including consideration of risk.

It was heard that all relevant managers and their teams had received training on their responsibilities from their host organisations and which featured in their continued training, Performance objectives and quarterly reviews. The culture of financial spending was discussed together with the lack of direct management responsibility by the Chief Finance Officer (CFO) of relevant staff.

Assurance was provided that the CFO was satisfied that the appropriate recognition of the Office and good working relationships mitigated those risks.

The Committee resolved:-
to note the content of the report and the accompanying results of the Executive team review contained in Appendix 1.

DRAFT ANNUAL GOVERNANCE STATEMENT

7. The Committee had before it the report by Alex Stephen (Chief Finance Officer) on the Draft Annual Governance Statement who provided a brief overview of the report.

The Committee resolved:-
to approve the draft annual governance statement, as set out in appendix 1,

UNAUDITED ACCOUNTS

8. The Committee had before it the Unaudited Accounts prepared by Alex Stephen (Chief Finance Officer) who provided a brief overview of the content and provided an amendment to pages 113 and 114 of the report.

The Committee heard that the accounts as set out are compliant for their third year.

The accounts were largely in line with the previously projected Medium Term Financial Strategy.

The Committee heard that whilst the presentation style of the Accounts may not best please all, the format was such to comply with statutory requirements and had matured despite the very tight timelines in which to produce such a report.

The Committee resolved:-
To approve the Unaudited Accounts for 2018/19

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE
30 April 2019

CONFIRMATION OF ASSURANCE

11. The Committee were satisfied to confirm reasonable assurance for the items on this agenda.

- Luan Grugeon (Chairperson)

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE
30 April 2019

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AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

BUSINESS PLANNER

28.05.2019

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 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 (transformation report). On this agenda	Item 8(21)	G Woodcock	12.02.19
2	IJB 28.08.18 Article 12	**Annual Performance Report** **RECOMMENDED FOR REMOVAL** 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 strategic	Item 8(16)	A MacLeod	12.02.19

No.	Minute Reference	APS/IJB/CCG Decision	Update	Terms of Reference	Lead Officer(s)	Expected
			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	Aug 19
4	IJB 28.08.18 Article 18	**Transformation Decisions** **RECOMMENDED FOR REMOVAL** 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.	Received 12.02.2019	Item 8(16)	G Woodcock	12.02.19
5	IJB 22.05.18 Article 1	**Strategic Risk Register Review** **RECOMMENDED FOR REMOVAL** 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 next	Item 8(11)	M Allan	12.02.19

No.	Minute Reference	APS/IJB/CCG Decision	Update	Terms of Reference	Lead Officer(s)	Expected
			meeting of the Audit and Performance Systems Committee. This Strategic Risk Register will be presented to Committee in February 2019.			
6	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.	On agenda	Item 8(6)	D Hughes	28.05.19
7	IJB 30.01.18 Article 13	**Strategic Commissioning Plan** **RECOMMENDED FOR REMOVAL** To request an annual update on the implementation of the Strategic Commissioning Implementation Plan to both the IJB and APS Committee.	Received 12.02.2019	Item 8(4)	A MacLeod	12.02.19
8	IJB 06.06.17 Article 7	**Living Wage/Ethical Care Charter Implementation** **RECOMMENDED FOR REMOVAL** 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 was presented to Committee in February 2019. On agenda	Item 8(21)	C Duncan	12.02.19

No.	Minute Reference	APS/IJB/CCG Decision	Update	Terms of Reference	Lead Officer(s)	Expected
9	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 these duties in the financial year 2019-20.	On agenda	Item 8(1-22)	A Stephen	28.05.19
1	APS 11.09.18 Article 13	**Locality Planning** **RECOMMENDED FOR REMOVAL** The Committee requested assurance on the progress of locality planning in terms of meeting strategic outcomes.	This report was presented to Committee in February 2019.	Item 8(16)	S Ross G Woodcock L McKenna	12.02.19
1	APS 11.09.18 Article 13	**Future Financial Planning** **RECOMMENDED FOR REMOVAL** 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 item was received on 13 November 2018 **Recommend for removal**	Item 8(4)	A Stephen	Item received 13 Nov 18
1	APS 13.11.18	**Scottish Medium Term Financial Framework**	This was considered in the Medium Term Financial Framework Paper	Item 8 (4)	A Stephen	12.02.19

No.	Minute Reference	APS/IJB/CCG Decision	Update	Terms of Reference	Lead Officer(s)	Expected
	Article 8	**RECOMMENDED FOR REMOVAL** The Committee requested the Chief Finance Officer to produce a detailed action plan to address the longer term financial impact on services and submit a report to the Committee on 12 February 2019.	considered by the APS Committee in March 2019.			
1	APS 13.11.18 Article 6	**Financial Monitoring** **RECOMMENDED FOR REMOVAL** The Committee requested the Chief Finance Officer to provide an update in relation to the Grampian solution for Learning Disability Client care; and The Committee noted that a mapping exercise across the city had commenced to locate all services, where they were based and what was available and that a report on the outcome of the exercise would be submitted to the meeting in February 2019.	Update on the service mapping exercise was provided within the transformation report received by the Committee in February 2019..		A Stephen S Ross	12.02.19
1	APS 13.11.18 Article 10	**NHS Audit Scotland Report – Effective Leadership** **RECOMMENDED FOR REMOVAL** The Committee requested the Chief Finance Officer to prepare a report in relation to leadership development and the support model in place for the	This report was circulated by the Chief Officer at the last IJB.		A Stephen	28.05.19

No.	Minute Reference	APS/IJB/CCG Decision	Update	Terms of Reference	Lead Officer(s)	Expected
		leadership group and submit it to this Committee within six months.				
1	APS 13.11.18 Article 11	**Delayed Discharges** **RECOMMENDED FOR REMOVAL** Committee requested the Chief Officer to prepare a performance report on Delayed Discharges and present the report to the Committee's next meeting on 12 February 2019.	This report was considered by the Committee at its meeting in February 2019.		K O'Brien	12.02.19

Aberdeen City Health & Social Care Partnership
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INTEGRATION JOINT BOARD

Date of Meeting	28.05.2019
Report Title	Review of Duties & Year End Report
Report Number	HSCP.19.006
Lead Officer	Alex Stephen, Chief Finance Officer
Report Author Details	Name: Alex Stephen Job Title: Chief Finance Officer Email Address: AleStephen@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	a. Audit & Performance Systems Duties Report

1. Purpose of the Report

1.1. This report presents the Audit & Performance Systems (APS) Committee with a review of reporting for 2018-19 and an intended schedule of reporting for 2019-20 to ensure that the Committee is fulfilling all the duties as set out in its terms of reference.

2. Recommendations

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

a) Note the content of the APS Duties report as attached at Appendix A

b) Request that the Chief Finance Officer presents this report to the APS on an annual basis at the start of each financial year.

INTEGRATION JOINT BOARD

3. Summary of Key Information

3.1. The terms of reference indicate several duties which the APS committee should ensure that it meets each financial year. These are listed in Appendix A, with a review of when these were met in 2018/19 and an indication as to when these duties will be met in 2019/20.

3.2. The Chief Finance Officer will maintain this document as a record of the APS Committee's business and present it back to the Committee at the end of financial year 2019/20.

4. Implications for IJB

4.1. **Equalities –** there are no direct implications arising from this report.

4.2. **Fairer Scotland Duty –** there are no direct implications arising from this report.

4.3. **Financial –** there are no direct implications arising from this report.

4.4. **Workforce -** there are no direct implications arising from this report.

4.5. **Legal –** there are no direct implications arising from this report.

4.6. **Other** – NA

5. Links to ACHSCP Strategic Plan

5.1. Ensuring that the APS Committee is functioning effectively and fulfilling its duties will help ensure that the IJB achieves the strategic priorities as set out in the strategic plan.

6. Management of Risk

6.1. **Identified risk(s):** Good governance and ensuring that the IJB's committees are delivering on their duties are fundamental to the delivery of the strategic plan and therefore applicable to most of the risks within the strategic risk register.

INTEGRATION JOINT BOARD

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

6.3. How might the content of this report impact or mitigate the known risks: The Audit & Performance Systems Report, as attached at Appendix A, provides assurance that the APS committee is delivering on its duties.

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Audit & Performance Systems – Committee Duties & Annual Plan

Review Date: April 2019 (submitted APS May 2019)

Purpose of the Document

This document provides an overview of the duties of the Audit and Performance Systems Committee (APS) and indicates when the duty were fulfilled for the financial year 2018/19. It further provides a plan for fulfilment of the same duties for the financial year 2019/20.

Duties & When Considered

The Committee will review the overall Internal Control arrangements of the Board and make recommendations to the Board regarding signing of the Governance Statement, having received assurance from all relevant Committees.

Specifically it will be responsible for the following duties:

Duty	When considered in 2018/19 and Agenda Item No.					
	100418	190618	110918	131118	260219	Comments
1. The preparation and implementation of the strategy for Performance Review and monitoring the performance of the Partnership towards achieving its policy objectives and priorities in relation to all functions of the IJB;			X		X	Performance monitoring quarterly to APS/IJB alternatively.
	X	X	X	X	X	Quarterly transformation programme performance monitoring reports. Includes deep dive presentation into specific areas.
			X	X		Financial Monitoring Reports (APS/IJB quarterly)

Duty	When considered in 2018/19 and Agenda Item No.					
	100418	190618	110918	131118	260219	Comments
				X	X	Other Performance Reports as requested
2. Ensuring that the Chief Officer establishes and implements satisfactory arrangements for reviewing and appraising service performance against the national health and wellbeing outcomes, the associated core suite of indicators and other local objectives and outcomes and for reporting this appropriately to the Committee and Board. The performance systems scrutiny role of the Committee is underpinned by an Assurance Framework which itself is based on the Board's understanding of the nature of risk to its desired priorities and outcomes and its appetite for risk taking. This role will be reviewed and revised within the context of the Board and Committee reviewing these Terms of Reference and the Assurance Framework to ensure effective oversight and governance of the partnership's activities.			X		X	Performance monitoring quarterly to APS/IJB alternatively.
			X		X	Annual review of the performance monitoring framework & reporting.
					X	Annual review of the Board Assurance & Escalation Framework.
						APS ToRs have been reviewed directly by the IJB in May 2019.
3. Acting as a focus for value for money and service quality initiatives;						Reactive. Example of the living wage processes.

Duty	When considered in 2018/19 and Agenda Item No.					
	100418	190618	110918	131118	260219	Comments
4. To review and approve the annual audit plan on behalf of the IJB,	X					Internal Audit Plan (Apr 18).
receiving reports, overseeing and reviewing actions taken on audit recommendations and reporting to the Board;					X	External Audit Plan (Feb19)
	X	X	X			Internal Audit Annual report (Apr 18) External Audit Annual Report (Sept18) Internal audit reports received as per the internal audit plan, from both ACC & NHSG
5. Monitoring the annual work programme of Internal Audit, including ensuring IJB oversight of the clinical and care audit function and programme to ensure this is carried out strategically;		X	X			Internal audit plan, annual report & reports as required.
6. To consider matters arising from Internal and External Audit reports;		X	X	X		Each meeting as required, as per internal/external audit plans
7. Review on a regular basis actions planned by management to remedy		X	X		X	Each meeting as required, as per internal/external audit plans

Duty	When considered in 2018/19 and Agenda Item No.					
	100418	190618	110918	131118	260219	Comments
weaknesses or other criticisms made by Internal or External Audit.						
8. To support the IJB in ensuring that the strategic integrated assurance and performance framework is working effectively, and that escalation of notice and action is consistent with the risk tolerance set by the Board.			X		X	Performance monitoring Revised performance framework (Feb19)
9. To support the IJB in delivering and expecting cooperation in seeking assurance that hosted services run by partners are working effectively in order to allow Aberdeen City IJB to sign off on its accountabilities for its resident population.						
10. Review risk management arrangements, receive annual Risk Management updates and reports and annually review with the full Board the IJB's risk appetite document.	X		X	X	X	Reviewed risk appetite (Apr18) Risk Register (Apr18, Sept18, Nov18, Feb19)
11. Ensure existence of and compliance with an appropriate Risk Management Strategy.			X		X	Connected to 10 (one fulfils other)

Duty	When considered in 2018/19 and Agenda Item No.					
	100418	190618	110918	131118	260219	Comments
12. Reporting to the IJB on the resources required to carry out Performance Reviews and related processes;						Leadership Team currently undertaking series of service reviews. Updates on service mapping given in transformation report.
13. To consider and approve annual financial accounts and related matters;		X				Audited annual accounts (Jun18). Review of financial regulations (Jun18)
14. Approve & understand the sources of assurance used in the annual governance statement	X					Review of annual governance statement (Apr 18) Review of local code of governance (Apr18) Review of financial governance arrangements (Apr 18)
15. Review the Annual Performance Report to assess progress towards the implementation of the Strategic Plan			X		X	Review of annual report.
16. To be responsible for setting its own work programme which will include the right to undertake reviews following input from the IJB and any other IJB Committees;		X	X	X	X	As requested by the Committees & IJB, or as raised by APS Committee members. Statement of assurance included on agenda at end of every meeting.

Duty	When considered in 2018/19 and Agenda Item No.					
	100418	190618	110918	131118	260219	Comments
17. The Committee may at its discretion set up short term working groups for review work. Membership of the working group will be open to anyone whom the Committee considers will assist in the task assigned. The working groups will not be decision making bodies or formal committees but will make recommendations to the Audit Committee;						None raised during 2018/19.
18. Promoting the highest standards of conduct by Board Members; and 19. Monitoring and keeping under review the Codes of Conduct maintained by the IJB.						Review of Code of Conduct – not completed
20. Will have oversight of Information Governance arrangements and staffing arrangements as part of the Performance and Audit process.						
22. To be aware of, and act on, Audit Scotland, national and UK audit findings		X	X	X	X	Audit Scotland (Jun18) JISOP; Audit Scotland (Nov18) Audit Scotland (Feb19)

Duty	When considered in 2018/19 and Agenda Item No.					
	100418	190618	110918	131118	260219	Comments
and inspections/regulatory advice, and to confirm that all compliance has been responded to in timely fashion.						Horizon-scanning activity to be undertaken prior to each APS committee. Any relevant reports and recommendations will be taken to committee.
Review						
9.1 The Terms of Reference will be reviewed every year to ensure their ongoing appropriateness in dealing with the business of the IJB.	X					Reviewed & approved by IJB in May 18. Additionally, included as a standing item for noting at the start of the agenda.
9.2 As a matter of good practice, the Committee should expose itself to periodic review utilising best practice guidelines.			X			Annual review against TOR – deferred until September

Forward Planning:

The Committee will review the overall Internal Control arrangements of the Board and make recommendations to the Board regarding signing of the Governance Statement, having received assurance from all relevant Committees.

Specifically it will be responsible for the following duties:

Duty	2019/20					
	280519	**200819**	**291019**	**250220**	**280420**	**Comments**
1. The preparation and implementation of the strategy for Performance Review and monitoring the performance of the Partnership towards achieving its policy objectives and priorities in relation to all functions of the IJB;			X	X		Performance monitoring quarterly to APS/CCG alternatively (APS considers Personalisation & Communities) .
	X	X	X	X	X	Transformation programme performance monitoring reports. Includes deep dive presentation into specific areas.
		X		X		Financial Monitoring Reports (APS/IJB quarterly)
	TBC	TBC	TBC	TBC	TBC	Reactive performance reports as requested
2. Ensuring that the Chief Officer establishes and implements satisfactory arrangements for reviewing and appraising service performance against the national health and wellbeing outcomes, the associated core suite of indicators and other local objectives and outcomes and for reporting this appropriately to the Committee and Board.				X		Annual review of the performance monitoring framework & reporting.
				X		Annual review of the Board Assurance & Escalation Framework.
The performance systems scrutiny role of	X					

Duty	2019/20					
	280519	200819	291019	250220	280420	Comments
the Committee is underpinned by an Assurance Framework which itself is based on the Board's understanding of the nature of risk to its desired priorities and outcomes and its appetite for risk taking. This role will be reviewed and revised within the context of the Board and Committee reviewing these Terms of Reference and the Assurance Framework to ensure effective oversight and governance of the partnership's activities.						
3. Acting as a focus for value for money and service quality initiatives;						Reactive. Example of the living wage processes.
4. To review and approve the annual audit plan on behalf of the IJB,	X					
				X		External Audit Plan (Feb19)
receiving reports, overseeing and reviewing actions taken on audit recommendations and reporting to the Board;	X					External Audit Annual Report Internal audit reports received as per the internal audit plan, from both ACC & NHSG

Duty	2019/20					
	280519	200819	291019	250220	280420	Comments
5. Monitoring the annual work programme of Internal Audit, including ensuring IJB oversight of the clinical and care audit function and programme to ensure this is carried out strategically;	X					Internal audit plan
	X					Internal audit annual report (previously called Internal Financial Control Statement)
	X					Internal audit reports
6. To consider matters arising from Internal and External Audit reports;	TBC	TBC	TBC	TBC	TBC	Each meeting as required, as per internal/external audit plans
7. Review on a regular basis actions planned by management to remedy weaknesses or other criticisms made by Internal or External Audit.	TBC	TBC	TBC	TBC	TBC	Outstanding Recommendation Each meeting as required, as per internal/external audit plans
8. To support the IJB in ensuring that the strategic integrated assurance and performance framework is working effectively, and that escalation of notice and action is consistent with the risk tolerance set by the Board.				X		Performance monitoring Review of performance monitoring framework
9. To support the IJB in delivering and expecting cooperation in seeking						

Duty	2019/20					
	280519	200819	291019	250220	280420	Comments
assurance that hosted services run by partners are working effectively in order to allow Aberdeen City IJB to sign off on its accountabilities for its resident population.						
10. Review risk management arrangements, receive annual Risk Management updates and reports and annually review with the full Board the IJB's risk appetite document.			X			Reviewed risk appetite (following IJB workshop)
		X		X		Risk Register (Aug19)
11. Ensure existence of and compliance with an appropriate Risk Management Strategy.		X	X	X		Connected to 10 (one fulfils other)
12. Reporting to the IJB on the resources required to carry out Performance Reviews and related processes;						Reactive as and when requested
13. To consider and approve annual financial accounts and related matters;	X 30.04.19					Unaudited Accounts (special meeting 30.04.19)
		X				Audited Accounts
	X 30.04.19					ISA 260 Report (special meeting 30.04.19)
		X				

Duty	2019/20					
	280519	200819	291019	250220	280420	Comments
						Financial Regulations
14. Approve & understand the sources of assurance used in the annual governance statement	X 30.04.19					Review of annual governance statement; (special meeting 30.04.19) local code of governance; financial governance (May19)
15. Review the Annual Performance Report to assess progress towards the implementation of the Strategic Plan		X				Review of annual report.
16. To be responsible for setting its own work programme which will include the right to undertake reviews following input from the IJB and any other IJB Committees;	X	X	X	X	X	As requested by the Committees & IJB, or as raised by APS Committee members. Statement of assurance included on agenda at end of every meeting.
17. The Committee may at its discretion set up short term working groups for review work. Membership of the working group will be open to anyone whom the Committee considers will assist in the task assigned. The working groups will not be decision making bodies or formal committees but will make recommendations to the Audit Committee;	TBC	TBC	TBC	TBC	TBC	At the discretion of the committee so cannot comment on when they will be established. Statement of assurance at the end of every meeting provides opportunity to raise this.

Duty	2019/20					
	280519	200819	291019	250220	280420	Comments
18. Promoting the highest standards of conduct by Board Members; and 19. Monitoring and keeping under review the Codes of Conduct maintained by the IJB.	X					Review of Code of Conduct
20. Will have oversight of Information Governance arrangements and staffing arrangements as part of the Performance and Audit process.						As required
22. To be aware of, and act on, Audit Scotland, national and UK audit findings and inspections/regulatory advice, and to confirm that all compliance has been responded to in timely fashion.	X	TBC	TBC	TBC	TBC	Horizon-scanning activity to be undertaken prior to each APS committee. Any relevant reports and recommendations will be taken to committee.
Review						
9.1 The Terms of Reference will be reviewed every year to ensure their ongoing appropriateness in dealing with the business of the IJB.	X					Included as a standing item for noting at the start of the agenda. Will be reviewed and reported in September 2019.

Duty	2019/20					
	280519	200819	291019	250220	280420	Comments
9.2 As a matter of good practice, the Committee should expose itself to periodic review utilising best practice guidelines.					s	Annual review session

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

Date of Meeting	28th May 2019
Report Title	Transformation Progress Report
Report Number	
Lead Officer	Sandra Ross, Chief Officer
Report Author Details	Gail Woodcock Lead Transformation Manager gwoodcock@aberdeencity.gov.ujk 01224 523945
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	a. Transformation Programme: Acceleration and Pace Highlight Report - Feb – May 2019 b. AC@H Draft Evaluation Report c. House of Care Draft Evaluation Report d. Publication by C Leask & A Gilmartin, (2019), Patients' Perspectives of the INCA Service

1. Purpose of the Report

The purpose of this report is to provide an update on the progress of the Transformation Programme.

This includes a high-level overview of the full transformation programme, and detailed evaluations of two projects within the programme: Acute Care at Home and House of Care.

Finally, the report brings to the attention of the committee the first formal published report produced by the partnership: "Patient's Perspectives of the INCA Service".

2. Recommendations

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

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

a) Note the information provided in this report.

3. Summary of Key Information

3.1. Background

3.2. The Transformation Programme for the Aberdeen City Health and Social Care Partnership (ACHSCP), was updated in line with the refreshed Strategic Plan in March 2019 and consists of the following programmes of activity which aim to support the delivery of the strategic plan:

Transformation Programme of Work	Links to Strategic Aims	Links to Strategy Enablers	Comments
Primary Care Improvement Plan	Resilience Enabling Communities		Agreed by IJB in July 2018 Specific Funding Source.
Action 15 Plan	Prevention Resilience Enabling Communities	Workforce	Agreed by IJB in July 2018 Specific Funding Source.
Alcohol and Drugs Partnership Plan	Prevention Enabling Communities		Agreed by IJB in XX Part of Community Planning Aberdeen's Local Outcome Improvement Plan. Specific funding source.
Locality Development Transformation Programme	Prevention Resilience Enabling Communities Connections		Will capture change actions identified in Locality plans. Will also include significant cross-cutting projects such as Unscheduled Care and Social Transport.
Digital Transformation Programme	Prevention Resilience Enabling Communities Connections	Digital Transformation	Will support the delivery of the Digital Strategy.
Organisational Development	Prevention Resilience	Empowered Staff	Will support the delivery of the Workforce Plan.

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Transformation Programme	Enabling		
Efficient Resources Transformation Programme	Prevention Enabling	Sustainable Finance	Will utilised Lean Six Sigma methodology, working deep within teams delivering services to reduce variation and increase efficiency.
Resilient, Included and Supported Outcome Improvement Plan	Prevention Resilience Communities Connections		Part of Community Planning Aberdeen's Local Outcome Improvement Plan. No specific funding source.

3.3. Work is ongoing to update our reporting processes to align with these new programmes, and as such the attached Acceleration and Pace progress report for the period February to May 2019 (Appendix A), consists of updates covering most but not all of the current programme activity. This report provides a high-level overview of key milestones delivered during the reporting period, along with anticipated key milestones in the next reporting period and any significant issues, risks and changes.

Acute Care at Home

3.4. Acute Care at Home is a significant project which has been under development and implementation since 2016 as one of our major transformation workstreams. Acute Care at home seeks to change the way that specialist medical care is provided for patients. Where previously patients may have been admitted to hospital, work has been underway to shift where care takes place to prevent admission or expediate discharge from hospital.

3.5. A robust interim evaluation has now taken place and is attached at Appendix B. Key findings from this evaluation include:

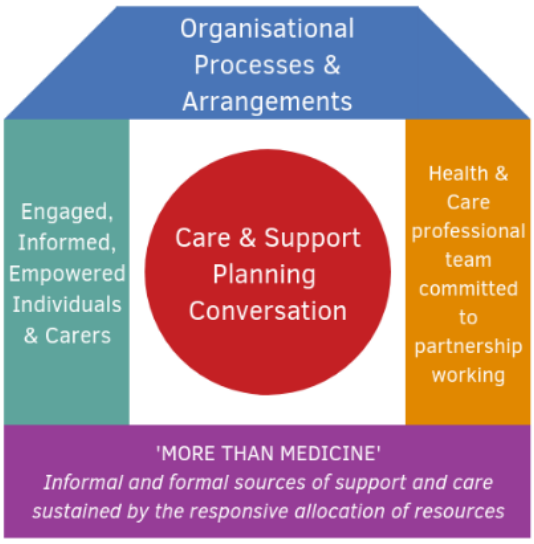
- Acute Care at Home is a feasible model in Aberdeen with care provision appearing to be no less safe than care in hospital.
- Patients, unpaid carer and staff were satisfied with the service.
- Unpaid carers report a preference for having their cared for person supported at home rather than in a hospital setting

- Mechanisms that appear to be integral to model success include; care provision at a vulnerable time for patients, continuity of care, rapid access to resources and the ability to carry out assessments in patients' own home.
- AC@H staff were particularly satisfied with their management style, which was inclusive and non-hierarchical in nature.
- Training opportunities are necessary to upskill staff members but can constrict the level of service provision if carried out during working hours in a small team.
- Co-location can enhance opportunities for partnership working, however, the environment that colleagues are based in also needs to be satisfactory for this to be successful.
- In the absence of Geriatric cover, it may be beneficial to explore other health professionals who could lead delivery a similar service function under the supervision of a GP/Consultant.
- Service purpose and function may be promoted most effectively through maintained relationships that the AC@H team had developed previously.
- For service expansion, consideration must be taken in provision of service covering evenings and weekends and broadening of referral pathways in conjunction with recruiting more staff.

House of Care

3.6. House of Care is a model that seeks to support a care planning conversation between a person and a healthcare professional. It does this through practitioner training which develops a person-centred ethos while building skills and leadership, underpinned by self-management principles. The approach strengthens patient and staff health literacy capabilities and builds knowledge of the relationships the local community assets and resources. The house analogy is used to support and enable people to articulate their own needs and decide on their own priorities, through a process of joint decision making, goal setting and action planning. The house consists of:

- The right hand wall: Health and care professional team committed to shared decision making, partnership working and a 'what matters to you?' conversation
- The left hand wall: Engaged, informed, empowered individuals and carers ready to engage in a 'what matters to you?' conversation
- The foundation: 'More than Medicine' Informal and formal sources of support and care sustained by the responsive allocation of resources
- The roof: Organisational processes, policies, systems and arrangements
- All built around the care and support planning conversation which is at the heart of the house.



3.7. A robust interim evaluation has now taken place and is attached at Appendix C. Key findings from this evaluation include:

- Care and Support Planning (CSP) appears acceptable to both patients and practice staff
- Patients report CSP as superior to traditional care delivery towards self-managing their wellbeing.

- Practice staff report CSP as a valuable method of delivery care to adopt.
- Training to deliver HoC should be provided in a tailored way, ensuring that only relevant content is delivered to the appropriate staff.
- Agility in delivering CSP (for example adapting the length and mode of consultations) may further reinforce a person-centred approach to care delivery.
- Implementation may be facilitated by practices assuming a project-coordination role.
- Embedding a social prescribing approach in General Practice is likely to be a medium-to-longer-term outcome

Published Report: Patients Perspective of INCA Service

3.8. The INCA model sought to test the Buurtzorg principles in Aberdeen: person centred care delivered by a self-managing team. The interim evaluation was considered by the APS committee at their meeting in February. Following on from this evaluation, we are pleased to report that an academic paper considering the service through the views of the public has now been published in the open access journal, AIMS Public Health. (AIMS Public Health, part of the AIMS Press Journal series, is a science organisation publisher based in the United States of America, providing scientific and professional communities with emerging evidence of best practice across the globe.) Formal publication of this nature both gives credibility to the work of Aberdeen City Integration Joint Board, but also highlights the innovative and evidenced approach that is being taken. A copy of this publication is attached at Appendix D.

4. Implications for IJB

4.1. Equalities - Equalities implications are considered on a project by project as well as programme wide basis.

4.2. Fairer Scotland Duty - There are no implications as a direct result of this report.

4.3. Financial - The partnership receives around £20million per year from a range of sources to support its transformation programme. Transformation also impacts on the overall partnership budget of approx. £260million.

4.4. Workforce - Workforce implications are considered at project, programme and overall portfolio levels.

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

4.6. Other - NA

5. Links to ACHSCP Strategic Plan

5.1. The activities within the transformation programme seek to directly contribute to the delivery of the strategic plan.

6. Management of Risk

6.1. **Identified risks(s)**

Risks relating to the Transformation Programme are managed throughout the transformation development and implementation processes. The Executive Programme Board and portfolio Programme Boards have a key role to ensure that these risks are identified and appropriately managed. High level risks to programme delivery and mitigating actions are identified within progress reports reported on a regular basis to the Audit and Performance Systems Committee.

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

The main risk relates to not achieving the transformation that we aspire to, and the resultant risk around the delivery of our strategic plan, and therefore our ability to sustain the delivery of our statutory services within the funding available.

9. Failure to deliver transformation at a pace or scale required by the demographic and financial pressures in the system

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:**

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

This paper brings to the attention of the Audit and Performance Systems Committee information about our programme management governance and reporting processes and specifically detailed financial information about our transformation programme, in order to provide assurance of the scrutiny provided across our programme management governance structure in order to help mitigate against the above risks.

Aberdeen City Health & Social Care Partnership
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Transformation Programme

Acceleration and Pace Highlight Report

Reporting Period: February 2019 – May 2019

- Organisational Development Transformation Programme
- Digital Transformation Programme
- Primary Care Improvement Plan
- Action 15
- Locality Development Transformation Programme
- Efficient Resources Transformation Programme

Highlight Report 7.0

V1.0

Overall Transformation Programme

The Aberdeen City Health and Social Care Partnership's Transformation Programme seeks to deliver the change that is required for the partnership to deliver its strategic priorities. The programme has recently been restructured and this report starts to align the progress reporting with this new structure. Further refinementment will come in subsequent reports.

Overall Programme Expenditure

Our transformation programme seeks to manage increasing demand, and where appropriate release savings, through the development of leaner and smarter systems, and most of our initial work and investment seeks to create the environment which will allow this to happen.

Due to the current process of re-aligning the projects and workstreams in line with the new strategic plan, work is still underway to finalise the overall programme expenditure and this information will be provided in this next transformation progress report.

Abbreviations used throughout the report:

ACHSCP:	Aberdeen City Health and Social Care Partnership
EPB:	Executive Programme Board
ODCC:	Organisational Development & Cultural Change

Organisational Development Transformation Programme

1. Programme Summary and Anticipated Benefits

This **ENABLING** work stream recognises that people are key to delivering our integration and transformation ambitions. The appropriate organisational culture is an essential core building block and we will be unable to successfully embed the transformation we seek without changing the culture of our organisation with the people who make it.

The work is aligned to the strategic priorities of the partnership and will work in a coordinated manner to ensure activities in this work stream support this our "Team Aberdeen" culture to be developed, and support the development of people in the right places and with the right skills and attributes to support people in communities. The work stream also recognises the anxiety many of our staff may feel as we integrate at every point of delivery, aligning with our values of caring, person centred and enabling.

2. Key Milestones during reporting period

Key milestones deliverables	**Planned Date**	**Achieved Date**	**Update**	**Comments**
Anticipated milestones from previous Programme Status Report:				
Heart Awards	1st March 2019	1st March 2019	The awards dinner to recognise staff, community and partner achievements had excellent evaluation and public coverage.	Evaluation of the event has now been carried out and will inform planning for 2020
iMatter	May 2019	May 2019	Completion of the staffing reporting lines for the structures has been completed.	Next phase for questionnaire to be sent and completed.
Workforce Plan "Empowered Workforce" finalised	March 2019	March 2019	Workforce Plan agreed by IJB and published.	Complete.
Training passport outline business case	April 2019	June 2019	Initial scoping meeting with key senior leads held 5th April. Scope and driver diagram to be developed and change ideas to be agreed.	
Career Ready - Internships	Summer 2019		Our first intern has now graduated from the programme at the end of May. Her mentor attended her graduation. Planning has begun to have 2 internships starting for a 4-week placement at start of July.	
Senior Leadership OD development	March 2019	Ongoing	OD work has been engaged by the leadership team to build on relationships and team effectiveness. This work continues and an ongoing schedule and plan is currently being implemented.	

3. Change Control

Change	Impact	
	Budget/Resource	Schedule
Workflow Optimisation budget decrease. Original Budget of £80,998 + VAT	New spend: £68,517+VAT (decrease of £12,481)	No impact on project delivery schedule

4. Issues and Opportunities *New and Update*

The workforce plan was approved by the IJB in March. The plan sets the direction for both OD and workforce plans. The OD and Culture Change Working Group have agreed to prioritise three aims; staff well being; attraction of new staff, retention of current staff. There are strong linkages with ensuring pathways for young people into health and social care from higher education institutions.

Development of the OD plan now includes a wide range of staff and partners tasked with shaping the plan and identifying areas of focus identified by those working across the organisation.

Increased leadership involvement and visibility via attendance at career fairs and visits to local schools to raise awareness and encourage young people into the health and social care sector.

Turas – the national online training and appraisal system for H&SC - is to be made available to independent and 3rd sector colleagues.

5. Major Risks *New and Update*

- No major risks during current reporting period

6. Outlook and Next Period

Anticipated milestones for the coming period include:

- Developing the Young Workforce programme agreement and Career Ready internships in place
- ACHSCP third annual conference date to be released and programme to be issued.
- Shaping of the OD plan by the newly formed staff group.
- Training Passport driver diagram and outline business case.
- iMatter questionnaire to be delivered
- Phase 2 of colocation of staff to Marischal College.
- Teach Back project to be scoped and begun.

Digital

1. Programme Summary and Anticipated Benefits

This programme includes the delivery of a range of projects which aim to improve efficiency and quality of service delivery through digital means.

There are clear links between this enabler work stream and service delivery programmes, including the provider of smart devices to support our workforce directly caring for people in our communities; and the provision of technology enabled care to support people in communities to effectively self manage their long term conditions.

The workstream has been refined over recent months to reflect our developing refreshed strategic plan.

2. Key Milestones during reporting period

Key milestones deliverables	Planned Date	Achieved Date	Update	Comments
Anticipated milestones from previous Programme Status Report:				
Interim Partnership Intranet development	June 2019		Further Development on the ACHSCP Intranet Connect is in progress. Additional content blocks for embedding content to the site and additional document icons have been developed for Word, Excel and Powerpoint. The staff Noticeboard is also progressing after early development issues and its hopeful this will be available in the coming weeks. A request has been submitted for the Intranet to open along with the Zone when ACC Partnership employees access Internet Explorer or Google Chrome.	Further investigation is taking place on the development required to provide a joint directory for NHS and ACC staff.
Business Case developed for replacement for Care First.	March 2019	ongoing	Initial Business Case considered by IJB. Further work is ongoing to explore the possibility of utilising Microsoft tools available inhouse (ACC). At the same time, work is ongoing to identify firmer cost benefits potential with the marketplace.	Planned to report back to IJB in August 2019.
Mobile devices	May 2019	Ongoing	Community Nursing are testing a proof of concept for mobile working, utilising lightweight laptops with 3g/4g sim cards.	
Digital collaboration with intranet diaries and file sharing etc.	Phase 1: April 2019	ongoing	Skype federation is now in place. NHSG is part of a national framework to implement O365 which will give shared calendars files etc.	It is expected that the earliest date where NHSG will be in a position to federate will be at the end of the year 2019
Implementation	May	ongoing	GovRoam is now available within	The solution is

of GovRoam (a public sector wifi solution).	2019		Council buildings for NHS staff and vice versa at NHS. Technically it does and can work for all staff. However, there are some performance issues with NHS at ACC buildings which are being investigated.	anticipated to take some time to achieve.
Clinical Care and Governance complaint process review	March 2019	ongoing	Reviewing the processes for recording complaints and clinical governance across ACC and NHSG and how these can be effectively reported upon.	Delay due to review of scope and investigation into falls data.
Leadership team Office 365	May 2019		Initial investigation work completed to enable the ACHSCP Leadership team to have access to O365. NHS members have been issued with ACC credentials to enable them to access through the ACC solution YourDesktop. Requirements gathering for devices is progressing to enable easier access to Office 365 for the Leadership team NHS colleagues.	
Hunchbuzz / Our Ideas replacement	April 2019	May 2019	The current Our Ideas (Hunchbuzz) contract expired on the 30th April 2019. Interim replacement solution is now in place to allow staff to submit ideas through simple "Forms" solution.	Due to federation issues with NHS and the blocking of Office 365, further investigation is required to ensure NHS colleagues can access the Ideas Hub replacement.
Other milestones delivered				
Scottish Government funding award – TEC Pathway Programme	April 2019	ongoing	£195,000 awarded to partnership to further investigate the current recovery pathways for survivors of abuse: • who our key stakeholders are and what the key components of support are for this key vulnerable client group • how demographics and social determinants of health play or contribute to the incidence and occurrence • map and identify local, regional and national research and intelligence • what the benefits of current services and supports are to service users and service providers and what is missing.	Awaiting further direction in relation to national reporting. Project Group and Governance processes to be finalised following national launch in June 2019. Project will be progressed in partnership with ACVO.
Health Visitor Digitialisation Options Appraisal	June 2019		This project seeks to procure and implement an solution for Health Visiting teams to allow them to work in a digitally mobile manner, in order to reduce current operational risks and issues.	

			Currently undertaking business analysis with the service and meeting with suppliers to build an options appraisal.	
TEC National Scale Up of BP Home Health Monitoring Programme (Florence)	April 2020	ongoing	Bid for funding has been successful which will see the scale up of the Blood Pressure Home Health Monitoring Project called 'Florence' across the three partnerships in Grampian.	Project is led by Aberdeenshire HSCP.

3. Change Control

Change	Impact	
	Budget/Resource	**Schedule**
NA		

4. Issues and Opportunities *News and Update*

Funding awarded (£195,000) to support TEC pathway work over next 2 years.
Funding awarded to support scale up of Florence.

5. Major Risks *New and Update*

6. Outlook and Next Period

Anticipated milestones for the coming period include:

- Health & Social Care Case load Management (Carefirst replacement) revised business case complete
- Interim device solution for health visitors options appraisal complete
- Office Move – Phase 2 underway/ complete

Primary Care Improvement Plan

1. Programme Summary and Anticipated Benefits

This workstream includes projects, improvements and strategies to support the introduction of the new GP contract and the delivery against commitments set out in the underpinning Memorandum of Understanding (MOU) between Scottish Government and GPs.

The vehicle to support this change is the Primary Care Improvement Plan which seeks to provide additional support to GPs so that their capacity can be released thus enabling them to develop their role from General Practitioner to that of Expert Medical Generalist.

The key areas outlined in the MOU are:

- Vaccinations
- Pharmacotherapy Services
- Community Treatment and Care Services
- Urgent Care
- Additional Professional Roles
- Community Link Practitioners

2. Key milestones during reporting period

Key milestones deliverables	Planned Date	Achieved Date	Update	Comments
Aberdeen Links Phase two Link Practitioners recruited, and in post resulting in full roll out of Aberdeen Links Service across all 29 GP Practices in Aberdeen	March 2019	March 2019	10 additional Primary Care Link Practitioners started in post on 4th March and started taking referrals as of the 1st April	Referral information available in appendix A of this report A further 3.15 Link Practitioners have been recruited in April and will be in post by July 2019, taking the service up to its full complement (20.8)
House of Care (HoC) cohort 3 practice recruitment complete	March 2019	March 2019	4 practices recruited for Hoc cohort three. 2 practices commenced training in April 2019, with a further 2 to commence training in May 2019.	
Workflow Optimisation	Dec 2019	Implementation ongoing	After a competitive tendering process, provider has been appointed. Implementation on target.	Roll-out of system to practices underway through training, support and development workshops.
'**Additional Professional Roles'**	March 2019	March 2019	MSK FCP and Psychological Therapists (PT) generated first 6 month operational data set presented and reviewed informing future delivery planning	PT service is city-wide, data used for service improvement / demand management.

3. Change Control

Change	Impact	
	Budget/Resource	Schedule
Alignment of Acute Care at Home to Modernising Primary and Community Care Programme	No impact	No impact
Extension of Community Link Working Contract with SAMH for the provision of Link Practitioners in GP practices to a total of 4 years, new end date 07/01/2022 (approved by IJB 26th March 2019)	No impact	No impact

4. Issues and Opportunities *New and Update*

An update event was held to update all GP practices in the city – 55 participants representing all GP practices in Aberdeen City attended. Required review of PCIP is currently progressing – planned to report to IJB in June 2019.

5. Major Risks *New and Update*

There is a risk that full implementation of commitments under Memorandum of Understanding between Scottish Government and GPs will not be deliverable with corresponding resource allocated through the Primary Care Fund.

There is a risk that we will not be able to recruit enough qualified staff to support implementation of commitments under Memorandum of Understanding between Scottish Government and GPs.

Data sharing continues to be a challenge for link workers. Work is ongoing with NHSG and ACC to ensure appropriate information sharing and data processing agreements are in place.

6. Outlook and Next Period

Anticipated milestones for next reporting period include:

- Expansion of Musculoskeletal (MSK) Physiotherapy First Contact Practitioner Role
- Workforce Optimisation System live across the city
- Revised Primary Care Improvement Plan developed, consulted on and approved through IJB
- Aberdeen Links Service up to full complement of Link Practitioners across Aberdeen City
- Training completed by House of Care cohort 3 practices

Action 15

1. Programme Summary and Anticipated Benefits

Action 15 is part of the Scottish Government's Mental Health Strategy 2017-2027, which maps out a 10-year vision to improve mental health services across Scotland.

Action 15 – one of 40 'actions' in the strategy – aims to grow the mental health workforce across the country so that people can get the right help, at the right time in the right place. Specifically by increasing the number of mental health workers to give better access to dedicated mental health professionals to Accident & Emergency, all GP practices, the police station custody suite, and to our local prison.

2. Key milestones during reporting period

Key milestones deliverables	Planned Date	Achieved Date	Update	Comments
Anticipated milestones from previous Programme Status Report:				
Community Chaplaincy Listening (CCL) Service Business Case Approved	March 2019	March 2019	Approval by ACHSCP IJB on 26th March to appoint Community Chaplaincy Listening Service Coordinator (CCLSC)- P/T 0.5FTE in year 1 and 2 increasing to 1 FTE in year 3 and 4 to support growth in programme	This project is linked to the Primary Care Improvement Plan
CCL coordinator recruited	December 2018	ongoing	CCL post is currently live.	Anticipated that someone will be in post by the end of Summer 2019

3. Change Control

Change	Impact	
	Budget/Resource	Schedule
n/a		

4. Issues and Opportunities *New and Update*

With cross agency and community models of working data sharing will potentially be an issue for increasing access to mental health services in key settings, with regards to the sharing of information with individuals. There are also several overlaps with other projects such as the ADP Custody Link Worker project, which present opportunities and challenges within a complex landscape.

5. Major Risks *New and Update*

There is a risk of time slippage to deliver projects due to scoping of several options and then potential tendering for services which can be lengthy and convoluted. Workstreams have been set up to help mitigate against this risk.

6. Outlook and Next Period

Anticipated milestones for the coming period include:

- To develop evidence based models and update and finalise business cases for the key projects.
- Community Chaplaincy Listening Service Coordinator recruitment complete.

Locality Development Transformation Programme

1. Programme Summary and Anticipated Benefits

This workstream includes a range of projects, improvements and strategies to support the implementation of integrated locality working.

The benefits of integrated operational working include:

- Improved outcomes for local residents and communities through collaboration, co-location and integration of services
- Improved customer focus through strategic data-sharing and delivery planning.
- Enhanced and purposeful alignment between wider locality plans and smaller area plans.
- Establishment of empowered integrated multi-agency teams to manage demand at a local level
- Development of a cross-system response to complex issues like obesity and population-wide public health priorities.
- Appropriate teams to be based together, guiding what is planned and progressing initiatives by involving a range of staff teams and partner organisations.

2. Key milestones during reporting period

Key milestones deliverables	Planned Date	Achieved Date	Update	Comments
Unscheduled care: Development of operating model and business case covering Unscheduled Care (UC)(incorporating Acute Care at Home and Unscheduled Visiting Service); GP and public engagement session on development of Unscheduled Care approach	April 2019	ongoing	Business Case development underway. Testing ability to integrate UC model articulated in business case within wider primary care system thus enabling spread and scale-up through MDTs.	Business Case to be presented at August IJB. Work is progressing slower than anticipated due to emerging complexities.

Social Transport demand responsive transport and booking office review completed with initial findings and recommendations which inform commissioning plan for next 3 years	Jan 2019	ongoing	Business Case approved by IJB in August 2018. Competitive tendering process for transport element to take place under new Aberdeen City Council transport providers framework	
Care about Physical Activity (CAPA)	March 2019	March 2019	CAPA Engagement Event took place with care homes and care at home providers on 5th March CAPA learning event planned for 10th May to help inform further development of programme in Aberdeen	Leads have been identified within ACHSCP and Scottish Care to take this work forward
Scotland's Service Directory (SSD)	December 2018	May 2019	Work progressing to capture city information live on digital platform ongoing.	Project live date moved to May 2019 due to national delay in the integration between ALISS (A Local Information System for Scotland) and SSD information.
Completing the Puzzle – Service Mapping	March 2019	ongoing	Working with Health Improvement Scotland (HIS) we have seen the development of a service map for older people services in Aberdeen (see appendix 1). A template has also been created to allow the development of other service maps for other priority services areas.	Following the Completing the Puzzle event in November a further service mapping event was planned for March 2019. This has been delayed due to the national delay in the integration between ALISS and SSD information
Agreement to move to 3 Localities	March 2019	March 2019	Approved by IJB March 2019.	Further work ongoing to plan next steps.

3. Change Control

Change	Impact	
	Budget/Resource	Schedule
N/A	-	-

4. Issues and Opportunities *New and Update*

None to report at current time.

5. Major Risks *New and Update*

None to report at current time.

6. Outlook and Next Period

Anticipated milestones for next reporting period include:

- Testing of a Single Point of Contact / Access in city.
- Workforce modelling for establishing MDTs
- Scotland's Service Directory 'live' in Aberdeen City
- Care about Physical Activity delivery plan developed for Aberdeen City.
- Localities position statement in place.

Efficient Resources Workstream

1. Programme Summary and Anticipated Benefits

In line with the Partnership's Medium-Term Financial Strategy (approved by IJB on 13 February 2018), a number of themed working groups have now been established with specific savings targets linked to each of these work streams.

These work streams would report on progress on a monthly basis through the Transformation Programme Management Governance Structure. A lead officer, responsible for reporting to the Programme Boards, has been identified for each work stream.

The anticipated benefits are cashable financial savings:

Work Stream	Savings Target				
	2018/19 £'000	2019/20 £'000	2020/21 £'000	2021/22 £'000	2022/23 £'000
Theme 1: review of pricing/ charging policies across the partnership	0	(300)	(300)	(300)	(300)
Theme 2: Review processes and ensure that these are streamlined and efficient: Direct Payments Cards; Financial Assessment Processes	(250)	(250)	(250)	(250)	(250)
Theme 3: Review of out of hours service	(400)	(100)	(100)	(100)	(100)
Theme 4: Review out of area placements	0	0	(500)	(500)	(500)
Theme 5: Bed Base Review	0	0	tbd	tbd	tbd
Theme 7: 3rd Party Spend	(250)	(500)	(500)	(500)	(500)
Theme 8: Prescribing/ Medicine Management	(200)	(1,000)	(1,000)	(1,000)	(1,000)
Theme 9: Service Review	0	(2,692)	(2,460)	(1,985)	(2,274)

In addition to these specific workstreams, in recognition of the learning achieved to date through our transformation programme and as we move forward to our next phase of transformation in line with our refreshed strategic plan, work is ongoing to utilise Lean Six Sigma methodology to improve business processes and sustainability – this will in turn positively contribute to our medium term financial plan.

2. Key milestones during reporting period

Key milestones deliverables	Planned Date	Achieved Date	Update	Comments
Learning Disability Transport	June 2019	ongoing	Initial investigation found lack of process or information around which (if any) clients were in receipt of double funding. Process improvements around accessing this information as part of assessment and transport planning identified and in development	Introduction of Contributing to your Care Policy, Financial Assessment processes are key dependencies.

Prepaid card	April 2019	ongoing	Pre-paid Financial Card service provider currently being procured – procurement process currently live.	Expiry of Surrey Framework in February extended timeline for procurement vis alternative framework.
Social Work Financial Assessments	May 2019	ongoing	Project continues to focus on reducing the lead time for a financial assessment for residential care clients. The team agreed scope and deliverables. Baseline data has been collated staff survey is being gathered and change ideas presented. The next workshop looks to develop PDSA cycles.	
Sexual Health Services	May 2019	ongoing	Project to focus on delays/ barriers to people accessing Sexual Health Services. Initial meetings held in Feb 2019. Workshop to kick-off project planned for June 2019.	Capacity within the Sexual Health Team has meant this project was put on hold until June 2019 (revised commencement date) – expected to be concluded November 2019.
School Immunisation Programme	May 2019	ongoing	Project is focused on releasing immunisation team capacity, by reducing administrative tasks associated with immunisation prep work to enable them to focus on value added tasks.	Process has been mapped and base line data is being collected to inform improvements.
Nursing – increasing patient facing time	May 2019	ongoing	Project has included working with nursing teams to identify processes, wastage, improvements. Improvements are now in process of being implemented and revised measurements will then be taken.	

3. Change Control

Change	Impact	
	Budget/Resource	Schedule
No changes in current reporting period.		

4. Issues and Opportunities *New and Update*

No new issues or opportunities during current reporting period.

5. Major Risks *New and Update*

No major risks during current reporting period.

6. Outlook and Next Period

Anticipated milestones for next reporting period include:

- First 5 projects using lean six sigma methodology mostly complete (with findings) by end of June 2019 – celebration showcase event to take place.
- Next round of projects identified, and initial work commenced

Document Location This document is only valid on the day it was printed and the electronic version is located with the document owner (Lead Transformation Manager)

Document Status The current status for this document is ***Final***

Distribution This document has been distributed as follows

Name	Responsibility	Date of issue	Version
APS consultation list	S Gibbon	15/5/19	V7.0

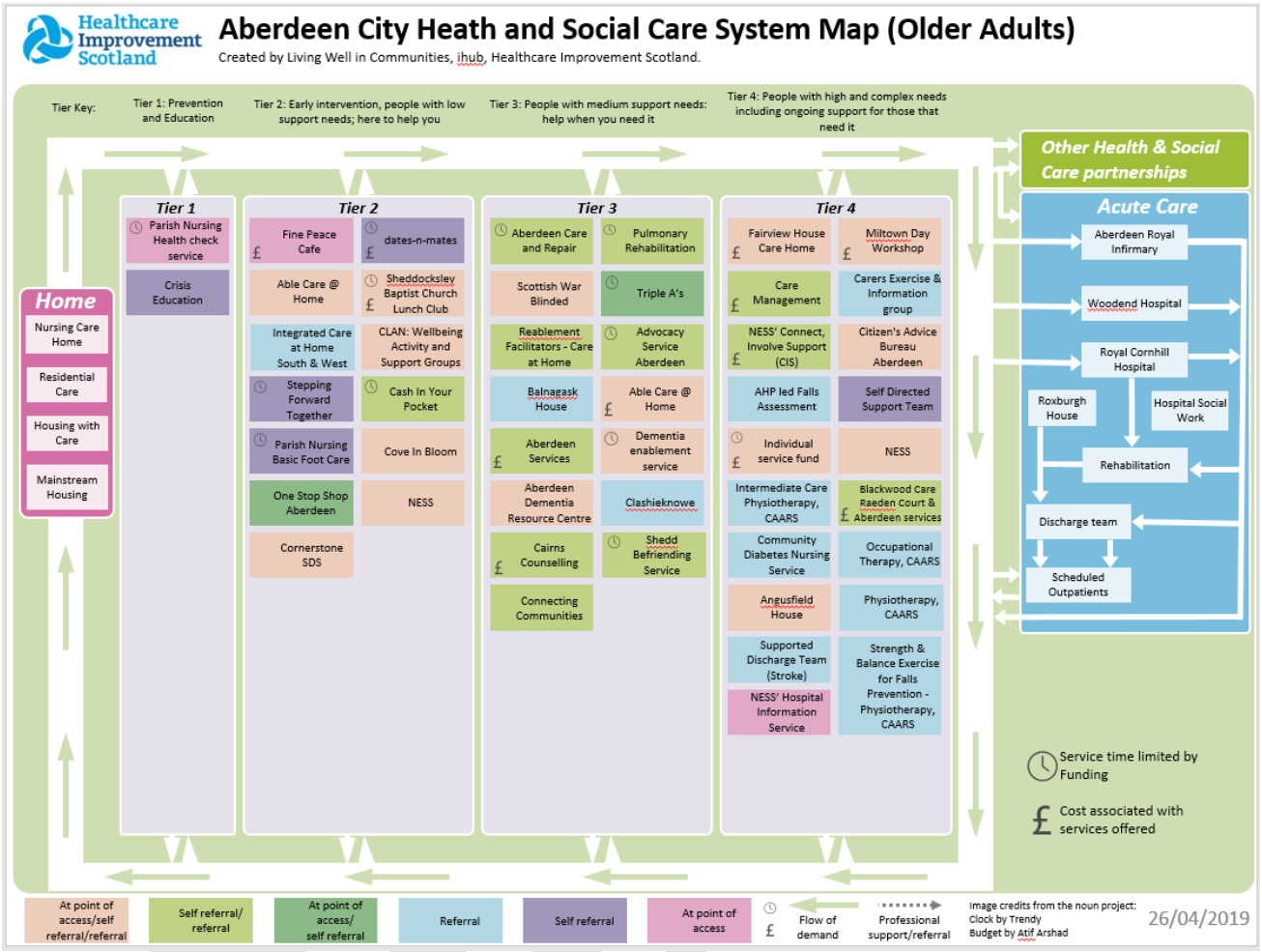
Purpose

The purpose of a Highlight Report is to provide the Integration Joint Board/ Audit and Performance Systems Committee/ Executive Programme Board with a summary of the stage status at intervals defined by the board. The board will use the report to monitor stage and project progress. The Lead Transformation Manager (who normally produces the report) also uses the report to advise the Project Board of any potential problems or areas where the Board could help.

Quality criteria

- Accurate reflection of checkpoint information
- Accurate summary of Risk & Issue Logs
- Accurate summary of plan status
- Highlighting any potential problem areas

Appendix 1 (Aberdeen City Health and Social Care System Map - Older Adults)



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Acute Care at Home (AC@H) Test of Change

Evaluation Report

April 2019

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Executive summary

Background

To meet increasing demographic and economic challenges, health and social care delivery may require adaptation. One priority is shifting the provision of care from an acute to community settings, with the intention of reducing pressure on hospital beds. A model receiving increasing interest is 'Hospital at Home' (H@H), in which patients receive acute care, usually provided in hospital, in their own home. Prior models predominantly utilise one of two distinct admission pathways: alternative to admission (referrals from community in order to prevent a hospital admission) and supported discharge (referrals from hospital settings to return home sooner and receive the final part of their hospital care at home). These models have demonstrated positive impact at patient and systems levels, however the model was yet to be tested within Aberdeen City.

This report describes the evaluation of a H@H model adapted to the local context and described as 'Acute Care at Home' (AC@H). The aims of this evaluation were to test feasibility, understand service perceptions and to explore mechanisms integral for implementation and scalability.

Methods

The AC@H service became operational in June 2018. The multidisciplinary team consisted of an Advanced Nurse Practitioner, Occupational Therapist, Physiotherapist, 2 x Pharmacy Technicians (covering 0.5 wte) and 5 x Healthcare Support Workers. Issues in recruitment of the Consultant Geriatrician resulted in the supported discharge model being predominantly utilised.

The evaluation framework was co-created in one workshop with the project team. Service data collected included: caseload characteristics (including referral source, number of admissions, care provided and location of discharge). Patient data collected included: patient location 90 days following AC@H admission, re-admission rates, satisfaction questionnaire responses and two detailed case studies. Staff level data collected included a satisfaction questionnaire and semi-structured interviews. A satisfaction survey was also completed by unpaid carers and staff interacting with the service.

Results

Results described are inclusive of the first six months of service operation (12/06/18 - 12/12/18).

Service perspective: There were a total of 84 admissions to the service, most of which were from GAU (Geriatric Assessment Unit) using the early discharge model (67%) and consisted of older adults with frailty requiring support following hospital discharge. The majority of the caseload were referred due to mobility concerns or other functional assessments, with social input predominantly provided such as equipment provision and personal care.

In comparison to a GAU admission, more patients from AC@H were living at home 90 days following AC@H discharge (2.5% more) and lower mortality rates were reported (6.8% less), suggesting the service is no less safe than usual care.

In order to address medical recruitment challenges, AC@H staff identified a solution to better utilise GPs and other health professionals. It was also identified that referral pathways and operating hours would require expansion for service scaling. IT system issues included AC@H staff not gaining access to all the systems required to plan patient care effectively.

Patient perspective: Patients were highly satisfied with the service (average score 4.1/5), particularly that they felt confident in the team (average score 4.5/5). AC@H staff identified that it was reassuring for people to receive care at a vulnerable time period transitioning from hospital to home and that continuity of staff facilitated relationship building. Potential mechanisms in model success include: rapid access to care and resources, the ability to carry out assessment in a home environment.

Unpaid carer perspective: The majority of unpaid carers were family members (88%), and reported a preference to having their cared for person supported at home as opposed to in hospital (average score 4.3/5), resulting in reductions in self-reported stress levels (average score 4.4/5).

Staff perspective: The AC@H team were satisfied with their job (average score 73%), and a positive team dynamic was present, facilitated by management staff who demonstrated a more inclusive, non-hierarchical management style. Staff were highly satisfied with training provided although, it should be clearly noted, the quantity of training provided limited admissions entering the service.

AC@H Staff overall had a positive experience working other teams. Co-location supported relationship building, however there was dissatisfaction with the office environment. Most AC@H staff had pre-existing relationships that they could engage with which improved intra-professional collaboration. Staff interacting with AC@H also report high satisfaction with the service overall (average score 79%). AC@H staff reported that interacting organisations viewed their service function to address social care needs.

Discussion and recommendations

The service appears no less safe than usual care and satisfactory to patients, unpaid carers, staff and interacting organisations, primarily due to rapid access to care and resources in facilitating reablement. A predominantly transformative management style may have enabled strong team dynamic. Training needs to be managed so that staff can be sufficiently upskilled to deliver a high quality care without negatively impacting service provision. Co-location can be successful, but requires that the office environment is also satisfactory for a sustained benefit. The team's network of pre-existing relationships may be a tool to promote service function, which is described as often mistaken. In the absence of consultant geriatric cover, there are many other health professionals that could be utilised in delivering a comparable service. If there are adequate solutions to ensure the team can access information on both acute and community systems, this will enhance effective patient care coordination.

Key points

- Acute Care at Home is a feasible model in Aberdeen with care provision appearing to be no less safe than care in hospital.
- Patients, unpaid carers, staff and staff interacting with AC@H were satisfied with the service.
- Unpaid carers had a preference for having their cared for person treated at home rather than in hospital and that this reduced their stress levels.
- Mechanisms that appear to be integral to model success include; care provision at a vulnerable time for patients, continuity of care, rapid access to resources and the ability to carry out assessments in patients' own home.
- Having a more inclusive management style which is non-hierarchical in nature appears to lead to high staff satisfaction.
- Prioritisation between service operation and staff upskilling should be identified – both cannot progress simultaneously.
- Co-location can enhance opportunities for partnership working, however, the environment that colleagues are based in also needs to be satisfactory for this to be sustainable.
- Considering localised recruitment challenges, theoretically-sound models of care delivery should be sought out and adapted to deliver locally to account for these challenges.
- In order for service expansion, broadening of referral pathways and operational hours is necessary, in conjunction with more staff delivering the AC@H approach.

1. Introduction

Scotland's demographic climate is changing, with predictions the population of 65-74 years will increase by 17%, and over 75 years by 79% in the next 25 years[1]. As a result acute services are becoming increasingly challenged, with unscheduled hospital admissions rising primarily from those over 65 years[2]. Furthermore, over 75 years olds make up the majority of delayed discharges from hospital (69%)[3]. Inefficiencies are predominantly due to a lack of resources available in the community which are able to provide escalated levels of care in situations of temporary decline or ill health[4]. The financial environment is also tightening, with Health Boards pushed to make savings of £449.1 million in 2017/18 despite increasing operational costs[5]. It is well recognised nationally that continuing to use current models of health and social care delivery is unsustainable. From a patient perspective, treatment in hospital may not always be the best environment for frail older adults, with potential risks such as functional decline due to immobility[6] and acquiring infections[7], rising with increasing length of stay.

A local[8] and national[9] approach to tackle these challenges is to shift the balance of care from acute settings into the community, with the aim of alleviating pressure on hospital beds. One model of care receiving increasing interest is Hospital at Home (H@H), characterised by providing acute care, which would usually be provided in a hospital setting, in an individual's own home. A coordinated multi-disciplinary team of health professionals provide active treatment for a time limited period, typically between 1 and 7 days. Support from friends, family members and other unpaid networks is an important element to provide patient care in their own home[10]. The model can be categorised by two separate elements and typically when implemented, the focus of care is on one of these two elements. Patients may be admitted through primary care services (e.g. GP) or the emergency department (ED), to receive acute care at home and avoiding a hospital admission (alternative to admission). Patients can also

[1] National Records of Scotland (2017). Projected Population of Scotland (2016-based). National Population Projections by sex and age with UK comparisons. Edinburgh: Scottish Government.
[2] ISD (2018). Acute Hospital Activity and NHS Beds information in Scotland. Annual Year ending 31st March 2018. Information Services Division Scotland.
[3] ISD (2018). Delayed discharges in NHSScotland: Annual summary of occupied bed days and census figures. Figures up to March 2018. Information Services Division Scotland.
[4] Scottish Government (2016). A national clinical strategy for Scotland. Edinburgh: Scottish Government.
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[6] Hoogerduijn, J. G., et al. (2007). A systematic review of predictors and screening instruments to identify older hospitalized patients at risk for functional decline. *Journal of Clinical Nursing*, *16*(1), 46-5
[7] Hussain, M., et al. (1996). Prospective survey of the incidence, risk factors and outcome of hospital-acquired infections in the elderly. *Journal of Hospital Infection*, *32*(2), 117-126.
[8] Aberdeen City Health & Social Care Partnership. (2019). Aberdeen City Health and Social Care Partnership Strategic Plan 2019-22. Available from: https://www.aberdeencityhscp.scot/globalassets/strategic-plan-2019-2022.pdf [accessed 11/03/19].
[9] Scottish Government (2013). A Route Map to the 2020 Vision for Health and Social Care. Edinburgh: Scottish Government.
[10] Shepperd, S., et al. (2009). Early Discharge Hospital at Home. *Cochrane Database of Systematic Reviews*, 1.

be admitted from an acute hospital ward, being discharged early to receive the final part of their acute care with the H@H team (active recovery on discharge)[11].

H@H has demonstrated promising results such as reducing length of stay in hospital, with one study demonstrating a 62% shorter stay than those treated in hospital for comparable conditions[12]. Evidence has also shown a reduced risk of living in an institutional setting one year following care[13]. High service satisfaction rates has been reported with 95% of patients and 98% of relatives stating they would recommend the service to others[14]. Reasons reported by patients include being able to receive care at home, receiving frequent visits following hospital discharge when anxiety was high and being actively involved in their treatment plan. In addition, staff felt the provision of rehabilitation at home improved patient engagement[15].

This report describes the evaluation of the H@H model in Aberdeen City, which was adapted and described locally as Acute Care at Home (AC@H, described in the methods section). The aims of this evaluation were; 1) to test feasibility of the H@H model in the local context, 2) to understand service perceptions from multiple perspectives and 3) to understand integral mechanisms necessary for model success and scalability.

[11] Shepperd, S., et al. (2016). Admission avoidance hospital at home. *Cochrane Database of Systematic Reviews*, 9.
[12] Richards, S. H., et al., (1998). Randomised controlled trial comparing effectiveness and acceptability of an early discharge, hospital at home scheme with acute hospital care. *British Medical Journal*, *316*(7147), 1796-1801.
[13] Gonçalves-Bradley, D.C., et al. (2017). Early discharge hospital at home. *Cochrane Database of Systematic Reviews*, 6.
[14] Harris, R., et al. (2005). The effectiveness, acceptability and costs of a hospital-at-home service compared with acute hospital care: a randomized controlled trial. *Journal of Health Services Research & Policy*, *10*(3), 158-166.
[15] Cunliffe, A. L. et al., (2004). Sooner and healthier: a randomised controlled trial and interview study of an early discharge rehabilitation service for older people. *Age and Ageing*, *33*(3), 246-252.

2. Methods

2.1 Service Design

The Acute Care at Home (AC@H) project was funded by Aberdeen City Health and Social Care Partnership's Integrated Joint Board as part of a transformation programme to redesign local services. The service became operational on 12/06/18 and was based at Links Resource Centre, City Hospital (Aberdeen City Centre, Central Locality). The multi-disciplinary team consisted of 1 x Advanced Nurse Practitioner (ANP), 1 x Physiotherapist (PT), 1 x Occupational Therapist (OT), 5 x Health Care Support Workers (HCSWs), 2 x Pharmacy Technicians (PTech, covering 0.5wte post) and overseen by a Team Leader (TL). The AC@H theoretical model follows two distinct patient pathways of activity described previously: 1) alternative to admission and 2) supported discharge. Due to recruitment challenges (described in the results section), the first six months of service operation predominantly utilised the supported discharge model (Appendix A). In December 2018, the service begin receiving referrals from GPs from one locality (West) through the alternative to admission pathway (Appendix B). Inclusion criteria consisted of those over 75 years, either requiring assistance or managing independently with personal care and where support was required during their acute need (or following recovering of an acute condition) e.g. nursing, therapy input was necessary.

2.2 Data collection and analysis

2.2.1 Evaluation framework development

The evaluation framework was developed through a co-creation workshop, informed by theory described elsewhere[16]. A Research & Evaluation Manager and a Public Health Researcher facilitated the four hour workshop with a range of key stakeholders (Table 1) from the project team prior to the service go live date (April 2018). The workshop was separated into two parts: 1) what key outcomes the project would achieve; and 2) how these outcomes would be measured.

In the first part of the workshop, co-creators discussed and agreed which key outcomes should be measured to determine project success. Two types of evaluation were explored; 1) process evaluation (considering the project's implementation); and 2) outcome evaluation (considering the impact of the project on patients, informal carers, staff and at a service level). A scoping review was carried out prior to the co-creation workshop which was presented to co-creators to initiate conversation and stimulate thinking around appropriate measures. Examples from previous literature, for each target group, were presented and co-creators discussed in small groups which outcomes would be important to measure. Ideas were fed back to the wider group and facilitators provided support to identify and prioritise which key components to be measured.

[16] Leask, C. F. et al. (2019). Framework, principles and recommendations for utilising participatory methodologies in the co-creation and evaluation of public health interventions. *Research Involvement and Engagement*, *5*(1), 2.

The second part of the workshop considered how the outcomes agreed in part 1, would be practically measured (e.g. when, how and who would collect relevant data). Facilitators provided co-creators with information about methods to measure outcomes (e.g. interviews, focus groups and questionnaires) and (dis)advantages to each approach. Co-creators discussed possible approaches in small groups and fed back ideas to the larger group. Facilitators supported in reaching collective agreement on how components would be measured. The information from the workshop was used to develop the project evaluation framework.

The framework developed was an idealistic representation of the evaluation that could be carried out. The complex nature of the new service meant it was necessary that the framework was agile and could adapt if and when circumstances or need changed. There was both acknowledgement and agreement from the co-creators that the developed framework may be required to be adapted once the service had been implemented.

Table 1. Co-creation workshop attendees (N=10)

Workshop Attendees
Research Manager x 1
Public Health Researcher x 1
Team Leader x 1
Senior Healthcare Support Worker x 3
Occupational Therapist x 1
Advanced Nurse Practitioner x 1
Consultant Geriatrician x 1
Transformation Programme Manager x 1

2.2.2 Service level data

Service level data collected included: caseload (total and by month), patient characteristics, length of stay (days), referral reason & source, discharge location and type of input provided.

2.2.3 Patient data collection

Patient location at 90 days was measured (e.g. in a hospital-setting/non-hospital community-setting/deceased). To provide context to these numbers, figures from GAU for the comparable time period were also gathered.

Patient satisfaction was measured using a satisfaction questionnaire which was completed by patients on discharge from AC@H (Appendix C). The questionnaire consisted of four components; 1) overall satisfaction; 2) recommendations to others; 3) confidence in the AC@H

team: and 4) coordination of care. Overall satisfaction was measured using a 10 point Likert scale (1-extremely unsatisfied to 10 – extremely satisfied) and the other components were measured on a 5 point Likert scale (strongly agree-strongly disagree). Qualitative responses were also captured to supplement this data.

Two detailed patient case studies were carried out by AC@H staff which described each patient's experience with the AC@H service (including background, treatment provided and outcomes).

2.2.4 Unpaid carers experience

Unpaid carers' satisfaction with the service was measured using a questionnaire completed on patient discharge (Appendix D). Caseload characteristics were recorded (e.g. gender, age, relationship, time spent in caring role). Components assessed included how key constructs regarding perceived skill and knowledge attainment from the AC@H team, signposting to community assets, and whether responders would prefer individuals to be supported in a hospital or non-hospital setting. Constructs were measured on a 5 point Likert scale (strongly agree-strongly disagree).

2.2.5 AC@H staff measures

Individual interviews were conducted with staff members involved in delivering or managing the service (N=13). Interviews were semi-structured and followed a topic guide to stimulate discussion around their experience working in the new service (Appendix E). The topic guide covered four broad themes: 1) overall experience; 2) enablers to service implementation; 3) barriers to implementation; and 4) considerations for scaling (for topic guide, see supplementary material). Interviews were audio recorded and lasted no longer that 60 minutes. Field notes were taken by the interviewer during the interview, if necessary, for reference during data analysis.

Audio recordings were transcribed verbatim using internal audio typists, and were analysed thematically using NVivo software. Thematic analysis is a method of identifying patterns in data around a specific area of interest, in this case, staff experience of working in the AC@H team[17]. Data analysis using this approach, described by Braun and Clarke[18] follows a six step framework: 1) data familiarisation; 2) initial code development; 3) searching for themes; 4) reviewing of themes; 5) defining themes and 6) results write up. Two researchers independently analysed the data then compared findings and made adaptations, where necessary, until agreement was reached.

Interviews were supplemented with a questionnaire comprised of numerous constructs of interest that would impact on the implementation of the service (Appendix F). These included: perceived development opportunities; workload; team working and communication.

[17] Maguire, M & Delahunt, B. (2017). Doing a thematic analysis: a practical, step-by-step guide for learning and teaching scholars. *AISHE-J*; 9(3).
[18] Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research Psychology*, 3(2), 77-101.

A questionnaire was also distributed to staff interacting with AC@H, including other health and social care professionals (Appendix G). Responders assessed the AC@H communication qualities, referral process and overall satisfaction of their collaborative experience.

3. Results

3.1 Service overview

3.1.1 Caseload characteristics

To provide consistency, the results described were collected for the first six months of service operation (12/06/18 - 12/12/18) unless otherwise stated.

Table 2 displays characteristics of the AC@H caseload. There were approximately even numbers of male and females using the service, of which the majority were older adults. There was a roughly even split of those entering the service from the most affluent (SIMD 4 & 5, 47.6%) and most deprived areas (SIMD 1 & 2, 34.2%). Days spent in the service and number of visits required ranged widely possibly explained by variability in number of previous medical conditions reported, implicating a range of differing levels of need present in the caseload.

Table 2. Characteristics of AC@H caseload

Characteristic	Total
Caseload, N	84
Female, N (%)	54.8 (45.2)
Age, mean (range)	86.2 (67-102)
SIMD Scores N (%)	
1	9 (10.7)
2	19 (22.6)
3	6 (7.1)
4	10 (11.9)
5	31 (36.9)
Not reported	9 (10.7)
Caseload days, mean (range)	5.2 (1-17)
Mileage, mean (range)	4.1 (1-7)
Travel time per visit, minutes, mean (range)	14.6 (5-30)
Number of visits per patient (mean, range)	5 (1-21)
Admissions per month, mean (range)	14.1 (4-20)
Previous conditions reported, mean (range)	4 (1-10)
Disciplines inputted into care, mean (range)	1.6 (1-4)

NB: SIMD = Scottish index of multiple deprivation with scores from 1 (most deprived) to 5 (least deprived)

3.1.2 Admissions

The number of service admissions by month is described in Figure 1. Data is inclusive of 12/06/18 – 31/12/18, with only half a month of data presented for June when the first admission was received.

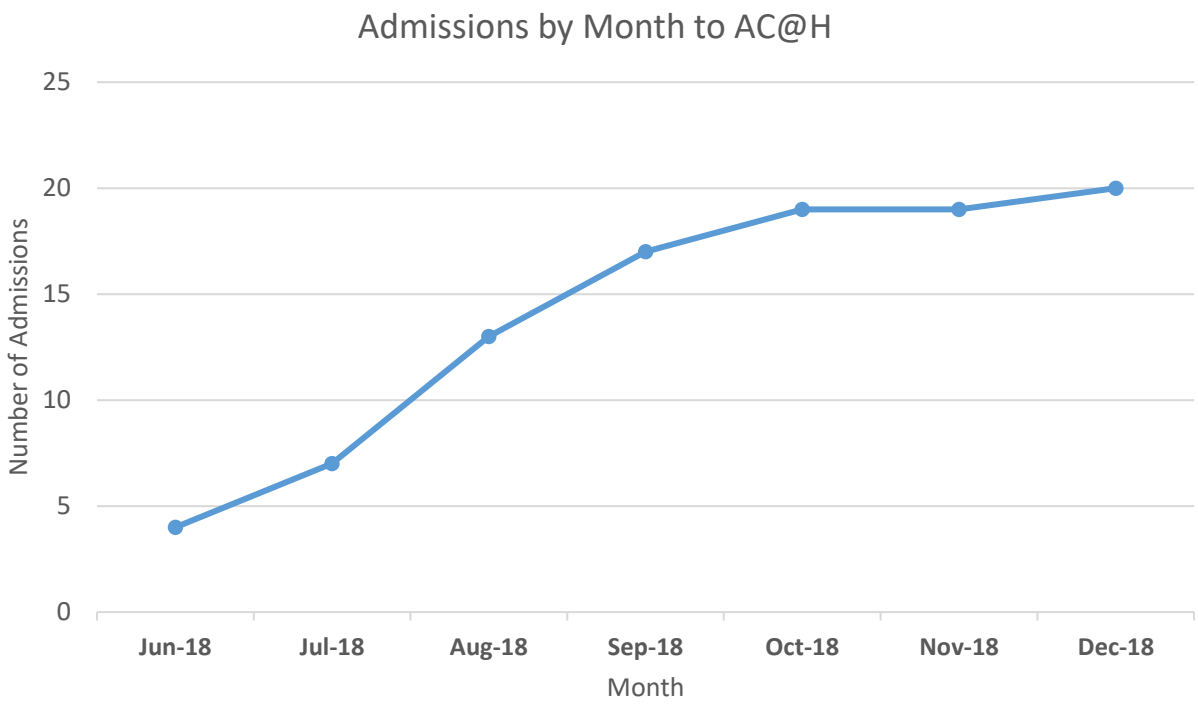

Figure 1. AC@H monthly admission rates (N=84)

Referral sources (N=84) are displayed in Figure 2 with the majority from the Geriatric Assessment Unit (GAU, 67%). A small number of referrals (8%) came from two sources; GAU and Community Links Service. Referrals sources described in the 'other' category (5%) were from; Link Geriatrician (n=1), Physiotherapy/Community Adult Assessment and Rehabilitation Service (n=1), Woodend Hospital (n=1) and Ward 105 (n=1).

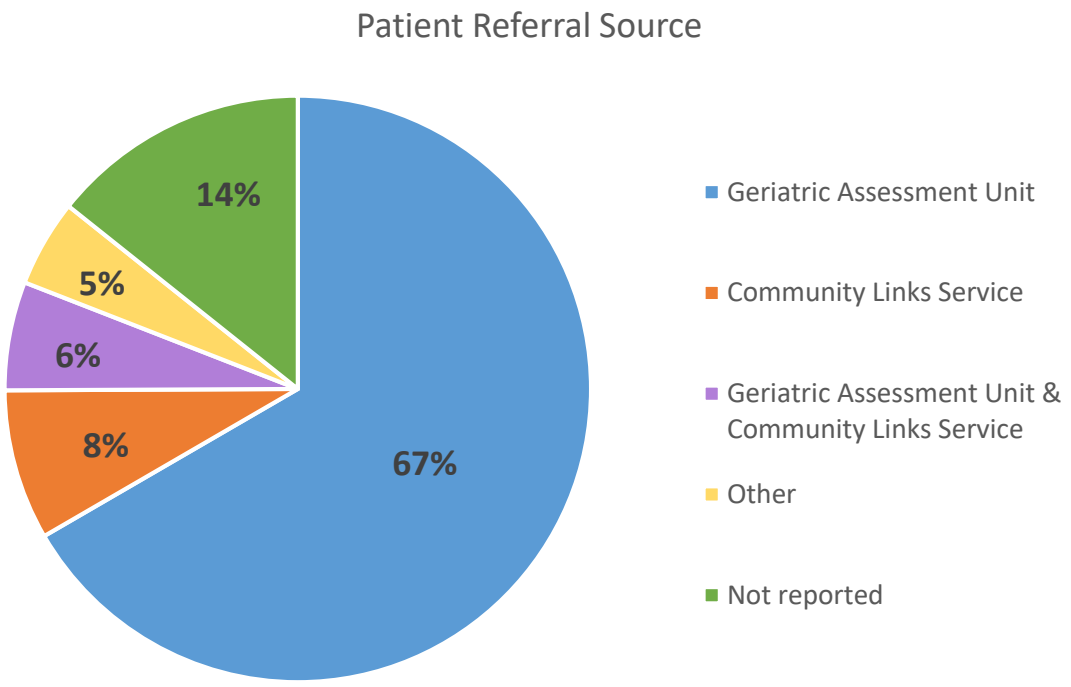

Figure 2. AC@H referral source

Figure 3 shows most frequently reported relevant past medical history, with many patients displaying multiple health conditions (N=171). Wide variability was present with many patients displaying comorbidities which highlights the complexity of the caseload. Most frequently reported conditions in the 'other' category include; kidney disease (4%), cognitive impairment (4%) and bowel condition (4%).

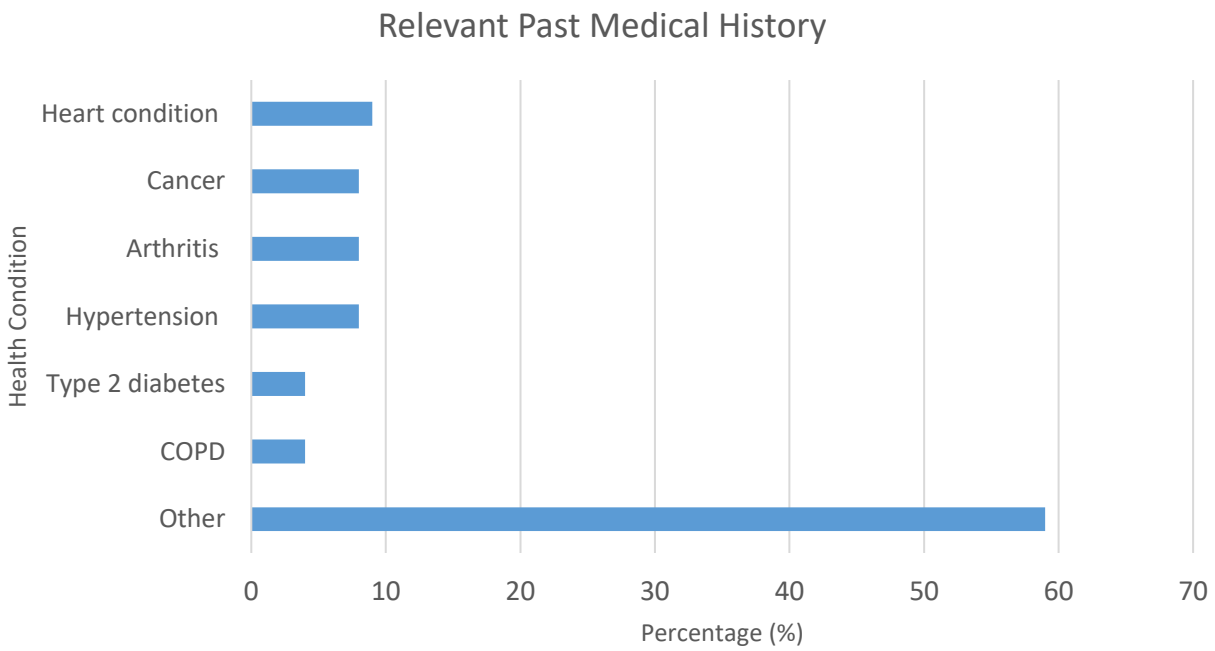

Figure 3. Relevant past medical history of the AC@H caseload

Figure 4 describes primary referral reasons to the AC@H service (N=84). Reasons for admission included in the 'other' category include; chest infection (1.2%), frailty (1.2%), fracture (1.2%) and OT equipment (1.2%).

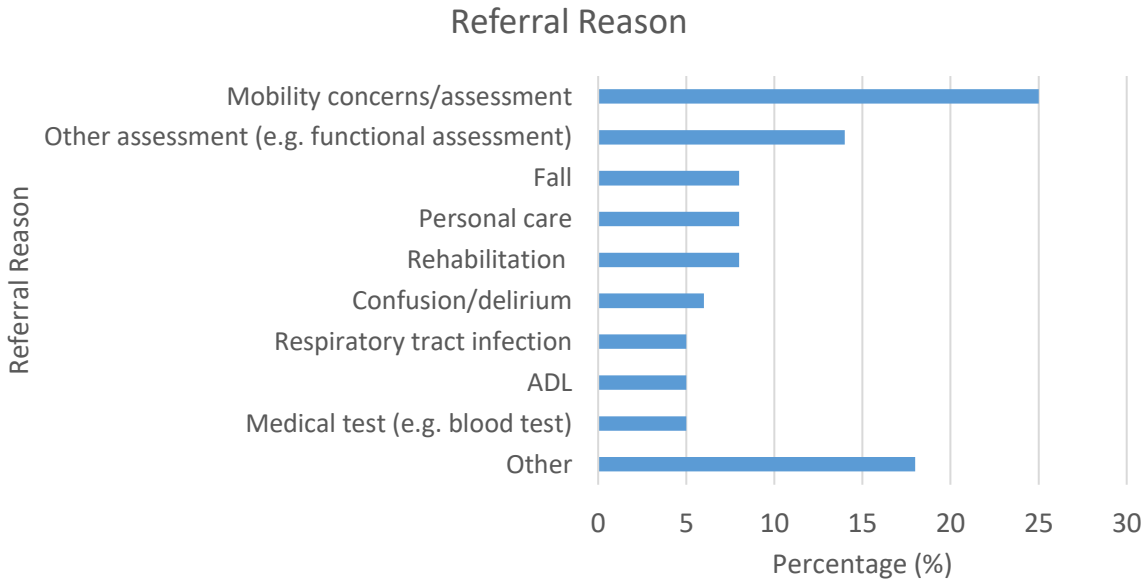

Figure 4. Primary AC@H referral reasons

Figure 5 displays primary diagnosis reasons, if reported, with patients often diagnosed with more than one issue (N=137). 'Other' category diagnosis reasons include; personal care (3%), dizziness (3%), fracture (3%) and heart condition (3%).

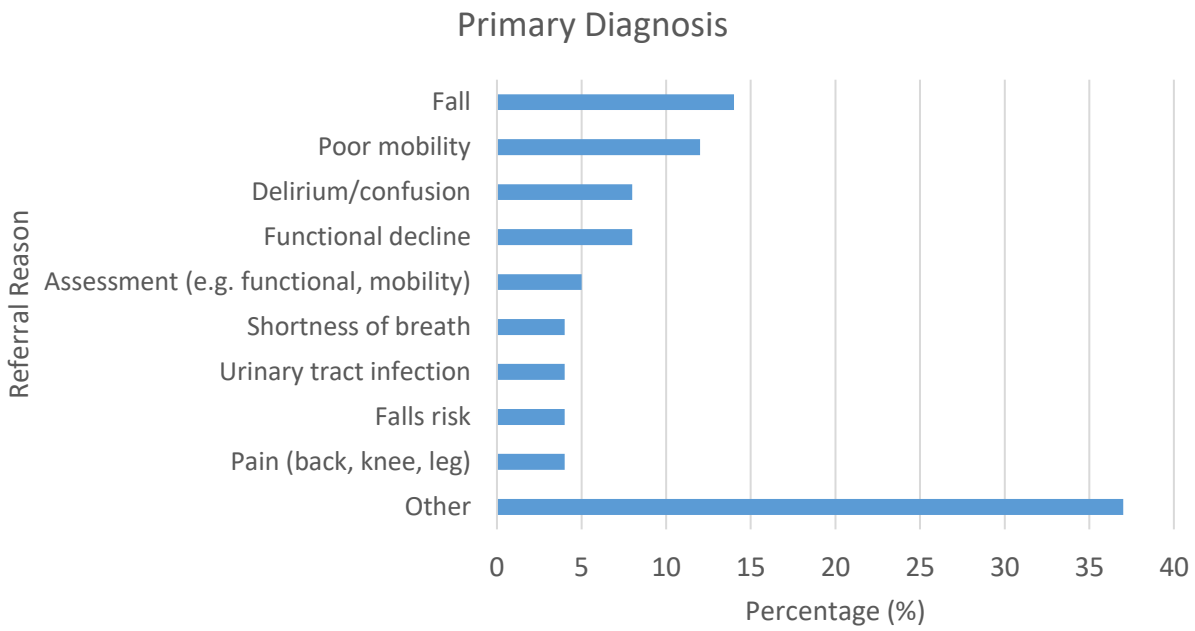

Figure 5. Primary diagnosis of the AC@H caseload

3.1.3 Patient discharge location

Discharge location following admission to AC@H is described in Figure 6, with the majority of patients discharged home (68%).

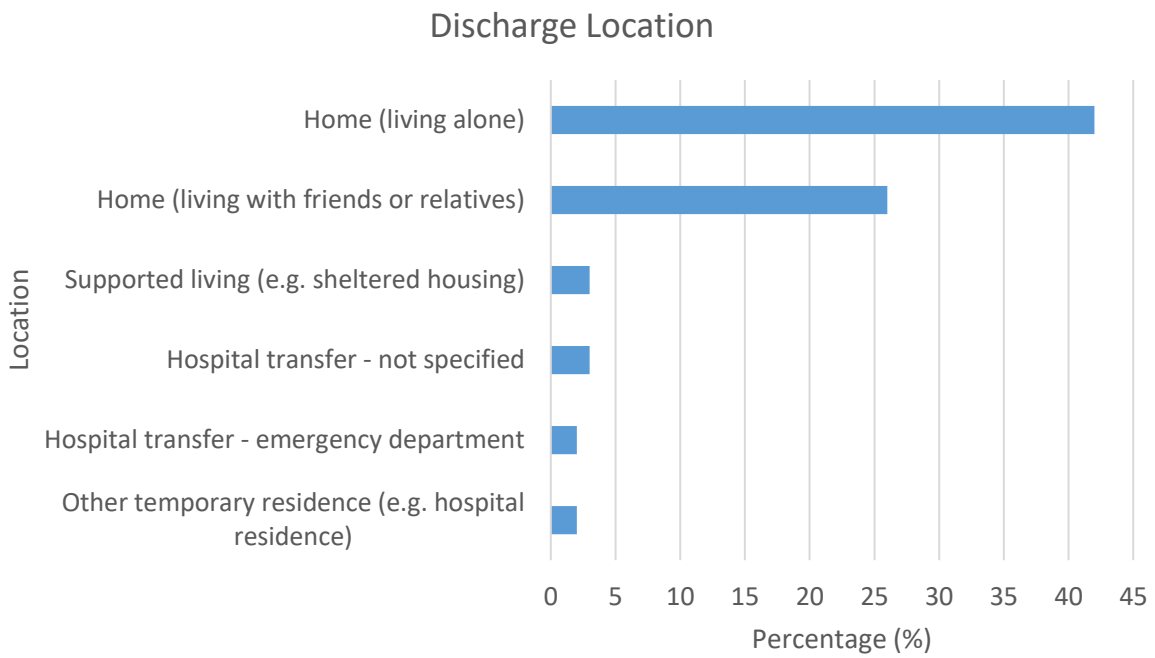

Figure 6. AC@H location of discharge (N=84)

3.1.4 Interventions

Figure 7 describes primary actions undertaken during an admission by the AC@H team, with numerous activities reported for each patient (N=215).

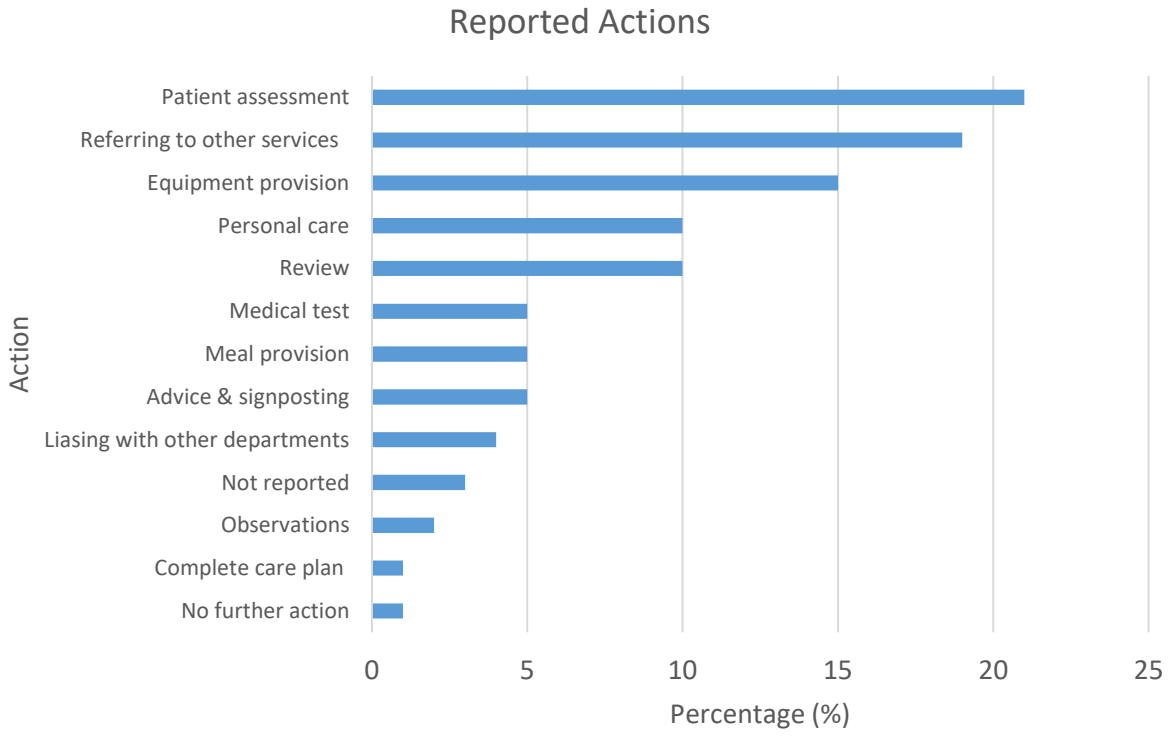

Figure 7. Primary actions carried out by the AC@H team

The type of specialities that provided input per admission, over and above care provided by HCSWs, are described in Figure 8. Most patients were seen by more than one speciality, predominantly OT and PT (N=123), which is reflective of the needs of patients referred into the service.

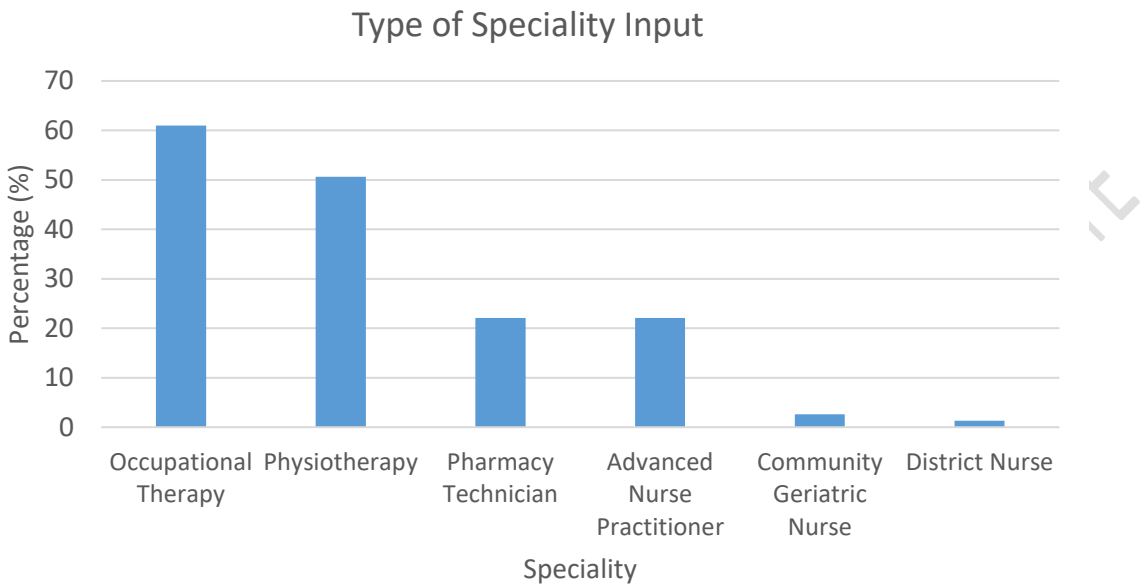

Figure 8. AC@H caseload speciality input type

Figure 9 displays the number of specialities that inputted into care per admission over and above care provided by HCSWs. Most were seen by 1 or 2 different specialities (74.1%), with only 6.5% seen by four different specialities during their episode of care. Speciality input was not reported for 15.9% (N=13) of the caseload.

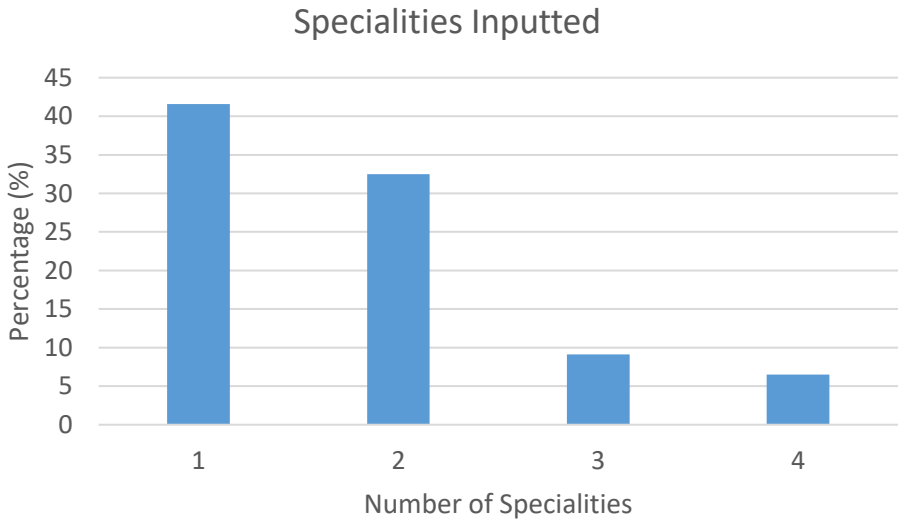

Figure 9. Number of specialities inputted into caseload

3.2 Patient results

3.2.1 Patient outcomes

Patient location 90 days following an AC@H and GAU admission is described in Table 3 (N=82). Due to data extraction timing, not all patients admitted to AC@H in the first six months were eligible to be followed up to 90 days. More patients were at home or a community setting 90 days following admission to AC@H than those admitted to GAU. Mortality rates were lower 90 days following admission to AC@H than GAU. However, slightly more of the AC@H case-load in hospital 90 days post admission, than those admitted to GAU. Readmission rates, 28 days following discharge, were comparable for both AC@H (32.9%) and GAU (32.4%). For the period of implementation, the acuity of patients was not necessarily representative of that of those in GAU so results should be interpreted with caution (as described later).

Table 3. Patient location 90 days following AC@H or GAU admission

Patient Location at 3 months	AC@H (N=82)	GAU (N=1028)
Hospital N, (%)	8 (10)	59 (5.7)
Deceased N, (%)	9 (11)	183 (17.8)
At home/community setting N, (%)	65 (79)	786 (76.5)

3.2.2 Patient service satisfaction

Responses to the patient service satisfaction questionnaire are displayed in Table 4. Satisfaction with the AC@H service was reported highly, with agreement or strong agreement they were satisfied with the service and would recommend it to others. Open-ended responses provided were all positive, including that they felt staff were skilled, knowledgeable, kind and caring and that patients felt comfortable. One responder reported: "*I was amazed at the amount of help I received. Each person knew exactly what they were going to do and did it all so cheerfully and willingly. Thank you all*" (Responder x). Another said: "*All of the members of the acute team I have met are well informed about the help that is out in the community*" (Responder x).

Due to the vulnerable nature of the patient cohort, most responses were completed by friends or family members: "*My mum was not really able to complete this but I know she enjoyed the care and attention of the team*" (Responder x). Another family member said: "*This home team is a great service, more info was passed on and explained than during the hospital stay. The nurses were able to spend time with my relative, listen to him, watch him and make a true assessment of his needs. The help put in place will allow him to stay at home and have as good a quality of life as possible. This service has also given us as a family peace of mind*" (Responder x).

Table 4. Patient satisfaction questionnaire scores (N=16)

Questionnaire components	Mean Score
Confidence in the team	4
Well-coordinated care	3.9
Recommend to others	4.1
Satisfied with the service	4.1

NB: Scores reflect Likert-scale responses (1 - strongly disagree to 5 - strongly agree)

3.2.3 Patient case studies

Two case studies describe two patient experiences of the AC@H service. Demographic details from case studies are described in Table 5 (Case study 1 – Mrs A) & 6 (Case study 2 – Mrs B).

Table 5. Case study 1: Mrs A's characteristics

Characteristic	Description
Age	92
Sex	Female
Patient location	Lives alone at home
Prior care needs	Care once a day, assisted with main meals provision
Referral pathway	Alternative to admission
Primary challenge	Falls recovery
Referral source	GP

Mrs A's Story

Mrs A fell alone in her own home. She pressed the community alarm she had in place and her daughter came round and took her to ED. She was x-rayed and no fracture was found so she was sent home with the promise of a nursing support visit overnight and carers once daily. Mrs A was in pain and found it difficult to mobilise. Her daughter didn't feel comfortable leaving her mother alone so stayed overnight. The following morning, Mrs A's daughter phoned the GP as no carers had arrived overnight and concern over how they would manage with carers only once a day. The GP referred Mrs A to AC@H, preventing admission to hospital.

Mrs A and her daughter were in distress following the events of past 24 hours. Mrs A complained of pain in her leg and she felt unable to weight bear on it. She was tired, physically fatigued, and felt a burden on her daughter. The OT from AC@H assessed Mrs A's ability to transfer and mobilise, and gave her recommendations regarding walking equipment. The OT

felt a toilet frame would be helpful as Mrs A was unable to transfer from the toilet without full assistance. She listened to Mrs A and her daughter's account of the past 24 hours, and offered understanding, support and reassurance. The OT contacted the hospital to request she attend the OT store to collect a toilet frame before they closed, however the duty staff offered to come to Mrs A's house and provide equipment immediately. A great example of partnership working.

The HCSWs visited twice daily assisting with personal care and meal preparation. Advice was given about returning to previous level of independence and encouraged her to do more for herself. After 48 hours, Mrs A was brighter, had improved confidence and mobility and almost back to baseline function. Mrs A's Daughter was delighted with her improvements and support received, which enabled her to continue working. She also understood the importance of Mrs A being kept at home rather than to be admitted to hospital as she had returned to 'normal' far quicker, and felt happier being in her own home.

The OT completed a care management care plan and requested an increase in her care package to 3 x daily in the short-term, to assist with personal care and all meals. It was recommended that as Mrs A recovered from her fall, the care could be reduced to twice daily. A preventative approach was adopted where morning support was provided including personal care in order to prevent fatigue lasting the rest of the day, thus reducing the risk of Mrs B falling. The OT also liaised with the GP informing him of AC@H intervention.

Table 6. Case study 2: Mrs B's characteristics

Characteristic	Description
Age	81
Sex	Female
Patient location	Lives at home
Past medical history	Alzheimer's, vascular dementia, hypertension, meningioma & raised cholesterol
Prior car needs	Mobilises independently with no aids, no care services. Husband was her full time carer until his own recent hospital admission, due to deteriorating health.
Referral pathway	Admission from GAU as well as alternative to admission from A&E
Primary challenge	Falls recovery
Referral source	GAU

Mrs B's story

Mrs B fell when she was walking to her local shop. She was taken to GAU where she was x-rayed and no fractures were found. Mrs B had sustained a superficial injury to her foot. She was referred to AC@H from ED, avoiding a hospital admission.

During Mrs B's initial visit from the AC@H team, the PT & ANP suspected she had delirium. The HCSW took routine observations such as blood pressure, temperature, respirations, oxygen saturations and pulse. On next visit, Mrs B was hallucinating and a urine sample test confirmed a urinary tract infection. Mrs B's mood was low on several occasions, stating she felt a burden as well as a nuisance towards her family and AC@H staff.

The AC@H team recommended Mrs B should have carers 3 x daily care to support with personal hygiene, diet and medication prompt. Mrs B required regular reminders not to go out walking alone, due to high fall risk. Family members were sign posted to relevant services which may benefit Mrs B's ability to remain at home safely (e.g. community alarm, key safe, city home helpers). The family decided to install a key safe following this advice. The TL completed a care management care plan. Due to care package not being in place and husband still in hospital, AC@H decided not to discharge Mrs B.

A&E informed AC@H that Mrs B fallen overnight and was in the department with a head injury receiving treatment. AC@H was informed Mrs B was to be admitted to GAU, however after discussion it was decided that AC@H would take over care, preventing hospital admission.

AC@H staff continued to provide 3 x daily care while awaiting Mrs B care package. The PTech liaised with care providers regarding medication. Mrs B was then discharged from AC@H and her care was handed over to the DN regarding Mrs B's ongoing care of foot dressing as well as the staple removal from head injury.

3.3 Unpaid carers' experience of service

Characteristics of unpaid carers who responded to the satisfaction questionnaire are described in Table 7. The majority of responders were female (87%), older adults and from affluent backgrounds (81.3%, SIMD 4 & 5). Most were family members (88%) and had been in their caring role for less than 5 years (57%).

Table 7. Characteristics of AC@H unpaid carers questionnaire responders (N=16)

Characteristic	Total
Female, N (%)	13 (87)
Age, mean (range)	73.6 (53-95)
SIMD Scores N (%)	
1	1 (6.3)
2	1 (6.3)
3	0 (0)
4	3 (18.8)
5	10 (62.5)
Not reported	1 (6.3)
Relationship N (%)	
Family Member	14 (88)
Friend	1 (6)
Not reported	1 (6)
Time spent caring N (%)	
Less than 6 months	2 (13)
Over 1 year but less than 3 years	3 (19)
Over 3 years but less than 5 years	4 (25)
Over 5 years but less than 10 years	3 (19)
Over 10 years but less than 15 years	1 (6)
20 years or more	1 (6)
Not reported	2 (13)

NB: SIMD = Scottish index of multiple deprivation with scores from 1 (most deprived) to 5 (least deprived)

Responses to the unpaid carer questionnaire are described in Table 8. Unpaid carers reported high satisfaction in all components. In particular, responders strongly agreed they preferred their cared for person was supported at home rather than in hospital. Responders also strongly agreed they would recommend the service to others and that they were given encouragement and support. Open-ended responses (N=11) were predominantly positive with unpaid carers describing AC@H staff as friendly, supportive and that they displayed effective partnership working: "*Very impressed with the well-coordinated, joined up care, supporting*

the transition from hospital to care management system…Excellent communication between team members, GP, care management and with me and my mum" (Responder x). Responders felt reassured with care provided, therefore able to take a break from caring: "*I could get my 3 hours social visit and had no worries about my mum, she was safe with him and I had a very relaxed time out shopping*" (Responder x). However, one responder had concerns around longer-term support which AC@H doesn't provide: "*I would have appreciated to see the AC@H for longer. My husband really did very well under the guidance of the lady from AC@H. He was very disappointed when he realised that she wouldn't be back*" (Responder x). Another responder highlighted the desire for continuity of care, which in their experience did not occur: "*I did appreciate the people who came to see mum for the week. It was a little confusing for her with so many people in and out - remembering all the names and the job title was difficult*" (Responder x).

Of responders, 37.5% (6/16) confirmed they had been signposted to a community resource, of which 83.3% (5/6) report that they contacted this recommended service.

Table 8. Unpaid carers satisfaction questionnaire scores (N=16)

Questionnaire components	Mean Score
Provided with extra resources, knowledge or skills needed to look after person?	4.6
Given encouragement and support?	4.8
Involved as much as wanted?	4.5
Less stressed?	4.4
Rather them at home?	4.3
Recommend service?	4.8

NB: Scores reflect Likert-scale responses (1 - strongly disagree to 5 - strongly agree)

3.4 AC@H staff results

3.4.1 AC@H staff satisfaction

Staff satisfaction questionnaire responses are described in Table 9. Staff were highly satisfied working in the AC@H service (average score 73%). In particular, staff felt supported by management staff, they felt it was easy to communicate with all members of the AC@H team and that they were shown recognition for performing well. However, staff had concerns around IT systems being fit for purpose and did not necessarily feel that the model was conducive to career progression.

Table 9. Staff satisfaction questionnaire scores (N=10)

Questionnaire components	Mean Score (%)
Support	72
Training	66
Development	56
Communication	72
Workload	62
Progression	50
Recognition	72
Teamwork	64
Systems	58
Satisfaction	73

3.4.2 AC@H staff experience

Characteristics of the AC@H team and key management staff interviewed are displayed in Table 10. Interviews were conducted from November 2018 to January 2019, therefore describe some developments that occurred from December onwards, not reflected in the service level data. The majority of the team (80%) had over a decade of experience prior to assuming their positions within this team. To ensure anonymity with a small sample of interviewees, the ANP, PT and OT have been grouped into 'Advanced Practitioners' (APs), The TL, Consultant Geriatrician (CG) and Senior Service Manager have been grouped into 'Management' and patient ID has been removed from quotes provided in the interview analysis.

Table 10. Characteristics of interviewed AC@H staff (N=13)

Participant ID	Sex (M/F)	Experience (yrs.)	Role
P1	F	>10	Advanced Practitioner
P2	F	>10	Advanced Practitioner
P3	F	>10	Advanced Practitioner
P4	M	2-5 years	Health Care Support Worker
P5	F	>10	Health Care Support Worker
P6	F	>10	Health Care Support Worker
P7	F	6-10 years	Health Care Support Worker
P8	F	>10	Health Care Support Worker
P9	F	>10	Pharmacy Technician
P10	F	>10	Pharmacy Technician
P11	F	-	Management
P12	M	-	Management
P14	F	-	Management

4.4.1.1 Themes

Thematic analysis of staff interviews resulted in the emergence of four key themes with corresponding subthemes; service development (steps put in place for the team to function effectively), service operation (characteristics of how the service operated), relationships (how the team worked together and with other services) and scaling considerations (key barriers and issues to consider in expanding the service) (Table 11).

Table 11. Themes and sub-themes derived from AC@H team interview analysis

Theme	Sub-theme
Service development	Upskilling
	Resources
Service operation	Care delivery
	Satisfaction
	Agility
Relationships	Inter-team collaboration
	Intra-team collaboration
Scaling considerations	Medical input solutions
	Operational adjustments

4.4.1.1.1 Service development

Upskilling - There was high satisfaction among staff with the wide range of training received in both clinical (such as venepuncture, cannulation and bladder scanning) and non-clinical (including food hygiene and note writing) areas. Professional development opportunities focused on specific areas and skills which staff would utilise frequently: "*I think it is just everything we are learning is necessary to do the job. I don't think they would put us on training just to do it. It is based around what we will be doing*" (Responder x). In addition, APs enrolled in an MSc (Clinical Practice) and gained management skills, which were new for most, including responsibility for professional development of the HCSWs: "*With the HCSWs it has been really helpful. That was something that was definitely new for me … managing HCSWs with regards to having them on the team or being responsible for kind of their education and development and that, that's new*" (Responder x).

Staff felt empowered to seek their own professional development opportunities, with encouragement to suggest training they felt beneficial to undertake: "*Anything that we can identify that we need training for, [management staff name] is brilliant at organising so we can do it*" (Responder x). There was a balance required between uptake of training opportunities and ensuring sufficient staff were available for service operation. APs described tensions between time required to undertake the MSc course and its impact on capacity to run the service,

particularly due to limited APs within the team: "*So I just couldn't understand how it would all work and it did not work and is not working, even now the other two have assignments due in tomorrow and have been off all week, so this has a massive effect on how many patients we can take into the service because there is only me here to assess them*" (Responder x). This resulted in one AP deciding to defer the MSc course for a year to ensure the service continued to function.

Staff were highly satisfied with training opportunities, however some raised concerns regarding gaining sufficient opportunities to utilise prior and newly acquired clinical skills: "*I have not really done a lot of other clinical skills we are all trained in venepuncture and all that, we do not really get to use that often, so we are all feeling de-skilling in things*" (Responder x). To help address this, management staff sought opportunities out with the service for staff to utilise these skills. For example, APs provided additional support to Geriatricians to gain opportunities to assess acutely unwell patient while HCSWs provided supported in clinics for patients with Parkinson's disease and were able to support community nurses: "*I got to go out with the CGN (Community Geriatric Nurse) Team…they are out regular doing bloods and ECG's so if a new member of staff starts, I mean they have the opportunity to go out with them and practice their skills"* (Responder x).

Resources – The team office at time of interview was a temporary location but brought about numerous challenges. Staff felt the office was overcrowded and not conducive to productivity: "*Where we are based it is a small room with a lot of people cramped in to it. It is very noisy, I think because everyone is there if there is any questions, you know, it is very difficult to concentrate and focus on bits of work because there are constant interruptions while you are there. Just at times it feels like you are a tin of sardines*" (Responder x). Solutions were sought out to cope with this challenge such as to keep busy out with the office and to book meeting rooms for space to concentrate. Staff overall remained optimistic about an imminent move to their permanent location: "*We will all have our own space. It is just a lot bigger, it is a lot nicer, it's a lot better*" (Responder x).

4.4.1.1.2 Service operation

Care delivery - The majority of referrals were received through GAU for social care and therapy needs utilising the supported discharge pathway, with only a few received from GPs with acute needs through the alternative to admission pathway. As a result, reablement care was predominantly provided which included taking observations, house modifications (including equipment provision), encouraging patients to mobilise safely at home and supporting daily tasks: "*Going in and assisting with personal hygiene, meal prep, bed prep, you know some medication prompt, we have had some physiotherapy where we have been going in and doing a bit of exercise with them…that is the majority of our work*" (Responder x). Initially, few referrals were received, leading to staff members feeling frustrated: "*Certainly to start with because we did not have a lot of patients, a bit soul destroying*" (Responder x). This was particularly challenging for unregistered staff (e.g. HCSWs) as once they had completed their training requirements (e.g. e-learning, mandatory training and additional training), they was

limited patient activity as the full complement of registered practitioners were not yet in place and those recruited had additional tasks to keep them busy: "*for those registered practitioners…the workload that they had was different because they have some of the development stuff, the patients that they do have require a lot of notes to be written and paperwork to do, so there was always that activity for them whereas it was a lull for the HCSWs because there was not the number of patients but now that patients numbers have increased slightly and the complexity of some of the patient we are seeing, has required a bit more input from the HCSWs*" (Responder x).

Positive patient outcomes were reported as a result of AC@H input, predominantly improvements in functional status with staff enabling patients to live as independently as possible: "*they have them [the patient] in the kitchen, they have given them various tasks that you want them to maybe practice in the kitchen with the person. I have given them an exercise programme that I want them to do with the patient. At the end of the seven days the person is actually back to their baseline and we are actually able to pull out*" (Responder x). More complex patients began entering the service and they showed improvements in acute symptoms; "*Chest infections. There have been a few over Christmas, we had seen a big improvement from when we started from day one to seeing them on their last day*" (Responder x). As care was received in patients' own homes, this also reduced concerns around infections acquired in hospital: "*Again the risks, they are exposed to more bugs and germs, they are at a higher risk for their health*" (Responder x).

Characteristics of the service that staff felt functioned well included assessment of patients' in their own home which was felt to be much more effective in identifying actual patient need, as opposed to assessing patients in hospital: "*You see a very small snapshot of how somebody actually functionally manages when you see them in an acute setting as oppose to when you see them at home*" (Responder x). In addition, service-specific efficiencies were reported such as rapid access to blood test results and equipment provision (such as raised toilet seats): "*Patients can get equipment faster through the OT rather than normally having to wait for the referral to go in. They get referred that morning, we go pick it up, the patient gets it that day. That doesn't happen usually so quickly"* (Responder x). Staff members also strived to ensure patients would be seen by the same staff members at each visit, where logistically feasible, as this helped build rapport: "*They all like continuity, they like the same person going in, which is not always the best thing for us but they look forward to you coming*" (Responder x).

Satisfaction - Staff received predominantly positive feedback from patients about the service, in particular being able to receive care in their own home: "*giving people the opportunity to stay at home, you know, and people actually appreciate and you can see, you know, they actually tell you that they think that we are a wonderful service and that is coming from patients and families*" (Responder x). Patients found having the team to support them at a critical time, transitioning home from hospital, was important to building confidence during their recovery:

"*they just feel relieved, more secure, comfortable realising that they have not just been put out of hospital and abandoned. They have been put out and we are coming in and making sure that they are settled and that you are alright*" (Responder x).

Agility – The service model was new in Aberdeen, and therefore required adjustments and modifications during initial operation to address unexpected contextual challenges. A key issue was being unable to recruit a CG, resulting in the inability to admit acutely unwell patients. Consequently, the model shifted its focus from clinical care provision, to an enablement focused model: "*it has been away from that kind of disease focused management or very medical kind of modelling, particularly because we have no medic leading, so we have been away from the medical model*" (Responder x). This was achieved by referrals being accepted from GAU once a CG had ensured the patient was medically fit: "*… because of the limited medical input, that's one reason we ended up going to a more of a rapid supported discharge type thing from ward (number) because at least then we would have control over the patients being medically stable so that we knew they would not be requiring huge amounts of our input that we couldn't necessarily provide*" (Responder x).

The daily functioning of the service was adapted to ensure the most efficient care was provided. In particular, the format that the team carried out visits changed over time to ensure most effective patient engagement: "*What we have discovered is that it is perhaps easier to do the visits individually rather than tag along with an OT or a PT because they are sort of wanting to talk about their side of things and we want to talk about our side of things. I think it can be a bit overwhelming for people sometimes if you are trying to ask them to much, especially a lot of our patients are just out of hospital and maybe still a wee bit wobbly*" (Responder x). The approach of providing numerous individual visits left the team with apprehensions it may become burdensome to patients, despite mimicking acute conditions: "*I suppose that's where we struggle with AC@H because we are sometimes almost tag tailing each other. I don't know if people feel overwhelmed at having so many people coming to their door all the time but again if they were in hospital on a ward it would be very busy and people would just come to them when they were available*" (Responder x).

4.4.1.1.3 Relationships

Inter-team collaboration - The AC@H team described having a positive relationship with each other and that they worked well together. Staff felt supported and valued team members regardless of their role: "*Staff over all get on, it's a great team, they get on really, really well you know. There is no like, you know, hierarchy or things like that. Everyone is treated as an equal*" (Responder x). One interviewee felt that their bond had grown stronger due to the challenges they had faced together: "*I think we have gelled because of the challenges that we face I think has let us get to know each other well, so this period of time where we have been stuck in a room together has had good and bad but I think it has helped us get to know each other and understand our ways of working and our experiences*" (Responder x).

A mechanism that facilitated this strong team dynamic was the high satisfaction with management staff, in particular, with the TL due to her personable qualities: "*She is really dynamic, very positive and you can see her passion for the whole project and wanting to drive it forward*" (Responder x). Management were seen to be transparent and involved staff members in all aspects of service development: "*I think the senior team members are good team players they are, how they include you in everything. [APs] have included you in everything, we know what's happening*" (Responder x). Staff also felt involved in decision making around patient care: "*any changes with the patient, we have a meeting and discuss the patient and we're asked for feedback once we've seen the patient so I do feel like we are really included*" (Responder x). In addition, management were seem as supportive and approachable, particularly for APs who were learning new and more advanced skills: "*I think we are very fortunate that [management staff name] is the one leading us. I think that any of us can go to her if her we are struggling or do not know, she always has an answer. This is really reassuring as well because at other times, I know myself, I would just be floundering just wondering where to go next*" (Responder x).

In addition to the team developing a strong bond, the presence of key personality traits played an integral role in enabling service success. This included having a caring personality, confidence and strong communication skills due to wide partnership working and the public facing nature of the role: "*Well you obviously have to have a good sense of humour and be able to communicate as I said you are going out to people's houses and you are meeting all different kinds of agencies out in the community*" (Responder x). The attribute of open mindedness was deemed particularly important due to the agile nature of the service, in which staff were required to be open to continual operational adaptations and to manage the unpredictable nature of home visits: "*Obviously being used to going into people's houses, because you just never really know what you are going to find when you go in. That would probably help unless you are quite open to that and you don't mind*" (Responder x).

Having a multi-disciplinary team with a positive dynamic enabled the team to gain benefits from each other's' expertise such as becoming upskilled in different approaches to care: "*Things that I was never exposed to. We had PTs and OTs but they never really mix with you on the wards. I think it has really been educational, certainly for me and it still is*" (Responder x). Another key benefit was the ability to discuss patient care from multiple perspectives, in particular the pace in which that support and advice from other specialities could be provided: "*…having that expertise from their perspective yeah, it is quite good to go and be able to go back and put that question or ask how we can refer on or sign post on, we have got an answer sort of there and then instead of waiting, no referring*" (Responder x). Coordination of care was also more efficient in addressing patients' needs: "*we can put things in place sort of really quickly where as if they weren't there then possibly I don't know how long these things take*" (Responder x).

Intra-team collaboration – Staff overall described positive relationships with other teams both in acute and community settings. One reason for this was that the AC@H team were co-located with other services whilst based at their temporary location: "*because we have the community OTs, PTs, Dietitians, Speech and Language. I think there are a lot of services, in fact the services that we would refer on to apart from Care Management are within the building. So from that point of view it has been great*" (Responder x). There were some concerns raised that communication may become more challenging following the move their permanent location: "*It will involve a lot more phone calls and things I would imagine once we move away from all being on one site*" (Responder x). Effective partnership working was also enabled by relationships staff members had developed prior to taking up their posts, such as therapists who had gained connections during rotational posts, an AP who had previously worked in the CGN team and the Team Leader who had a range connections to utilise. These established relationships facilitated efficient patient care co-coordination across services: "*with the CARS Team, I think that being based here and with those guys knowing already what the CGNs did and what AC@H is trying to achieve, it has been very easy to forge that working relationship with them and referral pathways*" (Responder x).

Partnership working was seen as positive, however a wider lack of awareness of the service and its function emerged. Many interacting services were unaware acute treatment could be provided (e.g. take bloods) and there was a perception that the service only provided social care input: "*They do, they think that we are there and even families, we do explain but it is just other agencies, it is just "Oh the Carers are in". Even the ambulance, we have had Paramedics and that "Oh the Carers". The Police as well*" (Responder x). Embedding awareness was challenging due to the quantity of services required to communicate with: "*The difficulty is at the moment, I suppose again it is that logistical thing. We are covering the whole city, there is loads of different GP Practices, lots of GP's in all of them, lots of different District Nurses in all of them and all of them, everybody nearly needs to be told individually and have that explained to them individually and what the service is doing*" (Responder x). Concerns were further raised around ensuring services understood how AC@H could complement and not duplicate current processes: "*I think at times other teams might see that we are not needed because that is what they do but you know we are not trying to stop other people doing their jobs but we are there to support them*" (Responder x). To improve understanding and awareness, the TL had approached GP practices and provided education sessions to GAU ward staff.

4.4.1.1.4 Scaling considerations

Medical input solutions – A potential option in addressing the lack of dedicated CG cover described was to utilise the expertise of GPs and to increase input from skilled APs in running the service: "*we just keep with GP as a responsible clinician but they have input from PA's or training GP, so we are exploring all of those possibilities at the minute. With skilled ANP's or APs I think is as good a concept, as long as we make sure it is safe and there is clear governance structures within that, so we have clear route to a GP if they were the responsible clinician to*

ensure links are not broken because we already have links with geriatrician's, so there is advice on hand it doesn't have to be a CG" (Responder x). There is potential for the responsible clinician (Consultant or GP) to support in the upskilling APs, along with formal training, ultimately leading to them to able to increase caseload responsibility safely: "*because there is a confidence between the medic, could that be the consultant or the GP with the team members, that there is less engagement between them as there is a confidence that has been built there so there is a need for a bit of supervision in there in checking but you are getting to know what that individual is doing*" (Responder x).

Operational adjustments – A key expansion consideration that emerged was to broaden the referral pathway to receive referrals from acute departments (such as ED) and GP practices: "*It will be very slow until it feeds into the GP practices. We could take a lot of load from them if they meet us half way. We can hopefully stop their patients getting admitted into hospital*" (Responder x). In addition, operational hours were seen as insufficient with staff describing the need for a more flexible service to suits to needs of patients: "*I think what I can see as being as much of a barrier really to doing the admission avoidance is that we have not had the staffing to kind of extend our hours in to the evenings and weekends as yet. You know you are taking on a sick patient, I mean they do not stop being sick at 4 o'clock or on a Friday*" (Responder x).

IT concerns were raised which should be considered in future service expansion. Challenges were apparent in operating a service which sits on the boundary between acute and community when their independent IT systems. Staff only had access to the acute IT system which made it difficult to plan patient care, the majority of which is in the community, as they were unable to see what prior community input had been provided. In order to address this in the short-term, staff felt it would be beneficial if GPs provided key patient information to them on admission: "*to have a GP summary of kind of their last visits and whatever else. I think this would be really helpful, at least we would know "well look, the DN's go in twice a week" you know these are the people who are normally involved in this patient's care that would be the best person to touch base with*" (Responder x). IT efficiencies required included the need for an IT system where letter templates are saved as opposed to typing or dictating a letters, to have a shared drive in order to have easy access to key documents and remote access capability: *"I do have a laptop and we are supposed to be able to access that from wherever but even when I go home to use to the laptop, I can only access emails I cannot do anything else"* (Responder x).

4.4.3 Staff interacting with AC@H satisfaction

Table 12 shows the roles of staff interacting with the AC@H team who completed the questionnaire, with findings described in Table 13. There was overall high satisfaction interacting with the AC@H team (average score 79%), particularly interacting staff found the team easy to contact.

Table 12. Profession of staff interacting with AC@H who completed the satisfaction questionnaire (N=8)

Profession	Frequency (%)
Physiotherapist	3 (37.5)
General Practitioner	2 (25)
District Nurse	2 (25)
Occupational Therapist	1 (12.5)

Table 13. Staff interacting with AC@H satisfaction questionnaire scores (N=8)

Questionnaire component	Mean Score (%)
The AC@H team are easy to contact	90
The referral process is easy to follow	84
The AC@H team communicated well with my team	78
The AC@H team are easy to work with	82
Experience working with AC@H team overall	79

Aspects staff interacting with the AC@H service report worked well and areas for improvement are described in Figure 10 & 11 respectively. What worked particularly well was that the team were easy to contact through a direct line and the close proximity the AC@H team had to staff they were interacting with, enabling effective partnership working: "*We are very lucky to have AC@H on site with us here at [temporary location name] and this is possibly why it is so easy to work with the staff in that team. This is about change and may impact in working relations, however I hope that we can preserve good practice*" (Responder x).

Despite high satisfaction, responders felt AC@H should have clearer referral pathways with community services and improved engagement with other staff around co-ordinating patient care: "*In order for the service to work there has to be clear communication as to what they are doing, what services they have been referred to, what care requires to be done after their input has finished and being respectful of my role in this"* (Responder x). One responder was concerned AC@H may be duplicating current services and showed concern around this reducing her workload: *"I do feel that my role will be diluted further by another team doing assessments/tasks that I more than qualified for. I feel there may be too much overlapping of services here*" (Responder x).

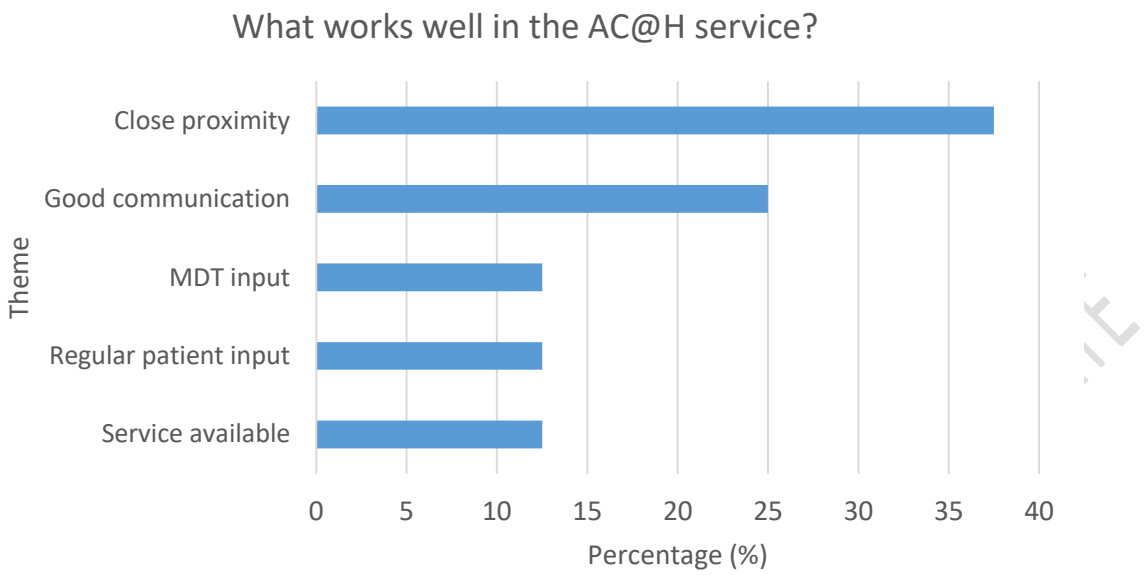

Figure 10. Staff interacting with the AC@H service perceptions of what worked well (N=8)

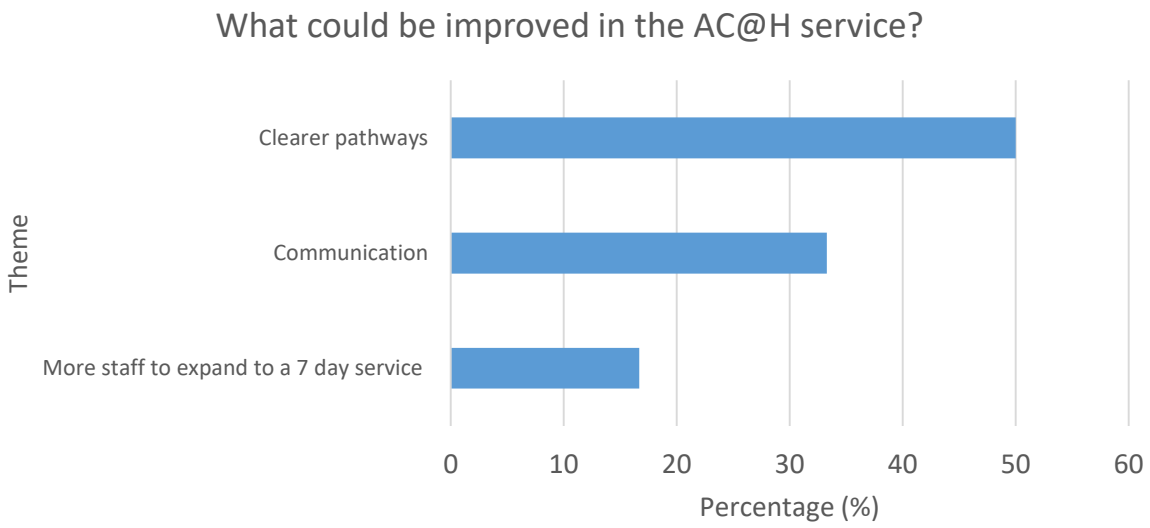

Figure 11. Staff interacting with the AC@H service perceptions of what could be improved (N=6)

4. Discussion

This report presents the evaluation findings of the AC@H service, specifically the impact on patients, unpaid carers, staff and resources. Results described explore aspects of implementation that appear to have functioned sufficiently and recommendations to inform service development and direction.

Service Perspective

The AC@H model appeared no less safe than usual care, with more patients in a community setting (79% AC@H, 76.5% GAU) and lower mortality rates (11% AC@H, 17.8% GAU) 90 days following AC@H discharge than from GAU. The main challenges the service encountered was the lack of medical input patients were able to receive due to difficulties in recruitment of a CG. Difficulties filling CG posts are evident nationally[19], with recruitment barriers (excluding those pertinent to the geographical location of Aberdeen) including a lack of doctors choosing to specialise in geriatric medicine, and a large majority who do, choosing to work part-time[20] [21]. One solution identified by AC@H staff was to utilise GPs with an interest in geriatrics. Considerable strain is already placed on primary care workloads due to increasing complexity of patients, resulting in more GPs choosing to work part-time or retire early[22]. National and local strategies have been developed specifically to reduce pressure on primary care by shifting workload, where appropriate, from GPs to other primary care professionals. As a result this theoretically should increase GP capacity, working as expert medical generalists, to focus input on patients more appropriately aligned to their skillset such as more complex patients with co-morbidities[23] [24]. If GP workload can be realigned to more appropriate professionals safely, GPs may be able to use their additional capacity to support services such as AC@H. It should be emphasised that when implementing a theoretical model, there needs to be appropriate plans in place to recruit the necessary skillset for the model to function and if there are any doubts that this can be achieved, there needs to be a clear plan about how the model can be adapted to provide the same function (e.g. to be able to provide acute care).

Staff identified another solution to the medical input limitations could be to better utilise other health professionals, such as APs. As alluded to previously, initiatives aim to shift community patient care from GPs, where appropriate, to other specialities including ANPs, Physician Associates, Clinical Development Fellows and specialised HCSW roles[25]. Embedded within

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[23] Aberdeen City Health & Social Care Partnership (2018) Primary Care Improvement Plan. Aberdeen.

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[25] NHS Health Scotland (2018). NHS Health Scotland's Workforce Plan: Delivering better health for everyone 2018-2019. NHS Health Scotland, Edinburgh.

this approach is the more effective utilisation of the workforce through provision of upskilling opportunities so staff can safely provide maximum contribution to health and social care delivery[26]. This model could potentially be operationalised through a specialist GP or Geriatrician, providing a supervisory function to allow for safe delivery of care[27] [28]. Replacing GPs consultation with nurses, where safe and appropriate, has been shown to generate similar health outcomes, with patients preferring nurse appointments when requiring urgent attention possibly due to longer consultations and more information provided[29]. Innovative utilisation of highly skilled nurses has shown promising results in Aberdeen in which an ANP carried out afternoon home visits on behalf of the patient's GP. This model reduced GP workload and high satisfaction rates were reported from both GPs (90%) and patients (100%), demonstrating a high quality service provision[30]. Therefore, there is opportunity to utilise a wide range of specialists in addressing recruitment challenges to continue delivering high quality care.

Staff identified the need to broaden referral pathways and operational hours to enable service expansion. Similar to other H@H models, a logical step is to test referral pathways from General Practice and other acute wards, such as ED, with the aim of preventing hospital admissions and reducing hospital stays[31] [32] [33]. Expansion of operational hours aligns with a key national priority to deliver a seven day service, allowing patients to receive high quality care across the whole healthcare system whenever they need it[34]. It is well evidenced that admission to hospital outside of standard working hours, particularly at weekends, is related to a significantly higher mortality risk, possibly due to lower staffing or less high grade doctors present[35] [36]. There appears value in testing new referral pathways and extending operational hours, in conjunction with an increase in the team composition, to provide a service that can support the wider system to deliver high quality care.

Staff reported average scores of 58% agreement that IT systems were fit for purpose. A key concern was that staff were positioned on the boundary between acute and community when only receiving access to the acute IT system. Having access to relevant IT systems aids care coordination activities such as monitoring, follow up for scheduled activities, information

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transfer and enable communication[37] [38]. In contrast, care coordination across different settings can be limited if IT systems are not either shared, integrated or there is an effective health information exchange is in place (e.g. electronic summary transferred, information sharing incentives)[39]. In the absence of communicating IT systems, electronic discharge summaries could be provided to the AC@H team which shorten communication delivery times, however do often lack important health information including diagnostic test results, hospital treatment, discharge medication, pending test results and follow up plans[40]. Effective health information transfer is necessary for high quality coordinated care and considerable effort needs to be invested into identifying effective solutions.

Patient perspective

The AC@H service appears acceptable to patients, who reported high satisfaction (average score 4.1/5) and confidence in the AC@H team (average score 4/5). Staff interviews identified provision of support during the transitioning from hospital to home (a critical time when patients are highly vulnerable) as particularly beneficial. Hospital stays are associated with extended inactivity, with estimates showing patients spent just 5% per day standing or walking[41]. Risks of prolonged sedentary periods include reduced muscle strength[42] and functional decline[43] which can lead to hazardous events such as falls[44]. The timely provision of support following hospital discharge (within 7 days) has been shown to reduce likelihood of hospital readmissions in those presenting with co-morbidities and high clinical complexity, demonstrating its value as a core component of transitional care[45]. This highlights that if it is safe

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enough to transition the patient from hospital to hospital at home, it may help mitigate de-conditioning risks associated with hospital admissions and instead facilitate the reablement process.

Staff identified positive feedback from patients regarding continuity of care, which appeared to facilitate relationship building between these groups. This is congruent with other community models developed and tested in Aberdeen, such as INCA, where continuity of care was a key, facilitating mechanism identified by both professionals and patients during the implementation of this service[46]. Consistency in staff providing care does not solely increase patient and staff satisfaction rates, but has also been demonstrated to improve patient outcomes[47], improve treatment adherence[48] and reduce resource utilisation (including prescription costs and hospital admissions[49]. Achieving said outcomes is facilitated by ensuring sufficient high quality conversation between professional and patient, in addition to adequate time provided to address the needs of the patient[50]. This reinforces the value of having a small cohort of staff delivering regular care to a defined cohort of patients and empowering staff to deliver a person-centred package of care to help achieve impact at both patient and system levels.

A theme that emerged from analysis that may have contributed to improvements in functional ability included rapid access to test results (e.g. blood test) and OT equipment (e.g. raised toilet seat). Prompt delivery of appropriate interventions is necessary to ensure timely care provision in addition to supporting independent living[51 52]. Equipment can allow patients to feel safer and increases confidence whilst reducing anxiety and likelihood of a fall[53]. Increased usage is seen when patients are both involved and perceive it is as beneficial, suggesting a person-centred approach is crucial[54]. This emphasises the value that providing the timely resource and care, that suits their individual needs, may have in supporting reablement.

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Staff highlighted advantages of carrying out assessments at home as opposed to hospital, including more accurate identification of patient needs. Home visits may allow health professionals to see the real life environment in which an individual functions, thus aiding the process of assessing and implementing care provision, specifically identification of hazards and appropriate household modifications[55]. Indeed environmental assessment, specifically by OTs, has been shown to significantly reduce the quantity of people falling and number of times individuals fall due to the detailed consideration of the person in their own environment[56]. Carrying out functional assessments in a patient's own home, as opposed to a hospital setting, may be important in identifying most effective strategies for self-management, independence and preventing adverse events.

Unpaid carer's perspective

Unpaid carers reported a preference to have the person they care for supported at home rather than in hospital (average score 4.3/5), resulting in a reduction of self-reported stress (average score 4.4/5). This may be due to the high satisfaction reported with support and encouragement in their caring role from AC@H staff and that they were reassured their cared for person was provided with high quality care. A preference with having their cared for person treated at home has also been demonstrated in other H@H models to be due to regular contact with the service team who provided more information about their cared for person, greater patient care involvement and alleviating travel requirements for hospital visiting[57]. Unpaid carers reported reductions in stress levels, a particularly beneficial finding considering the rise in unpaid carers and levels of carer they provide as a result of increasing population and epidemiological challenges[58]. With approximately 759,000 unpaid carers in Scotland[59], whom, in conjunction with other unpaid carers across Britain, save the UK as estimated £132 billion a year on health care costs, their role as part of the health and social care system cannot be understated[60]. However, unpaid carers self-report caregiving as detrimental to their health and evidence suggests there is a doubling of risk of a poor health outcomes for those in a caring role[61] [62], which subsequently could negatively impact the already tight demands on health and social care services. Therefore, it appears that this model does not just directly

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benefit the patients who are in receipt of care, but their friends and family who provide a caring role for them too.

Of the unpaid carers who engaged in the evaluation progress, 37.5% reported that the AC@H team had signposted them to a community resource and of which 83.3% contacted the service indicating a willingness to engage in these services. Community assets can help support their non-clinical needs including emotional, financial and physical health issues[63]. This is important because the majority (70%) of unpaid carers don't access available support[64], but we know that if they do, it can help improve their wellbeing (e.g. self-confidence) and reduce pressure (e.g. reduced demand for GPs, A&E attendances)[65] [66]. Patient engagement can be enhanced, particularly for those with more complex issues, by onward referrals to social prescribing professionals such as the Link Practitioner service in Aberdeen who provide increased knowledge of community resources and support[67] [68]. Signposting more people to services like Link Practitioners, doesn't just address the needs of unpaid carers (e.g. financial, stress), but also can, by association, improve their wellbeing and reduce pressure on health and social care services.

Staff satisfaction

AC@H staff reported an average job satisfaction score of 73%, a score 5.1% higher than the average job satisfaction score across all NHS Scotland staff[69]. It emerged that the team had a positive dynamic facilitated by management staff who were particularly supportive (average score 72%). Traditionally the NHS followed an autocratic leadership style where tasks are directed and success rewarded[70], however a 'transformative leadership' style has gained increased momentum[71], characterised by a collaborative effort between management and their staff to build morale, achieve shared goals and involve staff and patients in decisions[72]. Staff articulated qualities such as inclusive decision making, the lack of hierarchy and autonomy to solve issues such as home visit scheduling, all indicative of a transformative leadership style, shown to empower employees, increase job satisfaction and promotes effective team

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working[73] [74]. It does appear both management styles are valuable and that leaders need to adapt their style to suit individual needs. An autocratic style may be more beneficial for staff with less experience, knowledge and skills (to help them develop these) or in times of a crisis (where a quick decision needs to be made), whereas a transformative style may work better with more skilled individuals, such as the AC@H team in which most had over 10 years' experience working in health and social care[75] [76]. One exception may be the APs who were newly transitioning into a more skilled role, and they may have required a more mixed leadership style whilst they gained confidence. Considering the recruitment and retention challenges locally (annual NHS staff turnover 10.3%), coupled with the association between low job satisfaction and staff turnover, implementing a person-centred management style may not just ensure adequate staff provision, but improve collaboration and facilitate professional development[77] [78].

Staff valued the wide variety of clinical and non-clinical training that they were offered and were encouraged to seek out. Ensuring appropriate opportunities for professional development does not solely increase their knowledge, skills and abilities to carry out their job effectively, but may also improve staff satisfaction and wellbeing consequently leading to reductions in adverse events[79] [80] [81]. Staff were satisfied that they were involved in decision making processes around their personal development opportunities, reinforcing the effectiveness of transformative management in this context[82]. Due to the small size of team, and in particular only one of each AP, there was a tension between staff completion of training and having sufficient cover for service operation. Here, particularly whilst APs were undergoing advanced clinical training during the time of service operation, this inhibited the number and acuity of

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patients that could safely enter the service. Therefore, it should be stressed that, if staff require significant investment of time during their working hours towards attaining required training and skills, this will directly impact the pace at which the service can expand.

Intra-professional relationships were described as positive both by AC@H staff and those interacting with them (average score 79%), particularly that having the teams co-located was valuable. AC@H staff, however found their temporary office environment unsatisfactory due factors such as overcrowding and noise levels. When professionals are located in close proximity to each other, it can facilitate more effective partnership working and patient care co-ordination through increased opportunity for informal contacts, rapid communication, reductions in duplication, and cross speciality learning and knowledge transfer[83] [84]. However, this is only successful in conjunction with satisfactory environmental factors such as noise levels, amenities, temperatures, office layout and lighting, all of which impact employee satisfaction and productivity levels[85]. Locating employees in close proximity can provide an environment conductive to more effective communication and patient care collaboration which in turn may reduce prescriptions and contribute to improving system blockages such as delayed discharges[86] [87]. It is therefore of significant importance to ensure when staff are co-located, their environment is also satisfactory.

Many of the AC@H team identified pre-existing relationships which they could utilise whilst working in the AC@H team. Relationship development may have been facilitated by the length of time staff had worked for prior to taking up their AC@H role, with 80% of the team having worked for over 10 years. The longer employees have to develop relationships, the more opportunities they are presented with to demonstrate competency and credibility, develop trust and relationship commitment[88]. Strong workplace connections can enable inter-professional collaboration through knowledge and idea sharing and can diffuse innovative change[89]. These maintained relationships may not have only facilitated partnership working, but be utilised as an effective tool to raise awareness of the purpose and function of the AC@H service as it develops, with concerns services perceived AC@H as a carers service. Awareness raising through employee networks can be enhanced by communicating evidence of project effectiveness, particularly quantitative data, and adequate supply of resources (active promotion of innovation) including through awards, media and academic publications to

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widen reach[90]. The breadth of maintained relationships already established within the team could be the mechanism by which service awareness increases.

Limiting Factors

There are some important limitations to consider in this evaluation. The cohort of patients may not be representative of those entering the service as it expands in the future. This evaluation covered the initial stages of service development whilst there was considerable refinement of processes, and congruent with other evaluations[91], these initial patients were less fail and independent to ensure patient safety. As the service grows in confidence and processes develop further, the patient cohort may in turn become more complex.

When considering service level data, GAU was used as a proxy measure in which comparisons were made with the AC@H service, however this should be interpreted with caution as GAU treats acutely unwell patients. Due to the limited medical input, there was an acceptance that, for the most part, patients referred to the AC@H team were not acutely unwell. Finally, cost-effectiveness analysis or wider impact on acute service utilisation (e.g. reduced bed days, delayed discharges) was not considered. Although these would have been desirable, the primary function of this evaluation was to test model feasibility, to initially determine if the service can work, before consideration of future impact of scaling up[92].

From a patient perspective, whilst patient location was a primary outcome, there were secondary outcomes that weren't explored such as physical and mental wellbeing. However, we did receive positive feedback from questionnaires regarding patients experience with the service as preliminary evidence. It was only possible to follow up patients for 90 days after admission and this was due to both the small numbers of patients entering the service and the time constraints of delivering this evaluation. Conducting interviews for both patients and unpaid carers would have provided richer data on service experience, however it was decided that this may be burdensome for this cohort as many were vulnerable, unwell and had limited capacity.

From a staff perspective, the sample of professionals who interacted with the AC@H service and provided feedback was limited, therefore, may not be a representative view on the wider AC@H service perception. This was constrained by the responses received from the survey and could be explored in more depth in future to understand the wider impact on the service of other staff members.

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5. Conclusion and recommendations

AC@H appears no less safe than usual care and which patients, unpaid carers, staff and interacting organisations were satisfied with. AC@H staff identified that the rapid access to both care and resources at a considerably vulnerable time, the ability to carry out functional assessments in a patient's own home and providing continuity of care were particularly beneficial in supporting patient reablement. When considering scaling this model, these components should remain integral to the system.

From an unpaid carers perspective, there was a preference for their cared for person to be treated at home which reduced self-reported stress levels, suggesting the model positively impacts the wellbeing of family and friends. There appeared to be a willingness from unpaid carers to attend community services when these were recommended by AC@H staff, demonstrating that both signposting and onward referrals to Link Practitioners for more complex patients, is a feasible strategy in supporting unpaid carers within the AC@H service.

Staff described high satisfaction working in the AC@H service, with the team having a positive dynamic particularly due to the presence of a transformative management style. It appears a more participatory management style enabled the strong team dynamic, possibly due to the level of expertise present within the team. Staff valued the wide range of training provided in both clinical and non-clinical skills, however, the attendance of training during service operational hours restricted the level of service provision that could be delivered, particular due to the small size of team. Frequent staff training during operational hours to upskill staff inhibits both caseload size and patient acuity levels, therefore, will limit service expansion. Prioritisation needs to be considered around which aspect to focus as both cannot progress simultaneously.

Co-location of the AC@H team with other staff members appeared beneficial in collaborative working although there was a tension between the benefits of this and the unsatisfactory office environment. For co-location to effectively facilitate collaborative working and for staff to be most productive, adequate working environment (such as not overcrowded and noisy) needs to be provided. Pre-existing relationships may have also facilitated positive intra-collaborative working which could be an important tool to utilise when raising awareness of service function as it develops. Promoting regular AC@H progress updates through these communication channels will enhance the service function and reduce the quantity of inaccurate service perceptions.

The challenges with geriatric input into the AC@H service potentially could be resolved through better utilisation of other health professionals, such as specialist GPs providing a supervisory role to either APs, Physician Associates or Clinical Development Fellows. In order to scale the service, broadening of referral pathways and operational hours would be required along with more staff to ensure effective person-centred care is delivered. Finally, due to the

challenges accessing information from community IT systems, there needs to be a clear process of allowing staff to access this information through system access or well populated patient summary documents to enhance effective patient care planning.

6. Acknowledgements

The following individuals are acknowledged for their contribution to this report: The AC@H team, staff interacting with AC@H, patients and unpaid carers in engaging in the evaluation process/providing feedback; AC@H Greg Cook and the Health Intelligence team who provided caseload data extraction; Denise Johnson (AC@H Team Leader) and Stephen McNamee (Programme Manager) for leading the implementation of this project and providing input into this report.

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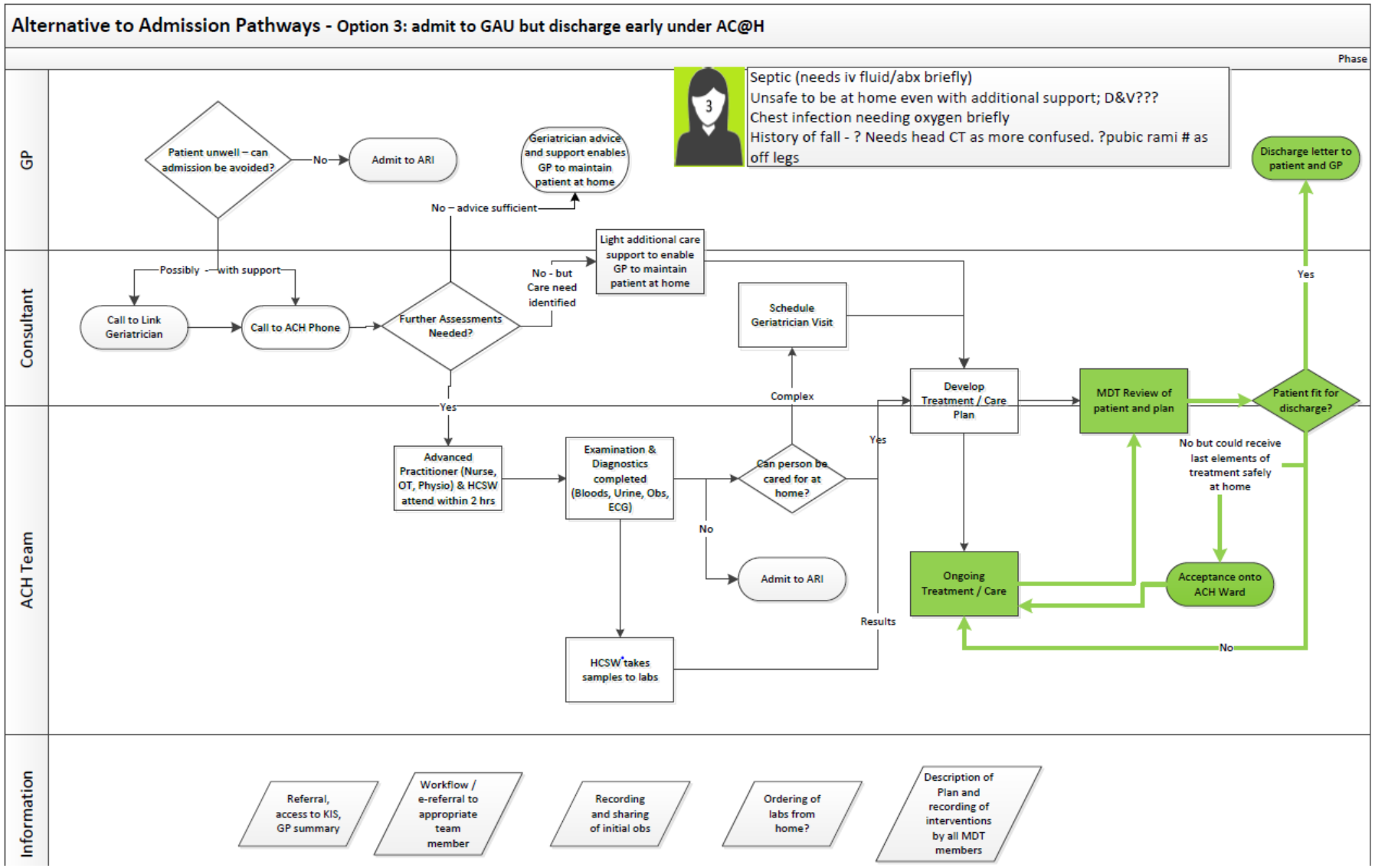
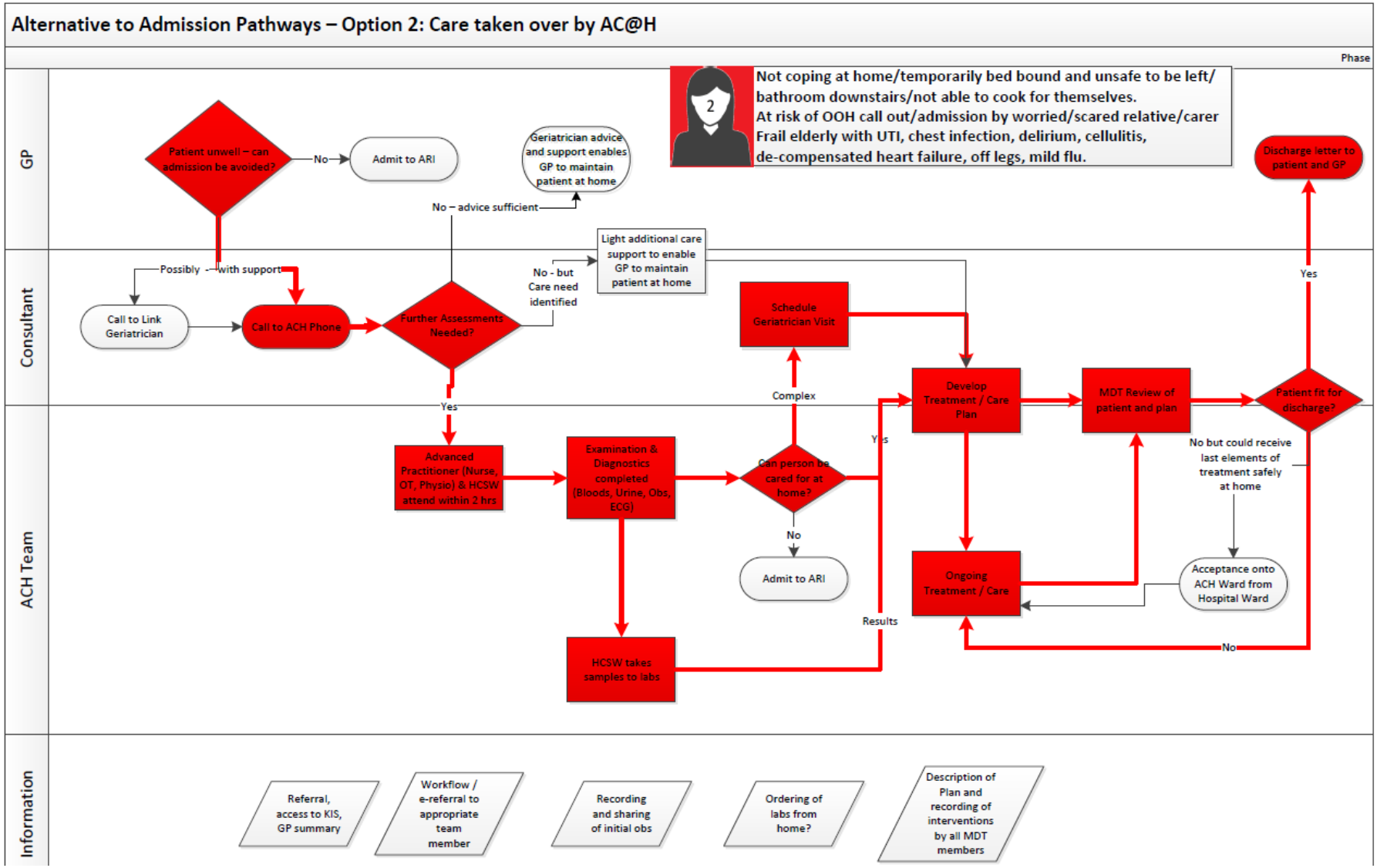
Appendix - Appendix A: Supported Discharge Pathway



Appendix B – Alternative to Admission Pathway



Appendix C – Patient Satisfaction Questionnaire

Acute Care at Home – Patient/Citizen Discharge Questionnaire

We are hoping to gather as many views as possible from patients to helps us recognise what we do well and what we can do to improve our Acute Care at Home service. Please take a few minutes to answer the questions below. All information collected in anonymous so please be honest. Once completed, place this questionnaire into the pre-paid return envelope (no stamp required) provided and send back to us.

To what extent do you agree or disagree with the following statements

	Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
I am satisfied with the Acute Care at Home service I have received					
I would recommend the Acute Care at Home service to others					
I have confidence in the Acute Care at Home team members supporting me					
My care through the Acute Care at Home team was well co-ordinated					

Please use the space provided below to describe any other experiences you would like to tell us about or to write any other comments you would like to make.

Thank you for your time.

Appendix D – Unpaid Carers Questionnaire

We are hoping to gather as many views as possible from family members / friends of patients to help us recognise what we do well and what we can do to improve our Acute Care at Home service. Please take a few minutes to complete this questionnaire. All information is anonymous, so please be honest. Once completed, place this questionnaire into the pre-paid envelope provided (no stamp required) and post it back to us.

Date of Birth:_____ **Postcode:** _____

What best describes your gender? Male ☐ Female ☐ Other ☐

Relationship to cared for person? Friend ☐ Family Member ☐

Your Experience of Acute Care at Home

To what extent do you agree or disagree with the following statements around your experience with Acute Care at Home.

	Strongly Agree	Agree	Neither Agree/ Disagree	Disagree	Strongly Disagree
The Acute Care at Home team provided me with any extra resources, knowledge or skills I needed to look after the person I care for					
The Acute Care at Home team gave me encouragement and support in my caring role					
I was involved or consulted by the Acute Care at Home team as much as I wanted to be, in discussions about the support or services provided to the person I care for					
I was less stressed having my cared for person treated at home than in hospital					
I would rather my cared for person was treated at home than in hospital					
I would recommend the Acute Care at Home service to others					

Did the Acute Care at Home team suggest any source of help or support in the community for you (for example, community groups or social activities)?

Yes ☐ No ☐ Can't Remember ☐

If YES, did you have contact with them?

Yes ☐ No ☐ Can't Remember ☐

Time Spent Caring

About how long have you been looking after or helping the person you care for?

-Less than 6 months	☐	-Over 5 years but less than 10 years	☐
-Over 6 months but less than a year	☐	-Over 10 years but less than 15 years	☐
-Over 1 year but less than 3 years	☐	-Over 15 years but less than 20 years	☐
-Over 3 years but less than 5 years	☐	-20 years or more	☐

Please use the space provided below to describe any other experiences you would like to tell us about or to write any other comments you would like to make

Thank you for completing this questionnaire

Appendix E – AC@H Staff Interview Topic Guide

Introductory Questions

1. Tell me about your experience of working in the AC@H team?
2. How have you found working as part of a multi-disciplinary team?
3. Tell me about the training you have received for this job?
    a. Prompts: during induction and ongoing training. Have these met your needs?
4. Tell me about the caseload of patients that you have cared for?
    a. Prompts: numbers; acuity
5. How have you got on interacting with colleagues outside of the team
    a. Prompts: such as in GAU; GPs; community nursing teams

Positives of working in this way/Enablers

6. What has worked well in AC@H?
7. Was there anything that helped to make this new way of working successful?
8. What have you enjoyed most about this way of working?
9. Were these positives common for all team members?

Negatives of working in this way/Barriers

10. What have been the (biggest) challenges to this new way of working?
    a. IT / team base
11. How did you try and overcome these? Was this successful?
12. Were there any barriers that stopped you overcoming these challenges?
13. Did all staff face different types of challenges? (Were there differences in the types of challenges staff faced?
    a. Prompts: If so, what were they? Why were there differences?)

Future considerations

14. If a new AC@H team member started, what advice would you give them coming into this new way of working?
15. In what way do you think the AC@H model/service could be improved in Aberdeen?
16. Is there anything else you would like to tell me about your experience working in the AC@H team?

Appendix F – AC@H Staff Satisfaction Questionnaire

What is your occupation? (*tick one option only*)

Geriatrician ☐ Advanced Nurse Practitioner ☐ Physiotherapist ☐

Occupational Therapist ☐ Health Care Support Worker ☐ Pharmacy technician ☐

Other (*please specify*): _____

How many years' experience do you have working in either health or social care?

<2 years ☐ 2-5 years ☐ 6-10 years ☐ >10 years ☐

To what extent do you agree with the following statements (tick one box only):

Construct	Question	Strongly disagree	Disagree	Agree	Strongly agree
Supported	*I feel supported by AC@H management staff*				
Training	*I am provided with all necessary training to do my job*				
Development	*I have adequate opportunities to develop my professional skills*				
Communication	*I feel I can easily communicate with members from all levels of the team*				
Workload	*The amount of work I am expected to finish each week is reasonable*				
Progression	*I am satisfied with my chances for promotion*				
Recognition	*I am appropriately recognised when I perform well at my regular work duties*				
Teamwork	*My co-workers and I work well together*				
Systems	*The IT systems I use to do my job are fit for purpose*				
Satisfaction	*How would you rate AC@H as a place to work on a scale of 1 (the worst) to 10 (the best)?*	**1 2 3 4 5 6 7 8 9 10** **Worst .....Best**			

Please let us know if you have any additional comments below.

_____

_____

_____

Thank you for taking the time to complete this questionnaire

Appendix G – Staff Interacting with AC@H Satisfaction Questionnaire

What is your occupation? (*tick one option only*)

Geriatrician ☐ General Practitioner ☐ Advanced Nurse Practitioner ☐

Acute Nurse ☐ Community Nurse ☐ Physiotherapist ☐

Occupational Therapist ☐ Health Care Support Worker ☐ Pharmacy technician ☐

Third Sector ☐ Other (*please specify*): _____

To what extent do you agree with the following statements (tick one box only):

Construct	Question	Strongly disagree	Disagree	Agree	Strongly agree
Teamwork	The AC@H team are easy to work with				
Communication	The AC@H team communicate well with my team				
Contact	The AC@H team are easy to contact				
Referral Pathway	The referral process to AC@H is easy to follow				
Satisfaction	*How would you rate your experience working with the AC@H service on a scale of 1 (the worst) to 10 (the best)?*	**1 2 3 4 5 6 7 8 9 10** **Worst .....Best**			

What do you think are the benefits of having the AC@H service?

_____

_____

_____

What parts of the AC@H service could be improved?

_____

_____

_____

Please let us know if you have any additional comments below.

_____

_____

_____

Thank you for taking the time to complete this questionnaire

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House of Care

Interim Evaluation Report

April 2019

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In Partnership With

Aberdeenshire Health & Social Care Partnership

HEALTH & SOCIAL CARE MORAY

Aberdeen City Health & Social Care Partnership
A caring partnership

Scotland's House of Care

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Executive Summary

Background

Increasing epidemiological challenges have resulted in a rise of individuals living with long-term conditions (LTCs). The consequential economic pressures mean alternative models of care delivery need to be considered. Addressing the needs of individuals living with LTCs through self-management support and collaborative care planning is emerging nationally. One model encapsulating these priorities is House of Care (HoC). The HoC model, developed by the Year of Care Partnership, is an improvement framework developed to enable services to embrace care and support planning (CSP) as an approach to support self-management of people living with LTCs. The model comprises of four interdependent components, with the collaborative CSP conversation at the centre of the house.

This evaluation describes the implementation and impact of HoC in the Grampian region during the first six months.

Methods

The model consists of two separate appointments: 1) an information gathering appointment, where the patient has their appropriate annual tests taken (such as blood pressure, blood & urine tests and weight). The tests results are sent to the patient at least one week before the patient attends the CSP appointment. The results letter also contains prompts and questions to encourage the patient to think about their results and aspects of their health/conditions, which they may wish to discuss. 2) At the CSP appointment, the patient and the Health Care Professional will jointly discuss the patient's results and any questions or support needs the patient may have. An agreed care plan is then developed.

A multi-level, mixed-methods evaluation framework was developed to understand the implementation and impact of the model in the local context. Service data collected included the number of patients and long term conditions targeted at each practice; patient's perception of professional empathy and enablement of self-management was assessed post CSP conversation. Practice staff perceived levels of confidence and knowledge of implementing the HoC model were assessed quantitatively. Qualitative interviews were conducted with practice staff to understand key implementation considerations to inform future service provision.

Results

Service data - Four practices commenced as part of the first cohort of HoC implementation: one in Aberdeen City; one in Aberdeenshire and two in Moray. Practices attended two days training prior to commencement. All practices focused on patients with diabetes and other multi-morbidity LTCs.

Practice populations combined totalled 26,221 patients, of which 4378 are eligible recipients of the model.

Patient data - Patients rated practice staff consistently high across constructs, for example letting them tell their story (85% of 113 responders either scored 'very good' or 'excellent') and showing care and compassion (88% of 110 responders either scored 'very good' or 'excellent'). There were 89% of 114 responders who thought that the professional was either very good or excellent in fully understanding their concerns. Of 114 responders, 72% felt more able to keep themselves healthy as a result of the CSP consultation. Approximately half of responders (55%) indicated that they were signposted to community services / groups for support.

Staff data - Practice staff overall rated HoC training as being 'very helpful' (≥80%), aspects rated most useful included goal-setting and consultation adjustment to improve patient care planning. However, staff commented on the relevance of aspects of the training to their role, for example administrative staff attending training regarding how to conduct the CSP consultation, however attendance to these sessions were not mandatory.

There were 97% of staff who agreed that CSP would be a valuable strategy to adopt. Of interviewees, a power-shift towards a collaborative consultation between professional and patient was described. The results letter patients received prior to the CSP consultation was highlighted as particularly valuable, allowing patients time to reflect and enter this session more informed and subsequently, empowered.

Practices utilising a birth of month recall system reported smoother implementation of HoC. Facilitators to implementation included practices willing to be agile in the delivery of CSP, for example having these consultations conducted remotely, or providing increased appointment lengths for patients with multiple LTCs. Further, practices having staff who assumed a project-coordination role appeared to aid its operation.

Staff reported differences in perceptions, confidence and subsequently, implementation of signposting patients to community services. Some interviewees described non-medical challenges such as financial concerns out with their areas of expertise, whilst others acknowledged the value of addressing these towards achieving holistic care.

Conclusion/Future Recommendations

The HoC model appears to be acceptable to both patients and practice staff. There are numerous aspects of interest that are likely to require longer-term implementation to evidence, including: 1) embedding of a social prescribing approach in General Practice; 2) clinical impact on patients; 3) a greater shift towards increasing patients self-perceptions of managing their own wellbeing; 4) system-wide impact on outcomes such as hospital admissions; 5) assessing the fidelity to which the CSP is being undertaken. It appears that tailoring the delivery of training to role-specific staff, assumption of a project-coordination role and willingness to be agile in HoC delivery will all facilitate its implementation within General Practice.

Key Points

- Notwithstanding logistical, capacity and recruitment challenges facing General Practices, it is feasible to implement the HoC model within the Grampian region
- CSP appears acceptable to both patients and practice staff
- Patients report CSP as superior to traditional care delivery towards self-managing their wellbeing
- Practice staff report CSP as a valuable method of delivery care to adopt
- Training to deliver HoC should be provided in a tailored way, ensuring that only relevant content is delivered to the appropriate staff
- Agility in delivering CSP (for example adapting the length and mode of consultations) may further reinforce a person-centred approach to care delivery.
- Implementation may be facilitated by practices assuming a project-coordination role
- Embedding a social prescribing approach in General Practice is likely to be a medium-to-longer-term outcome

Introduction

The population in the UK is getting older, with a predicted increase of 8.6 million people aged 65 years or over in the next 50 years. Over the same time period, the percentage of the population over 85 years old is expected to rise from 2% to 7%[1]. With an ageing population comes an increasing disease prevalence; with appointments related to long-term conditions (LTC) accounting for approximately 50% of General Practitioner and 64% of outpatient appointments[2]. The associated financial challenges resulting from the ever-increasing epidemiological challenges aforementioned mean that alternative models of delivering care are being considered.

Recently, there has been increasing emphasis on the importance of delivering care using an integrated and person-centred approach, characterised by putting the individual at the centre of the system and facilitating a shift towards empowering people to manage their own wellbeing[3]. Evidence shows that systems oriented around the needs of individuals and communities may be more effective, cost less and improve health literacy[4]. The challenge, however, lies in implementing and embedding such an approach within an integrated primary care context requiring cultural, system and organisational change for effective, economically-viable and sustainable implementation.

One model, which articulates the type of cultural, system and organisational changes required for the implementation of integrated and tailored care provision, is the House of Care (HoC) model. HoC is characterised by delivering person-centred care through collaborative care and support planning (CSP) conversations, helping individuals (living with LTCs) take an active role in the management of their wellbeing by identifying goals important to them. The model consists of two separate appointments: 1) an information gathering appointment, where the patient has their appropriate annual tests taken (such as blood pressure, blood & urine tests and weight). The tests results are sent to the patient at least one week before attending the CSP appointment. The results letter also contains prompts and questions to encourage the patient to think about their results and aspects of their health/conditions, which they may wish to discuss. 2) At the CSP appointment, the patient and the Health Care Professional will jointly discuss the patient's results and any questions or
support needs the patient may have. An agreed care plan is then developed (for more detailed information about the model, visit the work of Coulter et al. (2016)[5]. The model has demonstrated

[1] Office for National Statistics (2018). Living longer: how our population is changing and why it matters.
[2] Scottish Government. Department of Health. (2012). Long-term conditions compendium of Information: 3rd edition.
[3] Scottish Government (2010) NHS Five Year Forward View 2014.
[4] World Health Organisation -Global strategy on integrated people-centred health services 2016-2026: Placing people and communities at the centre of health services.

positive impact across several sites nationally[6] and locally, the decision was taken to test the feasibility of implementing such an approach.

This report explores implementation and impact of the House of Care Model in the Grampian Region.

[5] Coulter *et al*, (2016). *Building the House of Care for people with long-term conditions: the foundation of the House of Care framework*. Br J Gen Pract. 66 (645): e288-e290.
[6] British Heart Foundation - Evidence and findings from the BHF House of Care Programme.

Methods

Practice Recruitment

In January 2018, recruitment of General Practices in Grampian to participate in the delivery of HoC commenced. Eleven practices across the three Health and Social Care Partnerships (Aberdeen City, Aberdeenshire & Moray) were recruited to implement the model. Practices received training over two days (one full day and one half day) prior to go-live, with practice facilitation sessions (including process mapping and team engagement) being conducted onsite locally to understand current ways of working. All the practices received a bursary to help towards backfill to release staff for training and any other initial start-up costs.

This evaluation focuses on the first four practices that proceeded to 'live' implementation in Cohort 1. These practices have all been delivering CSP for a minimum of six months and targeting patients with multi-morbidities. Initially, eight practices were recruited for Cohort 1, however four withdrew from progression, citing staffing and time-associated challenges. As the data collection described within fell under the categorisation of service evaluation, ethical approval was not required.

Evaluation Design

A systematic process was followed in the development of the evaluation framework to support a local case-for-change. This framework was developed through an iterative cycle by an evaluation working group, which including experts in HoC delivery, self-management and public health research. The group used a combination of published reports, key learning from other health boards and gaps in the literature to develop and refine the framework.

A multi-level, mixed-methods framework was developed to delineate the data collection across the implementation of HoC. Evaluation metrics relevant to include in this report are visible below. It is important to note that several outcomes are to be reported on after 12 months and as such, are not described within. The primary aim of this evaluation is to determine whether the HoC model is feasible to implement within the Grampian region.

Staff Evaluation

Training – Practice staff from Cohort 1 who attended the HoC Training completed evaluation questionnaires at the end of each training day (one full day and one half day) (Appendix 1). Constructs measured included perceived value; clarity regarding implementation considerations and satisfaction of engagement. All forms were anonymous and returned to trainers at the end of training. One practice received tailored in house training.

Coherence and perceived engagement with the HoC model was assessed using an adapted NoMAD Survey[7] (Appendix 2). The tool, based on normalisation process theory, focuses on professionals' perceptions around implementing new complex interventions in a healthcare setting, specifically levels of confidence and engagement to change practice. The survey was completed before model commencement.

Perceived skill, knowledge and confidence to conduct CSP consultations were assessed using the Care, Support & Planning Consultation Questionnaire (CSPC-1)[8,] adapted from a Year of Care reflective tool (Appendix 3). This was completed upon completion of training by practice staff that would deliver the CSP conversation directly with patients.

Practice staff involved in the delivery and implementation of HoC were invited to participate in semi-structured interviews/focus groups to understand the implementation and impact of delivering HoC. The interview topic guides were semi-structured (Appendix 4). Interviews were audio recorded and transcribed verbatim and analysed thematically. Thematic analysis is useful towards understanding patterns occurring in the data in order to improve understanding on a particular topic[9]. Analysis followed the six step framework previously described by Braun and Clark (2006)[10], including: 1) familiarisation with the data; 2) developing initial codes; 3) searching for themes; 4) reviewing themes; 5) theme definition and 6) write up of results. The data were analysed independently by two researchers and then findings compared and adapted if required.

[7] Girling *et al*. (2018). *Improving the normalization of complex interventions: part 1 - development of the NoMAD instrument for assessing implementation work based on normalization process theory* (NPT). BMC Medical Research Methodology 18:133.
[8] Care, Support & Planning Consultation Questionnaire. Adapted from Year of Care V1.0 Sept 17
[9] Maguire, M. & Detahunt, B. (2017). *Doing a thematic analysis: practical step by step guide for learning and teaching scholars*. AISHE-J. 9(3).
[10] Braun, V. & Clark, V. (2006). *Using Thematic analysis in psychology*. Qual Res Psych. 3(2), 77-101
[11] Mercer, S. & Howie, J. (2006) *CQI-2 — a new measure of holistic interpersonal care in primary care consultations*. Br J Gen Pract. 56(525): 262–268.

Patient Evaluation

Patient-rated quality of the CSP consultation and perceptions of ability to self-manage their wellbeing as assessed using the Consultation Quality Index (CQI-2). The CQI-2 is a tool to measure holistic interpersonal care, with a specific focus on patient enablement, length of consultations and care continuity[11] (Appendix 5). The CQI-2 was administered once patients had received their second (CSP) appointment. Completed questionnaires were left in practice collection points and returned via mail to the research team, who inputted the data into an electronic database.

Results

The characteristics of Practices included in the first cohort of implementation are visible in Table 1.

Table 1. Cohort 1 Practice/Patient Demographics

Practice	Practice population	LTCs patient numbers	Staff description	Staff (N)	Training attendees	CSP delivered by
1	12,688	Diabetes M/M n=597	GPs	5	1	
			PM	1		
			OM	1		
			PN	4	2	Y
			HCA	1	1	
			Adm/Rec	N/R	2	
2	6,033	Diabetes M/M n=1786	GPs	3		
			Pharmacist	1		
			Physician Ass	1		
			PM	1		
			ANPs	2	1*	Y
			PNs	4		Y
			HCSW	1		
			Adm/Rec	10		
3	4,139	Diabetes M/M n=1245	GPs	2	1	
			PM	1	1	
			NP	2		Y
			PN	2	2	Y
			HCA	0		
			Adm/Rec	6	1	
4	3,361	Diabetes M/M n=750	GPs	2	1	
			PM	1	1	
			PN	2	2	Y
			HCA	N/R		
			Adm/Rec	N/R		

*One person from this practice attended the YoC training, but all practice staff received a tailored 'short' version of the training delivered at the practice.

LTCs = Long term conditions; N=number; N/R=Not Reported; M/M=Multi-morbidity; GPs=General Practitioners; PM=Practice Manager; OM=Operational Manager; PN=Practice Nurse; HCA=Health Care Assistant; NP=Nurse Practitioner; ANP=Advanced Nurse Practitioner; HCSW=Health Care Support Worker.; Adm=Administrator; Rec=Receptionist.

HoC Training Evaluation

Day 1 (Full day) – Table 2 reports the evaluation of the first day of training. Each construct was rated out of 10 and a total of 36 evaluation forms were completed, thus meaning constructs were scored out of a total of 360. Understanding of the CSP approach was the highest rated construct (91%), with understanding the consultation framework, core competencies and organisational requirements scoring lowest (83%).

Table 2 – Evaluation of training day one

Construct	Total Score Rating out of 360	Percentage (%)
Understanding the YoC approach to care and support planning	328	91
Reflect on your own approach/philosophy of care and how this fits with care and support planning	306	85
Understand the care and support planning consultation framework and the core competencies required	299	83
Helped you to be clear about the organisational requirements for implementing care and support planning in practices	298	83
How would you rate the overall session	317	88

Qualitative responses (direct quotations) that attendees regarded as most useful included:

- *'How to goal set/action plan, understand the HoC process'*
- *'How to adjust my consultations to improve patients care planning'*
- *'Watching and discussing consultations/role play'*
- *'Principles of HoC/Accessing tools to support HoC'*

Qualitative responses (direct quotations) that attendees regarded as requiring improvement included:

- *'Opportunity to hear and debate case analysis from different perspectives, ie, GP, Nurse, Administrator, Manager'*
- *'Day too long'*
- *'Separate session for admin would help/admin don't need to attend whole day'*

Day 2 (Half day) – Table 3 reports the evaluation of the second day of training. Each construct was rated out of 10 and a total of 26 evaluation forms were completed, thus meaning constructs were scored out of a total of 260. Reflection and planning CSP implementation was the highest rated construct (90%), with overall satisfaction of the session scoring lower (81%).

Table 3 – Evaluation of training day two

Construct	Total Score Rating Out of 260	Percentage (%)
Take stock and have an opportunity to reflect and plan the implementation of care and support planning for your practice teams	233	90
Reflect upon and practise care and support planning consultation skills	228	88
Consider strategies that might be useful for people with low levels of importance or confidence	231	89
Consider your next steps to implement care and support planning	215	83
How would you rate the session overall?	211	81

Qualitative responses (direct quotations) that attendees regarded as most useful included:

- *'Networking/ sharing ideas with other practices'*
- *'Techniques to deliver CSP role play'*
- *'Session better as not whole day'*

Qualitative responses (direct quotations) that attendees regarded as requiring improvement included:

- *'Clinical scenarios not relevant to admin staff'*
- *'Less role play'*

Practice evaluation results

Table 4 shows the NoMAD survey results for practice staff regarding coherence and cognitive participation (question completion ranged between 96-100 responses). The majority of staff agreed or strongly agreed that the method of CSP consultation made sense and that they would be involved and support the implementation of HoC in their practice (97%).

Table 4: NoMAD survey results – coherence and cognitive participation (% of responders)

Questions Relating to Coherence - Making sense.	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Don't know
I can see how care and support planning will differ from the usual way of working	35	61	3			
Staff in this practice have a shared understanding of the purpose of care and support planning	32	65	3			
I understand how care and support planning will affect the nature of my own work	39	52	6	3		
I can see the potential value of care and support planning for my work	52	45	3			
Cognitive Participation - Becoming Involved						
There are key people who will drive care and support planning forward and get others involved	45	52	3			
I believe that participating in care and support planning will be a legitimate part of my role	50	29	18	3		
I will be open to working with colleagues in new ways to use care and support planning	64	37				
I will support care and support planning	67	30	3			

Table 5 shows the NoMAD survey results for practice staff regarding perceived skills and knowledge. There was large variance from responders regarding perceived difficulties in conducting the CSP conversation, however responders indicated confidence in their knowledge and skills to carry out the CSP conversation.

Table 5: NoMAD survey results - perceived skills & knowledge (% of responders)

Skills &Knowledge (0 = not at all, 5= somewhat, 10 = completely)	0	1	2	3	4	5	6	7	8	9	10
How challenging do you feel the CSP conversation/discussion is going to be?		14		3	3	21	3	32	17	5	3
How easy will it be to signpost people to support in the local area for the issues they identify?		9				12	21	21	24	5	9
I feel confident in my knowledge and skills to have a CSP conversation with my patients							15	33	26	26	
I feel confident in my knowledge and skills to support patients with 'goal setting' and developing 'action plans'	4		4			8	17	25	21	17	4
I feel confident in my knowledge of community services and assets to signpost patients accordingly		4				13	24	20	20	16	3

Table 6 shows staff responses from the CSPC-1. The majority of practice staff had a high level of confidence to carry out all aspects of CSP consultations including identifying patient's main concerns identify goals and develop positive relationships. Given that only a small cohort of staff were delivering the CSP consultation (and subsequently only these individuals completed this survey), the numbers are presented as individual responses as opposed to percentages.

Table 6 - CSPC-1 – Staff Perceived Confidence (recorded as the number of staff responses)

How confident are you that you can: (1 is 'not confident at all' and 10 is 'very confident')	1	2	3	4	5	6	7	8	9	10
Describe the purpose of a care and support planning consultation?							2		1	3
Work with the person to develop an agreed agenda?							2	2	2	2
Elicit the person's knowledge and beliefs about their condition?							1	1	3	1
Elicit the person's main concerns and priorities?							1	1	3	1
Explore and elicit the person's goals?							1	1	3	1
Facilitate the person to develop their own action plan?							2	2	1	1
Explore the person's barriers to achieving their goal and their own personally relevant solutions?							1	2	1	2
Develop a positive working relationship (rapport) with the person?								1	3	2
Check out with the person how they feel your conversation is going particularly when you think it might not be going well?						1	1	3		1
Tell when you are trying to persuade the person to do what you think is the right thing?							1	3		2
Allow the person to take the lead in the consultation						1	1	2	1	1
Express your concerns or challenge the person in a way that maintains your relationship and their autonomy?						1		2	1	2
I have a good range of open questions to use in consultations					1		1	1	1	1
I can confidently use simple and complex reflections					1	1	1	1	2	
I can demonstrate understanding and empathy using reflections					1		1		2	
I can use scaling questions to explore importance and confidence					1			2	3	

Practice Interviews

Table 7 provides an overview of the four themes that emerged from the thematic analysis: 1) Service operation; 2) External support; 3) Enablers and 4) Impact. The sub-themes embedded within these themes are described below. For the purposes of interviewee confidentiality, all quotations have been anonymised.

Table 7. Themes and subthemes derived from thematic analysis

Theme	Subtheme
Service operation	Appointment planning
	Care delivery
	Model agility
	Patient correspondence
External support	Networking
	Training
	Support
Enablers	Attitudes
	Structure
Impact	Patient impact
	Staff impact
	Service impact

Service operation

Appointment planning – To facilitate delivery the CSP conversation, practices could implement a month of birth recall system. Those practices who were utilising this recall method prior to delivering HoC reported smoother implementation, with this approach providing a beneficial structure to both professionals and patients: *"From our point of view people would say, I think I am due my annual review and before you would have to go through the notes to see when they last had an appointment, whereas now you can go what is your date of birth, you will be due March time or whenever their birth month it. That makes it a lot quicker for us and from our point of view it is a lot more streamlined".* To avoid confusion and aid a systematic approach to delivering CSP, interviewees described the value of utilising a colour coding system for appoint coordination: *"All practices will do it differently but the way we do it works really well for us, like I say because we colour code the appointment and then we colour code the slips that they bring us out. They come out with a piece of paper that says a thirty minute appointment with [Staff name] ticked, we cannot really go astray with that, neither can the patients because it is quite clear what they need to do. That works really well".*

Care delivery – The HoC model was delivered over two main appointments: 1) the initial data collection meeting, which was used for: *"gathering information, blood tests, blood pressure, weight checks …"* and 2) a follow up action planning appointment: *"after they have already seen the data gathering, they [patient] come and we go over things and then we set goals together".* Participants described the implementation of the CSP conversation and discussed the value of providing a holistic appointment to ensure that agreed decisions moved beyond a sole improvement in clinical outcomes: "*we had a lady who had chill blains which … were stopping her from walking so much, so [Staff name] addressed the chill blains and she was given advice about more comfortable socks and creams for wrapping up well just to get her out. If she is walking more, her wellbeing is better and she might lose*

weight. You have to address what the real issues are and it is maybe not the time for weight loss but if you have addressed their needs, you will gain trust."

A fundamental change in this model compared to traditional care delivery was the mailing of results letters to patients prior to follow-up appointments: "*the big difference being that they got stuff on paper that they can see before they come in … previously they would just come in and I was giving them their results verbally".* The model also had a strong emphasis on the 'More than Medicine' approach and utilising community-based assets to support self-management. Here, participants described signposting patients to local, non-medical services they felt could be of benefit: *"Getting up to speed with what facilities are out there, now we are referring to agencies which you maybe knew of them but were not used to referring to them, money issues , we are only used to dealing with health issues and I know a lot of other things come into it also but it is just getting your head round what is available locally and doing a lot of work to get that information".*

Model agility – Interviewees described numerous adaptations they made to the model to ensure it was congruent with the local context. For instance, individuals with several LTCs required more discussion and consequently, more time allocated to their appointments (which was not initially envisaged). Changes to the appointment lengths in these circumstances reduced the subsequent stress on practice staff: *"There was a few times because we are seeing respiratory patient and diabetic patients at the same time, not enough time was allocated for both, so we realised that we needed more time to do the data gathering and the goal setting, we realised that we needed longer for those appointment that try to cover both big areas was just too much, we were running really late and getting stressed by it. Once the templates were changed so you were getting double, it just changed things completely."* Despite these changes in appointment lengths meaning the appropriate documentation also had to be adapted, this was not perceived as a particularly burdensome task: *"we did have to change all our templates for the appointments but this was reasonably easy enough to do. A bit time consuming trying to work out what you wanted to do, but once it was done, it was done".*

Further adaptations that were made to the model in by some practices included the mode of CSP delivery. Whilst typically, this model is delivered face-to-face, instances were described whereby these conversations were had remotely. Pre-existing relationships between the professionals involved in HoC and practice-attached nurses provided an efficient channel to ensure even housebound patients could engage: *"What we did, we printed out her care plan [results letter] and the district nursing team took it out to her. It was done over the phone, so you can do it remotely and that lady is so much happier, even when you speak to her on the phone her whole voice is different".*

Patient correspondence – Staff commented that the invitational letters encouraging patients to engage in CSP may have been more appealing than how they traditionally contacted individuals, particularly for those who did not attend practice for regular condition reviews: *"I have found that patients who have not come for a long time come, maybe it is the way the letter is worded as it is more detailed and it is worded different to our previous letters"*. There were some challenges reported with different modes of correspondence, such as virtually, which resulted in data loss: *"There were just a few teething issues with people who wanted the results emailed, I think sometimes they went into junk mail and there was some people who did not receive their results".* However, participants did not feel all patients would be appropriate to offer this model to and subsequently, developed inclusion criteria for whom they would choose to invite: *"Certain patients are maybe on the palliative list have complex medical health problems would all be removed at that point and then they would not be invited".*

External support

Training – Staff involved in the CSP conversation attended two training days prior to delivery to understand how it would be delivered in practice. Overall, feedback was positive, with attendees describing the value of having several members from the practice attending to gain a shared understanding and vision for this model: *"I think it was really good to the whole team involved. It was mainly a nurse led approach and to educate the nursing team and all the team about the care and support planning".* However, the structure of the training received mixed views, with some staff questioning the relevance of particular elements. For example, Health Care Support Workers discussed that the second day of training focused on the CSP conversation (however it was not mandatory to attend this session), which was undertaken by nurses and subsequently, not applicable to their role: *"The first one I thought was really good, it was explaining about House of Care … but the next one was more vocally about what we would tell the patients, I thought 'I do not do any of that'".*

Differences were also evident in the intensity of training delivery. Some interviewees felt overwhelmed with the quantity of information being given to them in a condensed period of time: *"I felt that one day was really intense and a lot to think about when you left … it was really hard going by the end of the day".* However, this contrasted with another participant who felt that particular components of the training could have been explored in greater depth, such as the action planning element with patients: *"I did struggle a wee bit at the beginning, being an older kind of nurse … I think I would have benefited from more training but some of the people found it adequate but I would have like to have had more training on my consultation skills. I am not a great role player and I think that is probably why I struggled with it because that format is not always for everyone".*

Networking – A perceived opportunity for future implementation was visiting other sites to gain an understanding of how the model worked in practice: *"It would have been good in hind sight to see how it was working in other practices and to see how there are doing their reviews. That is an option but then it was only [Practice name] then but now there is more and they would also like to meet with other practice nurses as well, especially the practice nurses and Health Care Assistants, sort of bouncing off thoughts and ideas especially around the care support planning conversations"*. However, other interviewees responded that, whilst this may be useful, they cited capacity issues as a barrier to networking opportunities: *"time is an issue, we most of the time struggle to fill the appointments, we are always very busy".*

Support – Participants were able to provide examples of a variety of different colleagues who were able to support them during the early stages of implementation, whether this was condition-specific queries, or issues related to IT: *"Anything we have needed, we have been able to get, so we have had support from Respiratory people, also from Vision people this has been great help and anything we need to ask any questions about things, it has always been answered".* The individuals who had delivered the training visited practices: *"a few times, before and after the training"* to provide any ongoing support that may be provided, however most interviewees felt this was not required: *"not for me, I do not feel that I was needing any [ongoing support]".*

Enablers

Attitudes – In making a significant change to how patient care was delivered, interviewees highlighted the value of having commitment from across all General Practice staff in order to make this change successful: *"I think we just thought sod it, it was a really good idea and we were really busy and we were passionate about it. When you are passionate about something you get going. When we went to the taster session and then the first day, they said this is what we want you to do, so that is what we did".* It was also felt that staff had to be open for asking for help and advice from others when necessary, understanding that it would be a learning process for everyone involved: *"Someone who communicates with someone quite well and ask for input, I do not think there would be a problem".*

Structure – Given the changes in delivery necessary for several members of General Practice, one pragmatic decision taken at one site that aided the delivery of the model was to assign an individual to a project management role to provide an oversight of implementation: *"You also need to have a dedicated clinic coordinator. I do not think it could be done by numerous people, I think someone needs to take the lead for it and have the overall responsibility, almost like a practice project manager as such that oversees all the different parts along the way to make sure it is running.* Further, thought had to be invested to ensure that clear delineating of roles and responsibilities for each staff member

was apparent: *"I think probably everyone has their own role in things from like admin setting it up, sending out letters, everything just kind of goes. I think because our admin team are going great with their job, so when patients come to me, they know a little bit about House of Care, they receive their letter and things. I do not think it has been a challenge".*

Impact

Patient impact – The majority of interviewees felt HoC had a positive impact on their patients' wellbeing. For example, they discussed the value of sending results to patients ahead of their goal-setting appointment, helping them feel more informed and taking ownership of their health: *"Say their Hba1C had gone up from 50 to 64, they are getting time to look at this and process the information, so when they come in for their review they can ask the questions that probably before they were coming in getting their results from the nurse and did not really want to ask much questions, so they are kind of in control".* In particular, the use of colour to highlight areas of their health that could be improved was seen as a motivator to promote positive behaviour change: *"I have had quite a number of people saying this is great, this is really good and they are really engaging with it. It has motivated them. I had one bloke I had been seeing for two years who has been obese for all that time, he gets his form back it is in the red and he sees that he is obese, he thought oh well I better do something about that then".*

Whilst the majority of interviewees reported positive impact on patients, particularly due to the results letter they received prior to the CSP appointment, this was not unanimous. Some professionals felt these results letters were not operationalised in an effective way due to issues with both length and content, however it should be acknowledged that this practice adapted the standard template: *"The results sheet going out is way too wordy and we have an awful lot of patients saying 'it does not make any sense to me, I cannot make head nor tail of this'".*

Staff impact – Participants described an overall improvement in their job satisfaction through delivering this model, commenting that it facilitated a holistic approach to care provision compared to a traditional emphasis on disease: *"It has been very fulfilling and I think in years to come, this is just six months it, it is very much person centred and you are dealing with issues that might not have nothing to do with chronic disease but we have a directory we use now that [Staff name] updates it and we are using it".* The focus on multiple morbidities led to the upskilling and professional development of some staff, particularly nurses, some of whom had not dealt with particularly diseases prior to implementation: *"The respiratory side is really new to me, I have only done that within basically the last year, so since we started talking about House of Care, developing a new skill at the same time was quite difficult but I am much more confident in that now".*

Service impact – This model was a much more efficient way of delivering care. In particular, having one appointment to collect all of the patient's data, especially if they had multiple conditions, was more streamlined than the traditional approach of separate visits: *"The main difference is they are getting everything done at that appointment. Before they used to just get a blood test and then you would send them to see [Practice Nurse] for everything else. Now they are seeing me for bloods, blood pressure, weight checks".* Whilst some appointments may take longer, it was thought that this would ultimately reduce the overall number of appointments that an individual would have to attend throughout the course of the year, subsequently reducing pressure on primary care: *"they do not have as much appointments in a day".*

Patient data results

Table 9 shows the empathy, enablement and continuity constructs of the CQI-2. Responders rated the professionals delivering the CSP consultation consistently high across interpersonal constructs, including 'showing care and compassion' (88% either scored 'very good' or 'excellent') and 'letting you tell your story' (85% either scored 'very good' or 'excellent').

Table 10 shows the perceived enablement of self-management constructs of the CQI-2. Of responders, 72% felt the CSP consultation had made them more able to keep themselves healthy compared to traditional consultation methods.

Table 11 shows the information sharing and signposting constructs of the CQI-2. Of responders, 91% of patients agreed that receiving the results letter prior to the CSP consultation was beneficial, with just over half reporting that, during this discussion, they were signposted to local support services.

Table 8 – CQI-2 Consultation Quality Index - Empathy, enablement and continuity

CQI-2 Question	Total responses	Options	Percent %
Letting you tell your "story"……		Poor	0
		Fair	1
	113	Good	12
		Very good	33
		Excellent	52
Fully understanding your concerns……		Poor	0
		Fair	0
	114	Good	9
		Very good	36
		Excellent	53
Showing care and compassion….		Poor	0
		Fair	1
	110	Good	5
		Very good	28
		Excellent	60
Explaining things clearly……..		Poor	0
		Fair	0
	115	Good	5
		Very good	31
		Excellent	63
Helping you to take control……		Poor	0
		Fair	1
	80	Good	4
		Very good	24
		Excellent	40
Making a plan of action with you with agreed 'goals'		Poor	0
		Fair	0
	79	Good	7
		Very good	21
		Excellent	47

Table 9 – CQI-2 Consultation Quality Index - Patients Perceived enablement of self-management

Questions	Total responders	Options	Percent %
Able to cope with life…	115	Much/better more	19
		Better/more	41
		Same or less	28
		Not applicable	11
Able to understand your condition(s)…	115	Much/better more	27
		Better/more	43
		Same or less	27
		Not applicable	3
Able to cope with your condition(s)…	113	Much/better more	22
		Better/more	40
		Same or less	34
		Not applicable	3
Able to keep yourself healthy…	114	Much/better more	21
		Better/more	51
		Same or less	24
		Not applicable	3
Confident about your health….	114	Much/better more	22
		Better/more	45
		Same or less	30
		Not applicable	1
Able to help yourself….	114	Much/better more	23
		Better/more	47
		Same or less	26
		Not applicable	3

Table 10- CQI-2 Consultation Quality Index – Information sharing/signposting

Consultation Quality Index - Information sharing/signposting Questions	Total responses	Options	Percent %
How useful was the letter you received with your test results in helping you to prepare for the care and support planning conversation?	70	Not at all useful	0
		Not very useful	0
		Somewhat useful	24
		Very useful	67
		Did not read	3
During your care planning conversation today, did you discuss services and supports based in your local community (for example, support groups, or patient organisations)?	78	yes	55
		no	12

Discussion

As part of the HoC model practice staff attended a 1.5 day training on the process of implementation in practice. Overall, training seemed acceptable with a high satisfaction rate (84%). Elements of the training that staff found particularly enjoyable included action planning, goal setting and how to adjust consultations to improve patients care planning. Interviewees did however have the view that elements of the training were not relevant to all staff members. For example the second day of the HoC training has a particular focus on the CSP consultation, which was not relevant to administrative staff or HCSWs. It is recognised that staff need to receive the correct training to ensure they can deliver best practice[12], however with ever decreasing resources in primary care[13] and associated time constraints[14] there is a need to ensure that available resources are used efficiently and effectively. Therefore, an alternative and potentially more efficient means of delivering HoC training to practice staff would be to tailor training so that the content included the relevant components to the appropriate Practice staff[15].

The HoC model is of a house built around a care planning conversation between people and the healthcare professional, the fundamental principles is that CSP focuses on a person-centred approach[16]. Patient consistently rated their CSP consultation experience with practice staff highly across all constructs of the CQI-2 questionnaire. For example, they felt that they were able to tell their story (85% of responders either scored 'very good' or 'excellent') and showing care and compassion (88% of responders either scored 'very good' or 'excellent') and with a high percentage of respondents (89%) who thought that the health professional was either 'very good' or 'excellent' in fully understanding their concerns. There is evidence that people who have the opportunity and support to make decisions about their treatment and care in partnership with their health professional(s) are more satisfied with their care, have improved clinical outcomes and have improved adherence to medication[17]. These findings are consistent with others in Scotland and reinforce its relevance locally, demonstrating that the model has high acceptability to patients. Although it is too early to evaluate clinical outcomes at this stage of

[12] NICE (2007). National Institute for Health and Clinical Excellence (NICE) (2007). *How to Change Practice. Understand, Identify and Overcome barriers to change*. London: NICE
[13] Audit Scotland (2017). NHS in Scotland. Edinburgh: Audit Scotland.
[14] Scottish Government (2016). A national clinical strategy for Scotland. Edinburgh: Scottish Government.
[15] Gesme *et al*. (2010). *Essentials of Staff Development and Why You Should Care*. J Oncol Pract 6(2).
[16] Scottish Government (2016) *Person-centred Care: What Non-Executive Directors Can Do* https://www.gov.scot/publications/person-centred-care-non-executive-directors/pages/1/
[17] The Health Foundation (2016). *Why person-centred care is important*. https://personcentredcare.health.org.uk/person-centred-care/overview-of-person-centred-care/why-person-centred-care-important

implementation, evidence elsewhere suggests that high acceptability is likely to lead to improved clinical outcomes.

The model appears highly acceptable to patients regarding aspects of perceived self-management, with the majority of patients reporting the CSP consultation to be better than previous consultations conducted in the traditional model. For example, patients reported a high score on elements of empathy, where they felt that the health practitioner let them tell their story (85% of respondents scored either 'very good' or 'excellent'), fully understood their concerns (89% of respondents scored either 'very good' or 'excellent') and explained things clearly (94% of respondents scored either 'very good' or 'excellent'). However, it is interesting, yet potentially unsurprising to note, that the constructs around self-management score consistently lower than the empathy constructs highlighted previously. A move towards self-management in healthcare requires a change in the collaborative exchange between health professionals and patients with LTCs. The process of building patients knowledge, skills, and confidence necessary to manage their condition(s) effectively in the context of their everyday life may be a longitudinal outcome[18]. This is reinforced by CSP being a relatively new model emphasising a shift towards self-management in health care, and consideration should also be given to that, at the time of analysis, all patients had only received one CSP consultation. Considering this, these findings are a positive first step towards indicating that the model may be valuable to implement at scale, however longer-term follow up is required with this cohort to ascertain whether patients report greater self-management.

As with patients, the model appeared to be highly acceptable to staff; one element highlighted as particularly enjoyable was a shift from talking "to" patients, to having more of partnership dialogue between the two. Partnership dialogue, characterised by patient's being involved in making decisions regarding their own health, has been shown to increase patient empowerment which in turn leads to patients improved self-management of their health[19]. One mechanism reported that was particularly beneficial towards attaining this shift was the results letter patients received prior to the CSP consultation. Providing patients with their results prior to their consultation facilitates patient education by allowing appropriate opportunity for reflection through discussion with significant others, potentially increasing a sense of empowerment over their health[20]. Therefore, this is likely to be an integral step towards

[18] The Health Foundation (2015). *A practical guide to self-management support: Key components for successful implementation*. https://www.health.org.uk/publications/a-practical-guide-to-self-management-support
[19] Nygårdh *et al* (2012). *The experience of empowerment in the patient–staff encounter: the patient's perspective*. Journal of Clinical Nursing. 21(5-6)
[20] Henwood *et al* (2003). *'Ignorance is bliss sometimes': constraints on the emergence of the 'informed patient' in the changing landscapes of health information*. Sociology of Health & Illness. 25(6) 589–607

achieving self-management. Presenting patient results visually, using the traffic light systems, has been shown to promote wellbeing across public health initiatives including enhanced diet from colour-coded food labelling[21], a particularly important consideration the association between LTCs and health illiteracy[22]. This is reinforced by 91% of patients highlighting that they agreed that results letter was somewhat to very helpful. However, it was acknowledged in one practice that they felt it was too much writing, therefore practices may prefer to tailor the content deemed appropriate for their local practice whilst retaining the beneficial principles of the letter (such as use of colour).

One of the main pillars of the HoC model is a whole system approach to provision of services, including social prescribing / signposting to services. However, there were differences in perceived knowledge of local services (only 3% of respondents indicating they thought it would be completely easy to sign post to services; 3% completely confident in their knowledge, most indicating they were somewhat or slightly greater in their confidence or knowledge of services) which likely impacted on the level of signposting patients to community services. This may explain why only 55% of patients reported that they were signposted to community assets, although it should be acknowledged that signposting may not be appropriate for all patients. Whilst some practice staff recognised the value of addressing non-medical patient challenges, such as financial concerns, other interviewees were hesitant to address these, citing they were out with their areas of knowledge. Lack of social prescribing may be attributed to a lack of awareness of available services, however with other local initiatives specifically focusing on social prescription, such as the Aberdeen Links Service, these are likely to directly contribute towards the upskilling and awareness-raising of practice staff regarding local community services and assets relevant to their patients. Introduction of a similar service across Grampian would contribute to an embedding of a links approach, however this is likely to be a longer-term outcome.

Regarding the implementation of the model, there appeared to be numerous facilitators that went beyond the staff acceptance and belief (97% of practice staff agreed to strongly agreed that they supported and could see the potential value of CSP) that a change of practice would be to the benefit of patients[23]. For example, practices reported smoother implementation if they were already using a birth of month recall system, as this was congruent with the method of inviting patients to attend the CSP consultation. Further, practices emphasised the importance of clear delineation of roles and

[21] Cecchini & Warin 2016). *Impact of food labelling systems on food choices and eating behaviours: a systematic review and meta-analysis of randomized studies*. Obesity Reviews: 17 (3).
[22] Panagioti *et al* (2018). *Effect of health literacy on the quality of life of older patients with long-term conditions: a large cohort study in UK general practice*. Quality of Life Research 27(3)

responsibilities towards successful delivery of the model. In particular, one practice contained an individual who assumed a project-coordination role to oversee the implementation. Notably, this practice appeared to report the highest acceptability of the model comparative to others. A change in health care practice can be aided through strong leadership, knowledge, understanding and skills[23], therefore this may be a particularly important consideration for future practices aiming to implement this model.

Other implementation considerations include the length of appointments. There was a consensus from practices that, depending on the cohort of patients, appointment lengths were not suitable. For example, patients with multiple LTCs required additional time to be able to discuss all concerns, whereas those with one LTC required less time, albeit there may be exceptions to this association. As a consequence, some interviewees described rushed appointments and running over time. However, other practices decided to adapt their appointment system and, in these scenarios, provide longer appointment lengths to patients who needed them. A person-centred focus, an integral component of the HoC model, aims to meet the needs of the patient rather than the needs of the service therefore, flexibility in care delivery should be championed if possible[24]. One practice took the implementation of HoC further by adapting the delivery of the CSP consultation to include remote patients. This was achieved by conducting CSP consultations virtually, making links with community staff who facilitated goals/action plans to patients. These examples outline the importance of adapting the model to ensure it is tailored to and is beneficial to local circumstances.

There were a number of limitations to consider. First, the fidelity of CSP consultation delivery is unknown, which future research should investigate. Further, it is too early to demonstrate whether CSP consultations improves patient outcomes or wider system-level outcomes (for example reduced prescription costs); this should also be examined in future work. Although the primary aim of this evaluation was not to determine the level of social prescribing, consideration should be given to this and the level of patient attendance of social prescribing in the future.

Conclusion and Recommendations

Notwithstanding the logistical, capacity and recruitment challenges facing General Practices in Grampian, it appears that it is feasible to implement the HoC model in the region. Particularly, the challenges

[23] National Institute for Health and Clinical Excellence (NICE) (2007). *How to Change Practice. Understand, Identify and Overcome barriers to change*. London: NICE

[24] NHS England. (2018) *House of Care – a framework for long term condition care*. https://www.england.nhs.uk/ourwork/clinical-policy/ltc/house-of-care/

highlighted as reasons for withdrawal of practices from Cohort 1 appeared evident within the practices who proceeded to implementation, demonstrating this re-design of care delivery is achievable. Further. the HoC model of patient centred care and CSP consultation appears to be highly acceptable to both patients and staff. In particular, the model allows for patients to have meaningful conversations about their wellbeing in an informed and empowered way and also allows practice staff to take the time to move from talking "to" patients, to having more of a partnership dialogue. It was acknowledged that for some practices the transition to this new model of care may be easier, if certain system processes are already in place, for example month of birth recall, therefore the process of change may be more complex for practices. It appears that tailoring the delivery of training to role-specific staff, assumption of a project-coordination role and willingness to be agile in HoC delivery will all facilitate its implementation within General Practice.

It would be beneficial if future work aimed to assess the fidelity of the CSP consultation, what is being delivered and how, and whether the content has an impact on patient outcomes (long term); clinical impact on patients; embedding of social prescribing ethos in General Practice and evaluation of uptake (specifically health related behaviour change); a greater shift towards increasing patients self-perceptions of managing their own wellbeing; In addition, the aim would be carry out an evaluation of service impact including; unscheduled hospital admissions, prescription costs and emergency hospital admissions.

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Appendix 1

Year of Care Partnerships
Evaluation Form Day 1

Trainers: **Date:**

On a scale of 1-10 (1 being 'did not help at all' and 10 being 'very helpful'). How much has the training helped you to?

	Rating of 1 - 10
1. Understand the Year of Care approach to care and support planning	
2. Reflect on your own approach/philosophy of care and how this fits with care and support planning	
3. Understand the care and support planning consultation framework and the core competencies required	
4. Helped you to be clear about the organisational requirements for implementing care and support planning in practices	

What aspect of today's session did you find particularly useful?

What could have been improved?

How would you rate the session overall?											
Poor	1	2	3	4	5	6	7	8	9	10	**Very Good**

Would you recommend this training to a colleague embarking on care and support planning?	**Yes** ☐ **No** ☐

Appendix 2

Please cite as: Finch, T.L., Girling, M., May, C.R., Mair, F.S., Murray, E., Treweek, S., Steen, I.N., McColl, E.M., Dickinson, C., Rapley, T. (2015). NoMad: Implementation measure based on Normalization Process Theory. [Measurement instrument]. Retrieved from http://www.normalizationprocess.org.

Survey Instructions

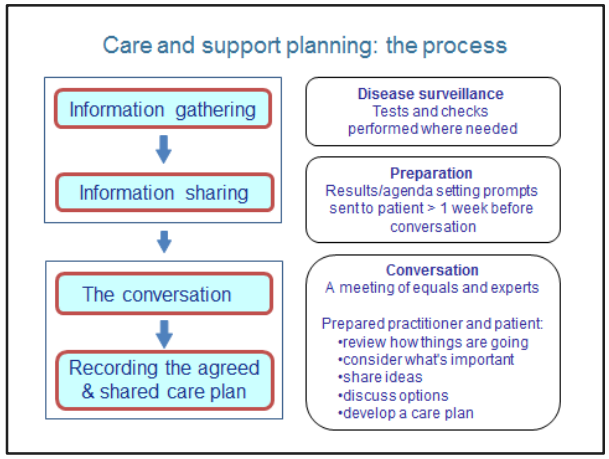
Care and support planning – practice team survey

This survey is designed to help get a better understanding of how to apply and integrate new technologies and complex interventions in health care.

This survey asks questions about the implementation of **care and support planning.** We understand that people involved with **care and support planning** have different roles, and that people may have more than one role. This survey is designed to allow you to reflect on your role in the team.

Your role in care and support planning in the practice team

Implementing care and support planning involves different people taking on different roles within the care and support planning process.



A successful care and support planning process relies on the work done by the whole team, how things happen at each stage in the process can make a big difference – understanding your role in this process is important to its success in the practice – this means administrators, receptionists, managers,nurses, healthcare assistants and doctors all make an important contribution.

Completing the survey

This survey is anonymous and should take about 5-10 minutes to complete. Please take the time to decide which **answer best suits your experience for each statement and tick the appropriate circle**. There is the option of indicating if a question isn't relevant to you.

Development of this survey was funded by the Economic and Social Research Council; Study Grant RES-062-23-3274. The core NPT items (20 construct items & 3 normalisation items) are Copyright © Newcastle University 2015.

Name of practice:

Part A: About yourself

1. How many years have you worked for this practice*? (If your practice has merged with another or changed its name, please include in your answer all the time you have worked with this practice and its predecessors)*

○ Less than one year ○ 1-2 years ○ 3-5 years ○ 6-10 years ○ 11-15 years ○ More than 15 years

2. How would you describe <u>your professional job category</u>?

○ Receptio ○ Administration ○ Practice Manag ○ Doctor ○ N e ○ HCA

3. My role in care and support planning will be to deliver or support activities to: *(tick more than one if relevant)*

○ administer processes, including dealing with questions about appointments and sending out results

○ complete the disease surveillance checks and help prepare people

○ have the care planning discussion/conversation with people at the second appointment

○ none of these

4. **From the statements below please choose an option that best describes what your main role will be in relation to care and support planning:**

- ○ I will be involved in leading or overseeing care and support planning
- ○ I will be involved in delivering or supporting the delivery of care and support planning
- ○ I will not be directly involved

For this survey, please answer all the statements from the perspective of this role. Depending on your role or responsibilities in care and support planning some statements may be more relevant than others.

Part B: General questions about care and support planning

I can see the value of patients being prepared in advance of care and support planning (by sending test results and agenda setting sheets)

Not at all **Somewhat** **Completely**

0 1 2 3 4 5 6 7 8 9 10

How "challenging " do you feel the care and support planning conversation/discussion is going to be?

Not at all **Somewhat** **Extremely**

0 1 2 3 4 5 6 7 8 9 10

How easy will it be to signpost people to support in the local area for the issues they identify?

Not at all **Somewhat** **Very Easy**

0 1 2 3 4 5 6 7 8 9 10

Part C: Detailed questions about care and support planning

For each statement please select an answer that best suits your experience.

Making sense of things

Section C1		Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
1.	I can see how care and support planning will differ from the usual way of working	○	○	○	○	○	○
2.	Staff in this practice have a shared understanding of the purpose of care and support planning	○	○	○	○	○	○
3.	I understand how care and support planning will affect the nature of my own work	○	○	○	○	○	○
4.	I can see the potential value of care and support planning for my work	○	○	○	○	○	○

What are the main differences you anticipate in this way of working compared to how things work now?

What do you feel is the main purpose ?

For each statement please select an answer that best suits your experience.

Becoming involved

Section C2		Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
1.	There are key people who will drive care and support planning forward and get others involved	○	○	○	○	○	○
2.	I believe that participating in care and support planning will be a legitimate part of my role	○	○	○	○	○	○
3.	I will be open to working with colleagues in new ways to use care and support planning	○	○	○	○	○	○
4.	I will support care and support planning	○	○	○	○	○	○

I can see the value of patients being prepared in advance of care and support planning (by sending test results and agenda setting sheets)

Not at all					Somewhat					Completely
0	1	2	3	4	5	6	7	8	9	10

How "challenging " do you feel the care and support planning conversation/discussion is going to be?

Not at all					Somewhat					Extremely
0	1	2	3	4	5	6	7	8	9	10

How easy will it be to signpost people to support in the local area for the issues they identify?

Not at all					Somewhat					Very Easy
0	1	2	3	4	5	6	7	8	9	10

Part D: House of Care Training – I attended the House of Care Training (please circle)	Yes	No

Yes, I attended the House of Care Training and I feel confident in my ability to support CSP within my practice

Not at all **Somewhat** **Completely**

0 1 2 3 4 5 6 7 8 9 10

No, I did not attend the House of Care training, but I feel well supported by my practice to support CSP within my practice

Not at all **Somewhat** **Extremely**

0 1 2 3 4 5 6 7 8 9 10

If you will be delivering CSP with patients, please answer the following questions:

I feel confident in my knowledge and skills to have a CSP conversation with my patients

Not at all **Somewhat** **Completely**

0 1 2 3 4 5 6 7 8 9 10

I feel confident in my knowledge and skills to support patients with 'goal setting' and developing 'action plans'

Not at all **Somewhat** **Extremely**

0 1 2 3 4 5 6 7 8 9 10

I feel confident in my knowledge of community services and assets to signpost patients accordingly

Not at all **Somewhat** **Very Easy**

0 1 2 3 4 5 6 7 8 9 10

SURVEY CONCLUSION

Thank you for completing our survey.

Appendix 3

NHS Grampian

Care, Support & Planning Consultation (CSPC-1)
Identifying my skills and areas for development

Practice Name

.....

Now that you have completed the Care and Support Planning Training we would like you to reflect on your skills and level of confidence to carry out care and support planning in your consultations.

We will ask you to repeat this exercise from time to time to ensure you are making the improvements you had hoped for and to identify any areas that you would like additional training or support with.

All responses are anonymous and data will be kept in a password protected folder that only the project team will have access to and will conform to General Data Protection Regulation (GDPR) (Regulation (EU) 2016/679).

	How confident are you that you can:	**Please circle (1 is 'not confident at all' and 10 is very confident')**									
1.	Describe the purpose of a care and support planning consultation?	1	2	3	4	5	6	7	8	9	10
2.	Work with the person to develop an agreed agenda?	1	2	3	4	5	6	7	8	9	10
3.	Elicit the person's knowledge and beliefs about their condition?	1	2	3	4	5	6	7	8	9	10
4.	Elicit the person's main concerns and priorities?	1	2	3	4	5	6	7	8	9	10
5.	Explore and elicit the person's goals?	1	2	3	4	5	6	7	8	9	10
6.	Facilitate the person to develop their own action plan?	1	2	3	4	5	6	7	8	9	10
7.	Explore the person's barriers to achieving their goal and their own personally relevant solutions?	1	2	3	4	5	6	7	8	9	10
8.	Develop a positive working relationship (rapport) with the person?	1	2	3	4	5	6	7	8	9	10

9.	Check out with the person how they feel your conversation is going particularly when you think it might not be going well?		1	2	3	4	5	6	7	8	9	10
10.	Tell when you are trying to persuade the person to do what you think is the right thing?		1	2	3	4	5	6	7	8	9	10
11.	Allow the person to take the lead in the consultation		1	2	3	4	5	6	7	8	9	10
12.	Express your concerns or challenge the person in a way that maintains your relationship and their autonomy?		1	2	3	4	5	6	7	8	9	10

In this exercise you might want to reflect briefly on your core consultation skills

My micro skills										
I have a good range of open questions to use in consultations										
Disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Agree
I can confidently use simple and complex reflections										
Disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Agree
I can demonstrate understanding and empathy using reflections										
Disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Agree
I can use scaling questions to explore importance and confidence										
Disagree	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	Agree

For a moment, in order to help you focus could you think a little bit about the areas where you scored yourself at less than 7? Which skills would you consider to be most important to focus upon?

What might need to happen to help you to increase your score?

Are there others ways to improve your skills and confidence in using these skills flexibly?

**(adapted from Neenan 2009*)

Appendix 4

HoC Interim Report

(Interviews to include GPs and Practice managers as appropriate)

Background

House of Care is characterised by the delivery of person centred care through collaborative 'care and support planning' conversations between health care professionals and patients. NHS Grampian recruited GP practices to trial 'this new way of working'. GP Practices recruited in Cohort 1 have now been delivering Care and Support Planning with identified patient groups for 6 months.

Evaluation Question

The aim of this interim report is to identify what, if any, changes, barriers or facilitators practice staff may have encountered whilst implementing' care and support planning over the last 6 months within normal practice.

Introduction

Introduce yourself....

The purpose of our interview today is to get your perceptions of how you feel the implementation of HoC has gone in the last 6 months, to give you a chance to describe the processes you have implemented within your practice, to share with us what has worked well and why and also to describe any problems you may have encountered and why they may have occurred. Your perceptions are what matter. There are no right or wrong or desirable or undesirable answers. I would like you to feel comfortable saying what you really think and how you really feel.

As previously mentioned I would like to audio record our interview, the purpose of this is not to identify you but to enable us to transcribe the interviews so we can identify any key themes which may arise. I have a consent form here for you to sign. On the form you will note that all recordings will be handled as per ***General Data Protection Regulation*** *(****GDPR****). All files will be anonymised, encrypted and stored securely with access restricted to the HoC research team.*

Appendix 4

Interview Topic Guide

"Understand the experience of supporting the delivery of and delivering person centred care through collaborative 'care and support planning' conversations between health care professionals and patients"

Introductory Questions

1. Tell me about your experience of being involved in the delivery of HoC - care and support planning?
2. How has this model differed to what your practice delivered previously?
3. What is your impression of the HoC model so far?
4. How do you think patients have found this new way of practice?

Positives of working in this way/Enablers

5. What has worked well in the delivery of HoC?
6. Was there anything that helped to make this new way of working successful?
7. What have you/are the (enjoyed-benefits-positives) about this way of working?
8. Were these positives common for all staff at the practice?

Negatives of working in this way/Barriers

9. What have been the (biggest) challenges to this new way of working?
10. How did you try and overcome these? Was this successful?
11. Were there any barriers that stopped you overcoming these challenges?
12. Did practice staff face different types of challenges?

Considerations for future GP practices

13. If a new GP practice were to enrol to deliver HoC (care and support planning), what advice would you give them to work in this new way?
14. What resources do you think are needed to successfully implement HoC in practices?
15. What qualities do practice staff need to successfully deliver HoC in practices?
16. In what way do you think the HoC training could be improved to support HoC delivery in Grampian?
17. If you were to start HoC (care and support planning) delivery again, what would you do differently?
18. Is there anything else you would like to tell me about your experience of implementing HoC (care and support planning) at your practice?

When discussing staff, this would include all levels – e.g. PM, GP, PN, Admin

Evaluation of the House of Care in Grampian

As part of the evaluation of the delivery of House of Care in Grampian you are invited to take part in face-to face discussions where you will be asked your views and experiences on delivering House of Care in your practice.

Information collected by the research team will be handled as per **General Data Protection Regulation** (**GDPR**). All files will be anonymised, encrypted and stored securely with access restricted to the House of Care research team.

Your participation is entirely voluntary. You have the right to change your mind about taking part at any time.

Please indicate whether you are willing to take part in an audio taped discussion by initialling the appropriate boxes below.

	Please **initial** each box you agree with.
I have read the paragraph above and have had the opportunity to ask questions. **I agree** to take part in discussions about the delivery of House of Care in my practice.	
I give permission for the discussions to be audio taped.	
I understand that my participation is voluntary and that I am free to withdraw at any time.	

Name: …… **Job title:** ……..…..

Signature: …… **Date:** ……..

Interviewer: …… **Date of interview:....**……..

Appendix 5

	Poor	Fair	Good	Very Good	Excellent	Does Not Apply
Letting you tell your "story"…… *(giving you time to fully describe your illness in your own words; not interrupting or diverting you)*	☐	☐	☐	☐	☐	☐
Fully understanding your concerns…… *(communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything)*	☐	☐	☐	☐	☐	☐
Showing care and compassion…. *(seeming genuinely concerned, connecting with you on a human level; not being indifferent or "detached")*	☐	☐	☐	☐	☐	☐
Explaining things clearly…….. *(fully answering your questions, explaining clearly, giving you adequate information; not being vague)*	☐	☐	☐	☐	☐	☐
Helping you to take control…… *(exploring with you what you can do to improve your health yourself; encouraging rather than "lecturing" you)*	☐	☐	☐	☐	☐	☐
Making a plan of action with you with agreed 'goals' *(discussing the options, involving you in decisions as much as you want to be involved; not ignoring your views)*	☐	☐	☐	☐	☐	☐

	Not at all useful	Not very useful	Somewhat useful	Very Useful	Did not read
How useful was the letter you received with your test results in helping you to prepare for the care and support planning conversation?	☐	☐	☐	☐	☐

	Yes	No
During your care planning conversation today, did you discuss services and supports based in your local community (for example, support groups, or patient organisations)?	☐	☐

	Much better	Better	Same or less	Not applicable
Able to cope with life…	☐	☐	☐	☐
Able to understand your condition(s)…	☐	☐	☐	☐
Able to cope with your condition(s)…	☐	☐	☐	☐
Able to keep yourself healthy…	☐	☐	☐	☐
	Much more	**More**	**Same or less**	**Not applicable**
Confident about your health….	☐	☐	☐	☐

Able to help yourself….	☐	☐	☐	☐

As a result of your consultation today, do you feel you are *(please tick one box in each row)*

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AIMS Public Health, 6(2): 143–153.
DOI: 10.3934/publichealth.2019.2.143
Received: 05 December 2018
Accepted: 11 April 2019
Published: 17 April 2019

http://www.aimspress.com/journal/aimsph

Research article

Implementation of a neighbourhood care model in a Scottish integrated context—views from patients

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Abstract: There is a need to test new models of integrated health and social care, particularly due to increasing financial and epidemiological pressures on services. One critical component of testing new models is the acceptability to patients. Here, the aim was to understand the acceptability of a new model of care to patients by understanding their experience of being supported by a self-managing, community-based, integrated, health and social care team. The INCA service consisted of three support workers and three nurses in two teams. These teams were self-managing and had autonomy over service operations and care delivery. Eight interviews and satisfaction questionnaires were conducted with patients. Interviews were transcribed and analysed thematically. Patients found the service highly acceptable (mean overall satisfaction of 98%), self-reporting a variety of benefits to their wellbeing. Central to this acceptability was the autonomy of staff to adjust care frequency and duration to patients' needs, in addition to describing an active engagement and partnership within their support plans. Future work should aim to ascertain the experiences of staff working in this model and whether receiving support in this way improves clinical outcomes.

Keywords: Buurtzorg; community; healthcare; social care; self-management; integration

Abbreviations: INCA: Integrated Neighbourhood Care Aberdeen; GP: General Practice; NHS: National Health Service.

1. Introduction

The demands on health and social care services are rising, with people living longer with multiple long-term conditions and increasingly complex needs [1]. Patients over 85 are seven times more likely to have an emergency hospital admission compared to those half their age, with bed day occupancies in this cohort growing by 76% in the last decade [2]. This demand, coupled with financial pressures, has resulted in National Health Service (NHS) spending failing to match the challenges associated with an ageing population [2]. The nature and scale of the above has resulted in a movement towards transformation of care delivery, with new, integrated models necessary to reduce pressure in acute settings by improving the capacity of community-based services. This aligns with Governmental commitments for ensuring that individuals can live longer and healthier lives in a homely setting, with health and social care integration seen as a pivotal enabler to achieving this vision [3].

When developing new community care initiatives, a critical component is to assess the acceptability to those receiving the service, allowing for a deeper understanding of to what extent its implementation meets their needs [4]. Highly acceptable interventions have been shown to increase adherence to treatment recommendations and improve clinical outcomes [5]. Therefore, it is imperative that, to develop and deliver new initiatives that are fit-for-purpose, patients' views regarding their implementation should be sought.

One model of care gaining increasing attention internationally is the Dutch model: Buurtzorg. This is characterised by nurses working in self-managing teams and advocating autonomy over all aspects of service delivery, such as care frequency, duration and working rotation [6]. Teams work closely with general practitioners and other community healthcare providers, founded on principles of relationship-based practice and empowerment, in order to improve outcomes for patients [7]. The service provided, from the patients' perspective, a higher standard of care comparative to other organisations and features consistently among the top 10 in the Netherlands for client acceptability and satisfaction [8]. Economically, Buurtzorg's average annual homecare costs per client were €6428 compared with an average for all others of €7995, thus providing a higher quality of care for less costs [9]. Despite these benefits, the principles of this model have yet to be tested within the Scottish health and social care system.

The aim of this paper is to explore the acceptability of a new neighbourhood care model by understanding the experiences of patients being supported by a self-managing, community-based, integrated, health and social care team.

2. Materials and methods

2.1. Service overview

The Integrated Neighbourhood Care Aberdeen (INCA) service was launched in February 2018 by Aberdeen City Health and Social Care Partnership (ACHSCP). As part of the Scottish Government's commitment to integrate health and social care in order to improve effectiveness and efficiencies in service provision [3], ACHSCP are responsible for delivering the integration agenda at a local level, with the INCA service being one of several piloted initiatives. The service consisted of two teams, comprised of three nurses and three support workers in each. Teams were based in two separate sites across the city—one co-located in a GP surgery in the West Locality and another based

in a corporate office suite in the South Locality. The teams were self-managing and had full autonomy over service delivery, including provision of care and staff rotas. A coach was provided as a support mechanism for team-building. This contrasts with how care is traditionally delivered, whereby both nursing and social care staff assess and deliver care separately, even if they are supporting the same individual. Inclusion criteria of patients were: living in the relevant postcode area and in no previous receipt of social care / nursing need. All patients that did not meet these criteria were excluded.

2.2. Research design

In total, 43 patients were supported over the first four months of implementation, with individual interviews conducted with eight patients from across both sites. Demographic information collated included: age; sex; primary referral reason and referral source. Satisfaction questionnaires were also administered, assessing components including: promotion of independent living; choice of received support and perceived confidence in teams. These components were chosen to closely mirror the underpinning principles of Buurtzorg, such as self-management and enablement [6].

As the data collection fell within the remit of service evaluation, ethical approval was not necessary to acquire.

2.3. Protocol

Interviews were based on a semi-structured topic guide. Discussions were based on a series of exploratory questions regarding patients' experience of being supported by the INCA teams. Example questions were: *"Tell me about the support you get from the INCA team?"* and *"Have you noticed any changes to your health and wellbeing as a result of seeing the INCA team?"* Interviews lasted no more than 60 minutes and were audio recorded. Fieldnotes were also taken during discussions and used as a reference point during analysis.

2.4. Data analysis

Audio recordings were transcribed verbatim and analysed thematically using NVIVO Version 11 (QSR International, Doncaster). Thematic analysis is useful towards understanding patterns occurring in the data in order to improve understanding on a particular topic [10], such as the experience of being cared for by a self-managing, integrated, health and social care team. Analysis followed the six step framework previously described by Braun and Clark [11], including: 1) familiarisation with the data; 2) developing initial codes; 3) searching for themes; 4) reviewing themes; 5) theme definition and 6) write up of results. The data were analysed independently by two researchers and then findings compared and adapted if required.

3. Results

3.1. Participants

Table 1 outlines the characteristics of patients whom were interviewed in Site 1 (C) and Site 2 (P). The number and sex of interviewees was consistent across both sites, with one man and three women from each participating. The cohort were predominantly older (mean age = 83 years) and were referred onto the caseload for a variety of reasons associated with ageing.

Table 1. Participant demographic information.

Participant ID	Age	Sex (M/F)	Referral reason	Referral source
C1	95	F	Mobility	Social care management
C2	93	M	Mobility	Family
C3	91	F	Heart failure	General practitioner
C4	84	F	Type 2 Diabetes	Family
P1	86	F	Cancer	General practitioner
P2	85	F	Frailty	District nursing
P3	64	F	Multiple sclerosis	Hospital discharge team
P4	66	M	Lung disease	Social care management

3.2. Satisfaction questionnaire responses

Table 2 shows the average scores of questionnaire components across both sites. All constructs were measured using likert-scales, scored from 1 (strongly disagree) to 5 (strongly agree). The highest average scores across all components were patients feeling well-informed about their care delivery and overall satisfaction with the support they received (4.9/5). Across both sites, "increasing available choices" received the lowest average score (3.4/5).

Table 2. Satisfaction questionnaire scores (N = 8).

Questionnaire components	Site 1 Average Score	Site 2 Average Score	Total Average score
Prevention			
Independent living	4.8	4.5	4.6
Reduce symptoms	3.7	4.7	4.2
Well-informed	4.8	5	4.9
Care well-explained	5	4.5	4.8
Choice			
Input of support	4.8	4.8	4.8
Things that matter	4.8	4.5	4.6
Encouraged to input	4.8	4.8	4.8
Increase available choices	3.5	3.3	3.4
Overall satisfaction			
Satisfied with support	4.8	5	4.9
Recommend support	5	5	5
Confidence in teams	5	5	5
Well-coordinated care	4.5	4.75	4.6

3.3. Themes

Table 3 outlines the four themes that emerged from thematic analysis: 1) Service Operation; 2) Staff Qualities; 3) Acceptability & Assets; 4) Confounding Factors. Each of these themes had a number of identified sub-themes that are described below.

Table 3. Themes and sub-themes derived from interviews.

Theme	Sub-theme
Service Operation	Care content
	Collaboration
	Delivery mechanisms
	External support
Staff Qualities	Compassion
	High quality staff
	Respectfulness
	Supportive
Acceptability & Assets	Patient characteristics
	Patient outcomes
Confounding Factors	Care discontinuation
	Consequences of ageing

3.4. Service operation

Care content: There were numerous examples described by patients of the care that they received, unique to their individual needs. For example, the INCA teams were able to support patients with aspects of personal care: *"They come to help you with the showers and that"* (P1), as well as providing clinical care to those who required it: *"The support I need at the moment is for my ears and eyes also my foot"* (P2).

As the INCA model did not restrict patients to pre-assigned times and days of care delivery, staff had the autonomy to arrange home visits at a time that was mutually beneficial: *"Initially it was first thing in the morning to get me up and then at bedtime to get me back into bed"* (P3). Managing their own time also meant that staff could be flexible, with patients providing examples of longer or shorter periods of support as required: "*There has been one or two changes of course but there are four of them coming in here at different times"* (P2). Over time, as patients became more independent, the number of visits they received reduced accordingly: "*In five months they got me from three times a day to be independent enough to have them just coming in once in a while, just a courtesy visit*" (P4).

Collaboration: Patients described forming a working partnership with staff and having active input regarding what care they received, for example: "*We talk about it and I have suggested about changing my going to bed time could be a bit earlier... is an opportunity if there is something I want to say or something I need help with"* (P3). Patients also commented how the INCA team ensured their unpaid carers were involved in decisions around the support they received. This resulted in feelings of ownership in the care process and an associated open dialogue between families and staff: "*So say they came in and X [patient's daughter] phoned me then the Nurse would have a word with her and I will say 'do you want to tell X anything?' it gives X confidence because she'll say 'are you*

sure you are alright mum, you're not just saying that?'. No, I'm not. So they know and they try to involve people, but in a nice way" (C1).

Good communication with staff was not only seen to encourage patients to take control of their own health, but led patients to express feelings of empowerment: "*I mean I like to do little things for myself and they will leave me to do it. You know, so I said 'don't fuss over me, if I need you I'll shout', so they have all just rallied round. That's about all I can say really. They respect your wishes"* (C4). Patients felt that the strong alliances that they had with staff directly contributed towards the re-ablement process: "*We agreed between us they would come in twice a day and then eventually as I was recovering and getting better through physiotherapy"* (P4).

Delivery Mechanisms: Patients unanimously agreed that the care delivered to them was positively received. Aspects that they specifically commented on included the availability of the team: "*If I need them, I phone them and they will be down"* (P2), the stability of care provided: "*I don't feel abandoned, I feel supported"* (P3) and the overall reliability of staff: "*They are always here about the time they say they will be"* (P1).

Patients were conscious of staff having to attend others on their caseload with varying needs, signalling their appreciation for the amount of input they received: "*I am aware that there is certainly more than me around and I don't know how health conditions are for people out with the area"* (P3). One patient did remark that they felt staff had excessive paperwork to complete and was unwieldy to store within their home: "*I have got stuff lying through there, on that dresser and they are writing in that writing books, I wonder if they are writing a book about me, it's taking up a lot of space and I have to keep that space for them, will just throw it in the bin because that's what's going to happen to it"* (C2).

External Support: Patients described the INCA team working with their family/friends where possible to enhance external support structures that facilitated patient mobility outside their home. The assistance provided by family members in turn aided staff by contributing towards patient re-ablement: "*I cannot get out by myself but then I don't need them to take me out because my son's .... I know if I phoned them, any of them, they would be here. I know they would"* (P2). Family and friend involvement in patient care ensured that, where possible, patients continued with everyday activities and experienced social inclusion: *"I have my cousin who stays about two minutes from here and we go shopping on a Tuesday... X [friend] and I meet every week and we do it together, she is very helpful" (P3).*

Regarding their network of support, patients reported being signposted to relevant community groups, such as tea dances or Men's Shed: "*Well they asked me if I would like to go [to a community group]"* (C4). However, patients did identify barriers to attending these services, such as no wheelchair access: "*I am on two crutches and then when I do go out I need a wheelchair and getting into places, sometimes there is no access for wheelchairs" (C3).* Others did not perceive barriers to attending community assets, however felt them unnecessary given the strong family connections they had locally: "*Yes, they did [signpost], but I think meantime I've got my daughter and granddaughter"* (C1).

Recognition was given to the INCA staffs' ability to engage with other professionals to provide additional support when required by patients. For example, the team were able to quickly gain patients access to further services that they otherwise had found challenging to receive: "*If we wanted to ask about some other service or something, they might be able to put in their outlines. I had said to the clinic that I hadn't seen a Physiotherapist since I had come home and then they saw*

about this for me... if we are wondering about something, some other help or something, they would try and find out for you" (P1).

3.5. Staff qualities

Compassion: Patients expressed a genuine concern from staff regarding their safety and wellbeing. For example, one individual described a recommendation from a staff member to have alarm systems installed in case of an emergency, for when team members may not be there to assist: "*They have been concerned about my safety since day one... they will not let me get myself into any dangerous situation. If they felt it was not appropriate for me to do something, they wouldn't let me do it... INCA suggested that I get a panic button... and I thought 'brilliant!'"* (P4). These feelings extended to ensuring disability aids in the home were used correctly and safely: *"We go upstairs on my...I've got a lift, so they see that I am on my lift right and see that I am strapped in"* (C1), in addition to staff providing supervision when patients were trying new aids/equipment to facilitate their recovery: " *When I got the walker for a start, I was able to go out, somebody took me sometimes... so we just walked around the corner and back again which was very kind of them"* (P1).

High quality: The standard of care provided by staff was consistently acknowledged by interviewees. In particular, they commented on the uniqueness of the team members, particularly by comparison to others they may have interacted with previously: *"That's what I always say, when they made X they threw away the mould, because you don't get many like her"* (C2). Patients also appreciated being one within the geographical catchment area of the pilot site, emphasising that there were thankful for how responsible the staff were: "*I think they do a good job. We are very fortunate here to have them and they never fail to come in so that's good"* (P2).

Respectfulness: Patients described being treated with dignity, beyond what they would typically expect from a professional: "*I mean there's nothing that she wouldn't do for you... she takes time to have a chat with you... you can speak to them. You know they would take time and listen to you"* (C4). These qualities resulted in patients having strong feelings of trust: "*I can depend on somebody to do something about it... I needn't feel I'm alone"* (C1) and that staff were providing a person-centred service: *"The girls have been helpful, they have come in and if I want anything done then they will do it"* (C3).

Supportive: Although staff ensured that patients were not attempting to unsafely escalate the re-ablement process, it appeared that patients gained motivation from the team to aid their recovery, for example by discouraging sedentary behaviour: "*They were super in encouraging me to not just sit about. They got me going and encouraged me to get up to go to the bathroom and back and ... because they were encouraging me so much to get me going"* (P4).

3.6. Acceptability and assets

Patient Characteristics: Patients described a desire not to become dependent on the care that they were being provided and instead, discussed a shift towards self-managing elements of their health: *"I am trying to be self sufficient as much as possible. I do what I can"* (P2). Even though service provision was free and tailored to the individual, it was evident that patients felt retention of control and continuing to complete tasks of everyday living they were capable of doing was

important: "*There are a few things that I can do myself and I keep saying to them 'no, don't make me redundant all the time'"* (C4).

Patient Outcomes: Interviewees were agreed in detailing the positive impact the INCA team had on their wellbeing. For some, simply receiving a telephone call to alert them of an upcoming visit had a positive effect on self-assurance: *"Really helps my confidence as I know someone is coming and that is a big thing for me anyway knowing that someone will be along"* (P3). This model of care and support appeared to build on patient's self-efficacy, with patients more likely to attempt to do more by themselves, knowing that support was at hand: *"As long as they are here when I am showering, I have no confidence to go in the shower myself, but they sit here and if I need them I shout"* (C4). Furthermore, patients' spoke of the learning experience that existed through detailed interactions and building relationships with the staff and provided examples whereby they had made positive changes to lifestyle behaviours over time: "*I am learning more and more as the time goes by and just watching my diet more than anything else"* (P3).

For some patients who had reduced mobility and were socially isolated, the companionship that the staff provided resulted in improved mental wellbeing, such as reduced feelings of loneliness: *"I know they are coming and I am grateful for them to come in just to speak to because there is nobody else ... I like their company when they come in...I have made friends"* (P2). In addition to personal outcomes however, patients described the relationships that they formed with staff over time that went beyond simply providing care, but into friendship: "*I just used to look forward to her visits and hear about her grandchildren and she heard about mine and that was just the highlight of my day"* (C4).

3.7. Confounding factors

Care discontinuation: During the time of interviewing, challenges with staff retention resulted in care being discontinued in one site. This was a consequence of double-running the service alongside traditional care delivery in a small geographical area, meaning limited nursing input was referred into the team. This had a direct impact on patients' experience, all of whom reported disappointment in their support coming to an end: "*I'm getting them moulded into my way and you are taking them away and putting them someplace else"* (C4). There was reference from a number of patients who appreciated the low staffing numbers in each team and this was identified as a possible consequence to staff moving on: "*There is often one Carer on alone to do the whole thing. That is hard going for one person... but they are especially busy in the morning"* (P2).

Consequences of ageing: Despite the high-quality of support described, some patients acknowledged that simply the process of living into old age had a deleterious effect on their health: "*I could do a lot more before"* (P2). However, these feelings of ill-health did not relate to the care received, but to patients' capabilities pre-referral to the team: *"I am not managing so well now"* (P1).

4. Discussion

The aim of this study was to understand the experiences of being supported under a new model of care, characterised by integrated health and social care teams self-managing in the community. In order to determine whether it is feasible to implement and scale localised tests of change, it is critical to understand the acceptability of these models to those receiving the service [12]. Overall, this service appeared to be highly acceptable to patients, with overall satisfaction scoring an average of 98%.

Components within the choice element of feedback that patients strongly agreed with were their input into the support they received (average score 4.8/5), along with the team encouraging patients to have their say (average score 4.8/5). These quantitative findings are supplemented by the collaboration sub-theme that emerged from interview analysis, with patients often referring to the team-working that occurred between the two parties. This highlights the perceived benefit to patients of having equality in the relationship with those who support them. Indeed, the National Institute for Health and Care Excellence have released specific guidelines stipulating the need to ensure that patients are active participants in the care and support that they receive [13]. These guidelines are reinforced by previous evidence demonstrating that joint decision-making leads to increased adherence to treatments [14] and improve knowledge of available options [15]. Given that the Buurtzorg principles on which this model was founded emphasise the importance of placing the patient in the centre of their care needs [7], it would appear that this component of the model worked well.

One reason that may have attributed to the high patient satisfaction was the ability of the team to be agile in their care delivery. For example, patients described circumstances where their health would fluctuate and would subsequently require more or less support. The autonomy the team possessed to escalate and de-escalate frequency and duration of support contrasts to traditional models, principally in social care, whereby care provision is fixed and requires reassessment to increase [16]. This would appear to be a particularly beneficial component of delivery care in community settings, especially considering the predominantly older cohort whom received care (mean age = 83 years), a population that report large variances in their health status from day-to-day [17]. Being able to tailor care delivery to compliment the needs of patients has been attributed as one of the key components of the Buurtzorg model in improving support for frail older adults [18].

Another important principle of the model incorporated within was the mobilisation of community assets and social networks to support patients towards enablement [6]. Here, participants all provided examples of signposting they received towards other forms of support locally, such as community groups and activities. Community assets have previously been championed as offering the potential to enhance quality and longevity of life by improving coping abilities and self-esteem of individuals [19]. Despite this however, there was a reticence to attending community assets, with patients citing logistical challenges and feelings of discomfort as barriers to attend new activities. Therefore, whilst strong relationships were formed between patients and staff, further support is required to integrate individuals into sources of community assets should they desire.

5. Conclusion

It appears that receiving care from a self-managing, integrated, health and social care team is acceptable to patients. In particular, empowering professionals with the autonomy to adjust frequency and duration of care provision facilitated a tailored approach, therefore it is recommended that care providers implement a similar method to ensure services are person-centred. Further, considering the positive impact that informal networks and community assets can have on an individual's wellbeing, appropriate thought and subsequent resource should be given to build and maintain relationships between services and these groups. Future work should determine whether this model of care results in clinically significant improvements in health, particularly compared to individuals in receipt of traditional methods of care delivery. Finally, understanding staffs' perspectives of working in this way would be valuable to explore.

Acknowledgements

Funding for this project was obtained from the Aberdeen City Health and Social Care Partnership Integration Joint Board.

Conflict of interest

All authors declare no conflict of interest.

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

Date of Meeting	28.05.2019
Report Title	Internal Audit Annual Report 2018/19
Report Number	HSCP/19/012
Lead Officer	David Hughes, Chief Internal Auditor
Report Author Details	Name: David Hughes Job Title: Chief Internal Auditor Email Address: david.hughes@aberdeenshire.gov.uk
Consultation Checklist Completed	Yes
Appendices	Appendix A – Progress with Planned Work. Appendix B – Internal Audit Annual Report for the year ended 31 March 2019. Appendix C – Progress with implemented agreed recommendations.

1. Purpose of the Report

1.1. The purpose of this report is to provide the Committee with Internal Audit's Annual Report for 2018/19.

2. Recommendations

It is recommended that the Audit & Performance Systems Committee:

2.1. Note the Internal Audit Annual Report 2018/19;

2.2. Note that the Chief Internal Auditor has confirmed the organisational independence of Internal Audit;

2.3. Note that there has been no limitation to the scope of Internal Audit work during 2018/19; and

2.4. Note the progress that management has made with implementing recommendations agreed in Internal Audit reports.

3. Summary of Key Information

3.1. It is one of the functions of the Integration Joint Board Audit and Performance Systems Committee to review the activities of the Internal Audit function, including its annual work programme.

3.2. The Internal Audit plan for 2018/19 was agreed by the Committee on 10 April 2018. The plan consisted of three audits for the IJB with a number of specific audits agreed by Aberdeen City Council's Audit, Risk and Scrutiny Committee relating to Adult Social Care in the Council and by NHS Grampian's Audit Committee in relation to audits for that body.

3.3. The resultant outputs are reported as follows:

- IJB Internal Audit reports reported to the IJB Audit and Performance Systems Committee in the first instance and thereafter to the Aberdeen City and NHS Grampian Audit Committees.
- Aberdeen City Council Adult Social Care audits reported to Aberdeen City Council's Audit, Risk and Scrutiny Committee in the first instance and thereafter to the IJB Audit and Performance Systems Committee.
- Audits in NHS Grampian to the NHS Grampian Audit Committee in the first instance and thereafter to the IJB Audit Committee for relevant audits.

3.4. Appendix A to this report details the position with audits contained in the 2018/19 plan and those carried forward from 2017/18.

3.5. It is considered that sufficient work was completed during the year, or was sufficiently advanced by the year-end, on which to base the conclusion drawn in the annual Internal Audit Report. This is supplemented by review of other relevant documentation, including Integration Joint Board and Audit and Performance Systems Committee papers, and the assessment of risk undertaken (by both Internal and External Audit) in updating the Internal (and External) Audit plan(s).

3.6. Internal Audit's annual opinion is attached as Appendix B, and concludes that reasonable assurance can be placed upon the adequacy and effectiveness of the Board's framework of governance, risk management

and control in the year to 31 March 2019.

3.7. Aberdeen City Council's Audit, Risk and Scrutiny Committee considered Internal Audit's annual report on the Council on 30 April 2019. It concluded that reasonable assurance could be placed on Aberdeen City Council's framework of governance, risk management and control in the year to 31 March 2019.

3.8. NHS Grampian's Audit Committee will consider their Internal Auditors annual report on 25 June 2019. An update will be provided to the Audit and Performance Systems Committee should there be any issues that require to be reported.

3.9. The Public Sector Internal Audit Standards (PSIAS) require that the Chief Internal Auditor report to Senior Management and the Board on the outcome of Internal Audit's Quality Assurance and Improvement Plan (QAIP). Following completion of the required review, the results were reported to Aberdeen City Council's Audit, Risk and Scrutiny Committee on 30 April 2019. An action plan was agreed in relation to recommendations made, and progress will be monitored by the Audit, Risk and Scrutiny Committee.

3.10. The Standards also require that Internal Audit confirms to the Board, at least annually, that it is organisationally independent. The organisational independence of Internal Audit is established through Financial Regulations (approved by the Board on 29 March 2016). Other factors which help ensure Internal Audit's independence are that: the Internal Audit plan is approved by the IJB Audit and Performance Systems Committee; and Internal Audit reports its outputs to Committee in the name of the Chief Internal Auditor. The Chief Internal Auditor considers that Internal Audit is organisationally independent.

3.11. There is also a requirement to report any instances where the scope of Internal Audit's work has been limited. During 2018/19, there have been no such limitations.

3.12. Internal Audit Standards require that Internal Audit implement a system to monitor the implementation of agreed recommendations by management arising from its reports. Appendix C to this report shows the progress that IJB management has made with implementing such recommendations.

Audit and Performance Systems Committee

4. Implications for IJB

4.1. **Equalities –** An equality impact assessment is not required because the reason for this report is for Committee to discuss, review and comment on the contents of the Internal Audit Annual Report for 2018/19 and there will be no differential impact, as a result of this report, on people with protected characteristics.

4.2. **Fairer Scotland Duty –** there are no direct implications arising from this report.

4.3. **Financial –** there are no direct implications arising from this report.

4.4. **Workforce -** there are no direct implications arising from this report.

4.5. **Legal** – there are no direct implications arising from this report.

4.6. Other - NA

5. Links to ACHSCP Strategic Plan

5.1. Internal Audit's role is to provide assurance regarding the adequacy and effectiveness of the Integration Joint Board's framework of governance, risk management and control. Each of these areas helps ensure that the IJB can deliver on all strategic priorities as identified in its strategic plan.

6. Management of Risk

6.1. **Identified risks(s):** The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are as detailed in the resultant report.

6.2. **Link to risks on strategic risk register:** The Internal Audit Plan is developed following consideration of the Aberdeen City Health and Social care Partnership Risk Register and through consultation with management.

6.3. **How might the content of this report impact or mitigate these risks:** Where risks are identified during the Internal Audit process, recommendations are made to management in order to mitigate these risks.

Audit and Performance Systems Committee

APPENDIX A

Service	Audit Topic	Position
2017/18 Planned Audit Work Completed in 2018/19		
Aberdeen City Council Adult Social Work	Care Management	Complete April 2018 Reported to A&PS Committee 12.06.18
NHS Grampian	Partnership Working: IJB Performance reporting and KPIs	Complete June 2018 Reported to A&PS Committee 11.09.18

Audit and Performance Systems Committee

Service	Audit Topic	Position
2018/19 Planned Audit Work		
Integration Joint Board	Budget Setting, Monitoring and Financial Reporting	Complete January 2019 Reported to A&PS Committee 12.02.19
	IJB Directions	Work in Progress
	New Models of Delivery / Co-location of Staff	Cancelled at request of Chief Finance Officer due to ongoing review of leadership structure.
Aberdeen City Council Adult Social Work	Criminal Justice	Complete April 2019 Reported to A&PS Committee 28.05.19
	Charging Policy	Draft report issued to management – March 2019
	National Care Home Contract	Complete January 2019 Reported to A&PS Committee 28.05.19
NHS Grampian	Health and Social Care Integration Governance Structures	Complete March 2019 Reported to A&PS Committee 28.05.19
	Health and Safety Governance	Complete March 2019 Reported to A&PS Committee 28.05.19
	Unscheduled Care Discharge Process	Complete March 2019 Reported to A&PS Committee 28.05.19

Audit and Performance Systems Committee

Appendix B

Internal Audit Annual Report for the year ended 31 March 2019

As Chief Internal Auditor of Aberdeen City Integration Joint Board, I am pleased to present my annual statement on the adequacy and effectiveness of the Board's framework of governance, risk management and control for the year ended 31 March 2019. The purpose of this statement is to assist the Chief Financial Officer in forming his opinion in relation to the Annual Governance Statement to be included in the Annual Accounts.

Opinion

It is my opinion that reasonable assurance can be placed upon the adequacy and effectiveness of the Board's framework of governance, risk management and control in the year to 31 March 2019.

Whilst issues were identified in audits that have been completed, as reported to the Audit and Performance Systems Committee, areas of good practice, improvement, and procedural compliance were also identified.

Basis of Opinion

My evaluation of the control environment is informed by a number of sources:

- The audit work completed by Internal Audit during the year to 31 March 2019 in relation to the Integration Joint Board and relevant areas within Aberdeen City Council;
- Progress made with implementing agreed Internal Audit recommendations;
- The assessment of risk completed during the updating of the audit plan;
- Reports issued by the Board's external auditors;
- Internal Audit's knowledge of the Board's and Aberdeen City Council's framework of governance, risk management and performance monitoring arrangements.
- Consideration will be given to the contents of NHS Grampian's Internal Audit annual report when available.

Audit and Performance Systems Committee

Respective responsibilities of management and internal auditors in relation to internal control

It is the responsibility of the Board's senior management to establish an appropriate and sound system of internal control and to monitor the continuing effectiveness of that system. It is the responsibility of the Chief Internal Auditor to provide an annual overall assessment on the adequacy and effectiveness of the Board's framework of governance, risk management and control.

Sound internal controls

The main objectives of the Board's internal control systems are to:

- ensure adherence to management policies and directives in order to achieve the organisation's objectives;
- safeguard assets;
- ensure the relevance, reliability and integrity of information, so ensuring as far as possible the completeness and accuracy of records; and
- ensure compliance with statutory requirements.

Any system of control can only ever provide reasonable and not absolute assurance that control weaknesses or irregularities do not exist or that there is no risk of material errors, losses, fraud, or breaches of laws or regulations. Accordingly, the Board is continually seeking to improve the effectiveness of its systems of internal control.

The Work of Internal Audit

Internal Audit is an independent appraisal function established by the Board for the review of the internal control system as a service to the organisation. It objectively examines, evaluates and reports on the adequacy of internal control as a contribution to the proper, economic, efficient and effective use of resources.

The section undertakes an annual programme of work agreed with Chief Officers and the Audit and Performance Systems Committee. The audit plan is based on a risk assessment process which is revised on an ongoing basis to reflect evolving risks and changes.

All Internal Audit reports identifying system weaknesses, non-compliance with expected controls, and / or assurance of satisfactory operation are brought to the attention of management and include appropriate recommendations and agreed

action plans. It is management's responsibility to ensure that proper consideration is given to Internal Audit reports and that appropriate action is taken on audit recommendations. The Internal Auditor is required to ensure that appropriate arrangements are made to determine whether action has been taken on internal audit recommendations or that management has understood and assumed the risk of not taking action.

David Hughes,
Chief Internal Auditor,
Aberdeen City Integration Joint Board
8 April 2019

Audit and Performance Systems Committee

Appendix C

POSITION WITH AGREED RECOMMENDATIONS INCLUDED IN INTEGRATION JOINT BOARD

INTERNAL AUDIT REPORTS

AS AT 5 APRIL 2019

Note: This is on an exception basis, where all recommendations in a report have been implemented, the report is not shown.

Audit and Performance Systems Committee

KEY TO COLOURING USED

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

Period Recommendation Overdue
Recommendation overdue by more than 12 months
Recommendation overdue by between 6 to 12 months
Recommendation overdue by less than 6 months

Audit and Performance Systems Committee

Report Number	Report Title	Date Issued	Number of Recommendations				
			Agreed in Report	Due for implementation by 28.02.19	Confirmed Implemented by Service	**Not implemented by original due date**	Grading of overdue recommendations
AC1724	**Health and Social Care Post Integration Review**	September 2017	11	11	10	**1**	1 Significant

The position with the overdue recommendations is as follows:

Chief Officer	Overdue Recommendation	Grading / Due Date	Position
Chief Finance Officer	The IJB should develop an asset management strategy (2.3.7)	Significant June 2018	The Service has advised that this had been delayed due to other capital planning priorities and would be complete by the end of December 2018. This recommendation has been delayed, as the focus over the last year has been on moving forward the primary care projects per the deadlines. It is anticipated that the asset management strategy will be completed by December 2019.

AC1915	**Budget Setting, Monitoring and Financial Reporting**	January 2019	4	0	0	**0**	

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

Date of Meeting	28.05.2019
Report Title	Internal Audit Plan 2019/20
Report Number	HSCP/19/017
Lead Officer	David Hughes, Chief Internal Auditor
Report Author Details	Name: David Hughes Job Title: Chief Internal Auditor Email Address: david.hughes@aberdeenshire.gov.uk
Consultation Checklist Completed	Yes
Appendices	Appendix A – Internal Audit Plan 2019/20 Appendix B – Extract from Aberdeen City Council Internal Audit Plan 2019/20

1. Purpose of the Report

1.1. The purpose of this report is to seek approval of the Internal Audit Plan for the Aberdeen City Integration Joint Board for 2019/20.

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems Committee approve the Internal Audit Plan for 2019/20.

3. Summary of Key Information

3.1. It is one of the duties of the Integration Joint Board Audit and Performance Systems Committee to review and approve the annual Internal Audit plan on behalf of the Integration Joint Board and, thereafter, receive reports on that planned work.

3.2. The Internal Audit plan, as it relates to the Integration Joint Board, is attached at Appendix A. Assurance will also be taken from the wider work

of Internal Audit within Aberdeen City Council, specific work relating to Adult Social Care Services in the Council, and from NHS Grampian Internal Audit reports, amongst other sources.

3.3. Outputs from the IJB Internal Audit plan will be shared with Aberdeen City Council's Audit, Risk and Scrutiny Committee once they have been considered by the IJB Audit and Performance Systems Committee.

3.4. Aberdeen City Council's Audit, Risk and Scrutiny Committee approved the 2019/20 Internal Audit Plan relating to Adult Social Care Services in the Council on 14 February (attached as Appendix B to this report) and the basis on which the overall plan was developed. Outputs from these reviews will be shared with the Aberdeen City IJB Audit and Performance Systems Committee for information once they have been considered by Aberdeen City Council's Audit, Risk and Scrutiny Committee.

3.5. Audits undertaken by NHS Grampian's Internal Auditors, PWC, will be reported to the NHS Grampian Audit Committee in the first instance. Where there is a direct relationship between the work undertaken and the IJB, the reports will be presented to the Aberdeen City IJB Audit and Performance Systems Committee for information. The Internal Audit plan for NHS Grampian for 2019/20 will be circulated when it has been agreed.

4. Implications for IJB

4.1. **Equalities –** An equality impact assessment is not required because the reason for this report is for Committee to discuss, review and comment on the contents of the Internal Audit Plan and there will be no differential impact, as a result of this report, on people with protected characteristics.

4.2. **Fairer Scotland Duty –** there are no direct implications arising from this report.

4.3. **Financial –** there are no direct implications arising from this report.

4.4. **Workforce -** there are no direct implications arising from this report.

4.5. **Legal** – there are no direct implications arising from this report.

4.6. Other - NA

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

5. Links to ACHSCP Strategic Plan

5.1. Internal Audit's role is to provide assurance regarding the adequacy and effectiveness of the Integration Joint Board's framework of governance, risk management and control. Each of these areas helps ensure that the IJB can deliver on all strategic priorities as identified in its strategic plan.

6. Management of Risk

6.1. **Identified risks(s):** The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are as detailed in the resultant report.

6.2. **Link to risks on strategic risk register:** The Internal Audit Plan has been developed following consideration of the Aberdeen City Health and Social care Partnership Risk Register and through consultation with management.

6.3. **How might the content of this report impact or mitigate these risks:** Where risks are identified during the Internal Audit process, recommendations are been made to management in order to mitigate these risks.

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

APPENDIX A

ABERDEEN CITY INTEGRATION JOINT BOARD

INTERNAL AUDIT PLAN 2019-20

SUBJECT	SCOPE	OBJECTIVE	Indicative Quarter
Risk Management	Risk Management	To review the process for identifying risks, managing them (including performance measures against each risk), and reporting to the IJB.	Q2

APPENDIX B

ABERDEEN CITY COUNCIL INTERNAL AUDIT PLAN 2019/20 (Extract)

SUBJECT	SCOPE	OBJECTIVE	Target AR&S Committee
HEALTH & SOCIAL CARE PARTNERSHIP			
Commissioned Services	Contract Monitoring	To provide assurance that contract monitoring arrangements relating to Social Care Commissioned Services are adequate.	April 2020

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

Date of Meeting	28.05.2019
Report Title	Internal Audit Report AC1920 – Criminal Justice
Report Number	HSCP/19/016
Lead Officer	David Hughes, Chief Internal Auditor
Report Author Details	Name: David Hughes Job Title: Chief Internal Auditor Email Address: david.hughes@aberdeenshire.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	None

1. Purpose of the Report

1.1. The purpose of this report is to present the outcome from the planned audit of the National Care Home Contract that was included in the 2018/19 Internal Audit Plan for Aberdeen City Council.

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems Committee review, discuss and comment on the issues raised within this report.

3. Summary of Key Information

3.1. Criminal justice social work services aim to reduce reoffending, increase social inclusion of offenders and ex-offenders and enhance public protection. Scottish local authorities have a legal duty to provide criminal justice social work services.

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

3.2. Aberdeen City Health and Social Care Partnership is the main provider of criminal justice social work services in the city, working in partnership with other statutory and voluntary agencies to provide these services.

3.3. Contact with Criminal Justice Social Work Services is normally as a result of report requests, court orders or supervision following release from prison, and additional support may be provided under relevant sections of the Social Work (Scotland) Act.

3.4. For 2018/19 the main costs of the Service are funded by a Section 27 grant from the Scottish Government (£4.6 million).

3.5. The objective of this audit was to provide assurance that adequate control is exercised over income and expenditure, that system data is accurate and adequately supported, and that reporting arrangements between the Council and IJB are appropriate.

3.6. In general, this is the case, however weaknesses were identified in the application of procedures for documenting and authorising low value regular expenditure provided to meet service users' immediate needs, including: petty cash, pre-paid shopping vouchers and bus tickets. The Service has agreed to reinforce existing procedures, and review where Service-specific processes could be improved.

3.7. Financial Regulations have been breached in respect of issuing purchase orders in advance of making payment for goods and services. The Service will remind teams of the requirements, which have also been reiterated by the Health and Social Care Partnership's Chief Finance Officer.

3.8. A small amount of income is generated through the Unpaid Work team, for items that have been crafted that are then sold for donations. Controls over receipt and use of this income require improvement in order to demonstrate that the income is complete and has been accounted for appropriately. The Service is implementing a new process to address these findings.

4. Implications for IJB

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

4.1. **Equalities –** An equality impact assessment is not required because the reason for this report is for Committee to discuss, review and comment on the contents of an Internal Audit report and there will be no differential impact, as a result of this report, on people with protected characteristics.

4.2. **Fairer Scotland Duty –** there are no direct implications arising from this report.

4.3. **Financial –** there are no direct implications arising from this report.

4.4. **Workforce -** there are no direct implications arising from this report.

4.5. **Legal** – there are no direct implications arising from this report.

4.6. Other - NA

5. Links to ACHSCP Strategic Plan

5.1. Ensuring effective performance reporting and use of Key Performance Indicators will help the IJB deliver on all strategic priorities as identified in its strategic plan.

6. Management of Risk

6.1. **Identified risks(s):** The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are as detailed in the resultant report.

6.2. **Link to risks on 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.

6.3. **How might the content of this report impact or mitigate these risks:** Where risks have been identified during the Internal Audit process, recommendations have been made to management in order to mitigate these risks.

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

Date of Meeting	28.05.2019
Report Title	Internal Audit Report AC1920 – National Care Home Contract
Report Number	HSCP/19/015
Lead Officer	David Hughes, Chief Internal Auditor
Report Author Details	Name: David Hughes Job Title: Chief Internal Auditor Email Address: david.hughes@aberdeenshire.gov.uk
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	None

1. Purpose of the Report

1.1. The purpose of this report is to present the outcome from the planned audit of the National Care Home Contract that was included in the 2018/19 Internal Audit Plan for Aberdeen City Council.

2. Recommendations

2.1. It is recommended that the Audit & Performance Systems Committee review, discuss and comment on the issues raised within this report.

3. Summary of Key Information

3.1. The following summary of the Internal Audit report relating to the National Care Home Contract was considered by the Council's Audit, Risk and Scrutiny Committee on 14 February 2019. After some discussion of the issues identified, the Committee noted the report and endorsed the recommendations for improvement.

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

3.2. The National Care Home Contract (NCHC) provides for agreement between providers of care facilities and Local Authorities for the provision of care facilities for those who have been assessed as requiring residential care. The agreement sets out the contractual obligations and responsibilities of each party and sets out minimum levels of monitoring which must be carried out on the provider by the Local Authority primarily to ensure quality of care towards clients who are resident in the provider's establishment.

3.3. The objective of this audit was to ensure that adequate monitoring of Suppliers is occurring in order to ensure continuity and quality of service provision and that contingency plans are in place to deal with any event which may see residents either temporarily or permanently displaced from the Care Home in which they are resident.

3.4. In general, contract monitoring is sufficient to meet the needs of the Service. However, some elements included in the NCHC are not well recorded. The NCHC predates changes to Procurement Legislation and the Integration of Health and Social Care, and a review is planned nationally during 2019/20 for implementation in 2020/21. At a Partnership level assurance is being obtained over Home and Provider activity, however this is not always being fully captured within contract monitoring records.

3.5. The Service commenced a review of its monitoring procedures in August 2018, in recognition of system complexities and limited resources impacting on the achievability of planned reviews, which have also been identified in this audit. Changes are planned to be implemented by April 2019, and the Service has agreed to add reference to capturing additional assurances and sources of information. Other improvements, including financial risk assessments and a review of Providers' contingency planning will be subject to further investigation by the Service as to the most appropriate method of implementation.

AUDIT AND PERFORMANCE SYSTEMS COMMITTEE

4. Implications for IJB

4.1. **Equalities –** An equality impact assessment is not required because the reason for this report is for Committee to discuss, review and comment on the contents of an Internal Audit report and there will be no differential impact, as a result of this report, on people with protected characteristics.

4.2. **Fairer Scotland Duty –** there are no direct implications arising from this report.

4.3. **Financial –** there are no direct implications arising from this report.

4.4. **Workforce -** there are no direct implications arising from this report.

4.5. **Legal** – there are no direct implications arising from this report.

4.6. Other - NA

5. Links to ACHSCP Strategic Plan

5.1. Ensuring effective performance reporting and use of Key Performance Indicators will help the IJB deliver on all strategic priorities as identified in its strategic plan.

6. Management of Risk

6.1. **Identified risks(s):** The Internal Audit process considers risks involved in the areas subject to review. Any risk implications identified through the Internal Audit process are as detailed in the resultant report.

6.2. **Link to risks on 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.

6.3. **How might the content of this report impact or mitigate these risks:** Where risks have been identified during the Internal Audit process, recommendations have been made to management in order to mitigate these risks.

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

Date of Meeting	28.05.2019
Report Title	NHSG Internal Audit Reports
Report Number	HSCP.19.018
Lead Officer	Alex Stephen, Chief Finance Officer
Report Author Details	PWC (NHSG Internal Auditors)
Consultation Checklist Completed	Yes
Appendices	a. Health & Social Care Governance b. Unscheduled Care Discharges c. Health & Safety Governance

1. Purpose of the Report

1.1. This report presents the Audit & Performance Systems (APS) Committee with a summary of recent NHSG Internal Audit reports prepared by PwC.

2. Recommendations

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

a) Note the content of the NHSG Internal Audit Reports, as attached at Appendix A, B & C.

b) Note the actions and timescales for Aberdeen City, as outlined in the action plan of the NHSG Internal Audit report attached at Appendix A and C.

Audit & Performance Systems Committee

3. Summary of Key Information

Health & Social Care Governance Structure (incl. hosted services)

3.1. The scope of our review was to assess the design and operating effectiveness of the key controls within the Health and Social Care Integration governance structures. In general, PwC found that the current arrangements for health and social care integration governance structures are generally well designed and operating effectively.

3.2. The report highlights a medium risk relating to the lack of formal oversight and reporting framework for all 3 IJBs and agreed an action that all relevant parties will reach agreement on forming a formal management reporting framework for IJB hosted services. There was an additional low risk found, however Aberdeen City IJB does not have an action arising from this.

Unscheduled Care Discharges

3.3. The scope of this audit review was to assess the discharge process in NHS Grampian following the creation of the Integration Joint Boards (IJBs) in Scotland. In general, PwC found that the current processes and controls in place are designed with a focus on patient rather than bed management and the provision of excellent patient care, recognising that there are areas for improvement but noting the current context for health and social care integration.

3.4. The report highlights two medium risks, related to control improvement opportunities:

- NHSG 'Patient Discharge from Hospital Protocol' prepared in September 2016 as a draft document has not been finalised or updated.
- Variances in recording and interpreting Estimated Dates of Discharge (EDDs).

3.5. The APS Committee should be aware of the findings of this report as they relate to ACHSCP's delayed discharge performance.

Audit & Performance Systems Committee

Health & Safety Governance

3.6. The internal audit report assesses the control design and effectiveness of the Health and Safety governance and oversight structures established by NHS Grampian ('NHSG') and the Health and Social Care Partnerships (HSCPs) and and looks to confirm that the issues identified by the HSE Improvement Notices served on NHSG have been, or are being, effectively managed through to resolution The report highlights one medium and one low risking finding in relation to control improvement opportunities.

3.7. The agreed action plan for the medium risk relating to the Health & Safety Committee commits the City IJB to the achieving the following:

- All draft Terms of Reference will be reviewed, updated where necessary, approved and published as final.
- All terms of reference that are overdue for review will be reviewed updated as necessary, approved and published as final.
- Arrangements will be put in place to ensure that all Terms of Reference are reviewed in accordance with document control requirements set out in the ToRs. Management notes that it is best practice to schedule a ToR review at least once a year.

4. Implications for IJB

4.1. **Equalities –** there are no direct implications arising from this report.

4.2. **Fairer Scotland Duty –** there are no direct implications arising from this report.

4.3. **Financial –** there are no direct implications arising from this report.

4.4. **Workforce -** there are no direct implications arising from this report.

4.5. **Legal** – there are no direct implications arising from this report.

4.6. Other - NA

5. Links to ACHSCP Strategic Plan

5.1. NA

Audit & Performance Systems Committee

6. Management of Risk

6.1. Identified risks(s): identified throughout the report

6.2. Link to risks on strategic risk register: # 7 *There is a risk that the IJB, and the services that it directs and has operational oversight, of fail to meet performance standards or outcomes as set by regulatory bodies*

6.3. How might the content of this report impact or mitigate these risks: implementing the actions from the internal audit reports will help to mitigate the identified risks.

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Internal Audit Report 2018/2019

Health and Social Care Integration Governance Structures (incl. hosted services)

March 2019

Final

NHS Grampian

pwc

Contents

Distribution List	
For action	Chief Officer, Aberdeenshire IJB
	Chief Officer, Aberdeen City IJB
	Chief Officer, Moray IJB
	Director of Planning/Deputy Chief Executive, NHS Grampian
For information	Audit Committee

This report has been prepared by PwC in accordance with our engagement contract dated 1 August 2017.

Internal audit work was performed in accordance with PwC's Internal Audit methodology which is aligned to the Public Sector Internal Auditing Standards. As a result, our work and deliverables are not designed or intended to comply with the International Auditing and Assurance Standards Board (IAASB), International Framework for Assurance Engagements (IFAE) and International Standard on Assurance Engagements (ISAE) 3000.

1. Executive summary

Report classification	*Trend*	**Total number of findings**				
			Critical	High	Medium	Low	Advisory
Low Risk	N/A – No prior year reviews for comparison	Control design	-	-	1	-	-
		Operating effectiveness	-	-	-	1	-
		Total	**-**	**-**	**1**	**1**	**-**

Summary of findings

The scope of our review was to assess the design and operating effectiveness of the key controls within the Health and Social Care Integration governance structures. Our review focused on:

- How each of the three Integration Joint Board (IJBs) link to the Board's governance arrangements
- The flow of information between the IJBs and the Board
- Consideration of the links between the Board and each of the three IJBs

Our view is that the current arrangements for Health and Social Care Integration governance structures are generally well designed and operating effectively.

In summary we have identified one 'medium' risk and one 'low' risk finding in relation to control improvement opportunities and these result in this report being classified as 'low' risk.

The medium risk finding is as follows:

- There is no formally established communication structures between the IJBs for the discussion of issues related to hosted services. There are weekly informal discussion but these meetings are not documented.

The full details of the above finding, the low rating finding and the agreed actions, can be found in **Section 3**.

Management comment

The next meeting of the NEPSG is on 15 April and the main topic for discussion is the establishment of a framework to review the performance of the hosted services. It is regarded as a high priority of all of the organisations i.e. councils, IJBs and NHS Grampian. The main problem has been getting a meeting organised as it is important that all of the senior stakeholders are present to agree the way forward. Confident that we will have that on 15 April.

Director of Planning & Deputy Chief Executive, NHS Grampian

2. Background and scope

Background

The Public Bodies (Joint Working) (Scotland) Act 2014 provided a framework for the effective integration of adult health and social care services. Its policy ambition was to:

- Improve the quality and consistency of services for patients, carers, service users and their families;
- Provide seamless, joined-up quality health and social care services in order to care for people in their own homes or a homely setting where it is safe to do so; and
- Ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older.

To realise this ambition NHS Grampian Health Board entered into Health and Social Care Integration Scheme Agreements with:

- Aberdeen City Council
- Aberdeenshire Council
- Moray Council

Three Integration Joint Boards (IJBs) were established through the Body Corporate model by which NHS Grampian and the three Local Authorities delegate a range of functions and resource to the IJBs who are responsible for the planning of integrated arrangements and onward service delivery.

Accountability and Responsibility

The IJB receives payment from NHS Grampian and the Council, and have:

- Responsibility for planning health and care services
- Full power to decide how to use resources and deliver delegated services to improve quality and people's outcomes

The IJB is jointly accountable to Council and NHS board through its voting membership and reporting to the public. In return, the NHS board and Council are accountable to the IJB for the delivery of services as directed. The IJB is also accountable for overseeing the delivery of services

Reporting framework

In summary there are four lines of reporting involving the IJBs as follows:

1) Annual reporting from the IJB to the Council and the NHS board as agreed via the sharing of the IJB Annual Performance Report the main report required to account for IJB Performance demonstrating to the public the achievements to date.

2) Quarterly performance reporting from Chief Officer of each IJB to the Council members.

- For Moray the CO and key personnel would address performance through elected member briefings that are held regularly throughout the year. There is not a performance report that goes formally to council committees, the annual performance report goes as noted previously to full council.
- For Aberdeen City service updates are to be provided on the council website quarterly commencing October 2019 following decision by Council.
- For Aberdeenshire there is a system of sharing reports with elected members through the Area Committee Structure with Officers in attendance and also through the policy committee called the Communities Committee.

3) Quarterly performance reporting from Chief Officer of each IJB to the NHS board members. Quarterly performance is monitored through the quarterly performance meetings with the NHS CEO and the Council CEO. A report that collates key items noted in the IJB Board Meetings is presented to the NHSG Board meeting each time and may include performance information or may not depending on what has been noted as key items for noting form the minute.

4) Ad hoc performance reporting from Chief Officer of each IJB to IJB members.

- In Moray the programme of IJB voting member briefings in place, there's the CO update report that goes to the IJB, also IJB development sessions can to an extent to discuss performance as well as ad-hoc meeting with the Chair and Vice-Chair.
- In Aberdeen quarterly meetings between the IJB Chair and Vice Chair, the Chief executive of NHSG and ACC and the Chief Officer meet to review performance.
  In addition monthly joint meetings are held with the Chief Executives of NHSG and ACC and the Chief Officer
  In Aberdeenshire there are regular meetings with the two CEOs, ad-hoc briefings on emergent issues and the formal performance review meetings with the two CEOs.

NB: The production of the IJB performance reports was reviewed by Internal Audit during 2017/18 and is therefore considered as out of scope for this review.

The Annual report produced and approved by each IJB is shared with NHS Grampian and the Council giving both the opportunity to assess whether the IJB has performed effectively both operationally and financially. NHS Grampian and the Council cannot request changes to the current year's Annual Report but can provide input into next year's planning and strategic direction.

There is limited need for joint decision making across the IJBs and NHS Grampian as each entity has its own governance framework and there is representation on the IJBs from both the Health Board and the relevant Council. The exception is services that are shared across IJBs known as 'hosted services' where there is a need to formalise the joint decision making and governance frameworks. This has been discussed by the IJB Chief Officers and it has been agreed that this year each IJB CO will produce a report on hosted services and this will be taken to the IJB. This will improve transparency and provide each IJB with more information on the services hosted by the other IJBs. These reports will include forward looking elements so that each IJB can comment on the strategy etc., of the others prior to sign-off. See also Finding 1 on Page 8 of this report as the management reporting/MI regime that needs to be put in place should feed into the proposed system of annual reporting on hosted services.

<u>Hosted Services</u>

Some integration services may be hosted by one IJB on behalf of the other integration authorities. The IJBs collectively consider and agree these hosting arrangements.

Shown below are the services currently hosted across the Partnership areas of the IJBs:

Service	Current Host
Sexual Health Services	Aberdeen City
Woodend Assessment of the Elderly (including Links Unit at City Hospital)	Aberdeen City
Woodend Rehabilitation Services (including Stroke Rehab, Neuro Rehab, Horizons, Craig Court and MARS)	Aberdeen City
Marie Curie Nursing	Aberdeenshire
Heart Failure Service	Aberdeenshire
Continence Service	Aberdeenshire
Diabetes MCN (including Retinal Screening)	Aberdeenshire
Chronic Oedema Service	Aberdeenshire
HMP Grampian	Aberdeenshire
Police Forensic Examiners	Aberdeenshire
Primary Care Contracts	Moray
GMED (Out of Hours Service)	Moray

A North East Partnership Steering Group (NEPSG) was established in 2014 to provide a forum for the emerging Integration Joint Boards and NHS Grampian to consider issues of joint interest in relation to the implementation of the Public Bodies Act (2014). A key function of the NEPSG is to discuss issues related to hosted services but formal arrangements for such discussions have not yet been established – see Finding 1 on Page 8 of this report.

Scope and limitations of scope

Our audit approach:

1. Obtain an understanding of the key controls through discussions with key personnel, review of systems documentation and walkthrough tests.
2. Evaluate the design of the controls in place to address the key risks.

3. Identify the key risks of each process.
4. Test the operating effectiveness of the key controls.

The scope of our review is outlined above and will be undertaken on a sample basis.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Our agreed Terms of Reference are set out at **Appendix 2**.

3. Detailed current year findings

3.01 North East Partnership Steering Group

Finding
A North East Partnership Steering Group (NEPSG) was established in 2014 to provide a forum for the emerging Integration Joint Boards , the Councils and NHS Grampian to consider issues of joint interest in relation to the implementation of the Public Bodies Act (2014). The initial membership of the NEPSG included the chairs and vice chairs of NHS Grampian and the shadow Integration Joint Boards for Aberdeen City, Aberdeenshire and Moray, together with the Chief Executives and senior officers in support. The agenda for the meetings of the NEPSG centres on the review of the Integration Schemes for each of the IJBs and the delegation of by NHS Grampian that required to be "hosted" by one of the IJBs. A Commission for the review of the NEPSG reported in August 2018 that the NEPSG has not, to date, undertaken any formal performance management of the hosted services although NEPSG meetings and discussions have identified and agreed the need to establish a subgroup of the NEPSG involving the IJB Chairs/vice chairs and appropriate senior officers with responsibility for reviewing and reporting on the performance of hosted services At the time of our review this sub-group and its oversight and reporting processes has still to be established.
Implications
• The lack of a formal oversight and reporting framework for IJBs hosted services may lead to unidentified inefficiencies or quality issues in the delivery of hosted services.

Action plan		
Finding rating	*Agreed action*	*Responsible person / title*
Medium	All relevant parties will reach agreement on forming a formal management reporting framework for IJB hosted services.	NHS Grampian Chief Executive NHS Grampian Deputy Chief Executive Chief Officer of Aberdeenshire IJB Chief Officer of Aberdeen City IJB

	Chief Officer of Moray IJB *Target date:* 31 December 2019 *Reference number:* NHS Grampian HSCG 3.01

3.02 Aberdeenshire IJB recognition of hosted services risks

Finding

Aberdeen City identifies risks related to hosted services at a strategic level on its strategic risk register. Moray has identified risks related to hosted services on its operational risk register.

NHS Grampian recognises Aberdeenshire IJB related risks on its strategic risk register as Aberdeenshire is the only IJB that made a loss in the past financial year.

Aberdeenshire IJB does not record any hosted services risks at either a strategic or operational level within its risk register

Implications

Risks related to hosted services may not be identified, properly understood or effectively managed.

Action plan

Finding rating	*Agreed action*	*Responsible person / title*	*Target date:*	*Reference number:*
Low	2.1 Aberdeenshire IJB should consider whether there are any risks related to hosted services that should be recorded in its strategic or operational risk registers with a view to ensuring a proper understanding and treatment of such risks. 2.2 Moray IJB will review the impact of hosted arrangements in the context of the strategic risk register ensuring that in line with the wider discussion on hosting arrangements a more formal framework is in place around assurance and performance monitoring. August 2018 target for wider discussion, immediate effect Strategic Risk Register.	2.1 Chief Officer of Aberdeenshire IJB 2.2 Chief Officer of Moray IJB	2.1 31 May 2019 2.2 31 August 2019	NHS Grampian HSCG 3.02

Appendix 1. Basis of our classifications

Individual finding ratings

Finding rating	*Assessment rationale*
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences**;** or • ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences**;** or • ***Significant*** impact on the reputation or brand of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation or brand of the organisation.
Low	A finding that could have a: • ***Minor*** impact on the organisation's operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***Minor*** impact on the reputation of the organisation.
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.

Report classifications

The report classification is determined by allocating points to each of the findings included in the report

Findings rating	Points
Critical	40 points per finding
High	10 points per finding
Medium	3 points per finding
Low	1 point per finding

Report classification	Points
Low risk	6 points or less
Medium risk	7– 15 points
High risk	16– 39 points
Critical risk	40 points and over

Appendix 2. Terms of Reference

Background and audit objectives

The public Bodies (Joint Working) (Scotland) Act put in place:

- Nationally agreed outcomes, which will apply across health and social care, and for which NHS Boards and Local Authorities will be held jointly accountable.
- A requirement on NHS Board and Local Authorities to integrate health and social care budgets.
- A requirement on Partnerships to strengthen the role of clinicians and care professionals, along with the third and independent sectors, in the planning and delivery of services.

NHS Grampian has three separate Health and Social Care Partnerships with Aberdeen City, Aberdeenshire and Moray.

Integrated Joint Boards are responsible for the strategic direction of the partnerships and are jointly accountable to Ministers, Local Authorities, NHS Board Chairs and the public for delivering the nationally agreed outcomes.

Each IJB will be required to publish an annual performance report, which will set out how they are improving the National Health and Wellbeing Outcomes. Following consultation with NHS Scotland and COSLA, the Scottish Government published a core suit of integration indicators in March 2015.

The Health and Social Care Partnerships may host services on behalf of the NHS Grampian, the local council and on a rotational basis, on behalf other IJBs. The arrangements if hosted services are outlined in Strategic Commissioning Plans of each respective IJBs.

The overall objective of this review is to consider how each of the three integrated Joint Boards (IJBs) link to the Board's governance arrangements and the flow of information between the IJBs and the Board. We will consider the links between the Board and each of the three IJBs.

Scope

We will review the design and operating effectiveness of key controls in place as at 31 October 2018.
The sub-processes and related control objectives included in this review are:

Sub-Process	Objectives
Roles and Responsibilities	• Links between NHS Grampian and the three IJBs have been considered and reporting lines have been established. • Responsibilities of the key officers within NHS Grampian in respect of the IJBs have been agreed and documented. • Communications lines have been established for where services are hosted by an IJB on behalf of the other IJBs.
Risk Assessment and Assurance Reporting	• NHS Grampian has considered the risks facing the Board as a result of the establishment of the IJBs and mitigating controls are in place. • NHS Grampian has identified and agreed key areas where it requires assurance from the IJBs, e.g.: budget monitoring, key services and workforce decisions. • NHS Grampian receives regular performance/ status reports from the IJBs on agreed areas that are discussed at Board level. • Where any areas of concern are identified these are fed back to the IJBs with relevant assurance sought. • Risk assessments for IJB hosted services are prepared and approved. • Plans are in place to mitigate the risks identified in relation to hosted services and there is regular report of the status and adequacy of such plans.

Audit approach

Our audit approach is as follows:

- Obtain an understanding of the key controls through discussions with key personnel, review of systems documentation and walkthrough tests.
- Evaluate the design of the controls in place to address the key risks.
- Identify the key risks of each process.
- Test the operating effectiveness of the key controls.

Appendix 3. Limitations and responsibilities

Limitations of scope

The scope of our review is outlines above and will be undertaken on a sample basis.

Internal control systems, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

NB: This review does not include performance reporting by the IJBs against the National Outcomes as this was the subject of an Internal Audit review in 2017/18.

Future periods

Our assessment of controls is for the period specified only. Historic evaluation of effectiveness is not relevant to future periods due to the risk that:

- the design of controls may become inadequate because of changes in operating environment, law, regulation or other; or
- the degree of compliance with policies and procedures may deteriorate.

Responsibilities of management and internal auditors

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We endeavour to plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we shall carry out additional work directed towards identification of consequent fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, do not guarantee that fraud will be detected.

Accordingly, our examinations as internal auditors should not be relied upon solely to disclose fraud, defalcations or other irregularities which may exist.

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Internal Audit Report 2018/2019

Unscheduled Care Discharge Process (incl. interaction with IJBs)

March 2019

Final

NHS Grampian

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Distribution List

For action	General Manager – Acute Sector, NHS Grampian
	Acute Director (Nursing and Midwifery)
For information	Audit Committee
	Chief Officer, Aberdeenshire Health & Social Care Partnership
	Chief Officer, Aberdeen City Health & Social Care Partnership
	Chief Officer, Moray Health & Social Care Partnership

This report has been prepared by PwC in accordance with our engagement contract dated 1 August 2017.

Internal audit work was performed in accordance with PwC's Internal Audit methodology which is aligned to the Public Sector Internal Auditing Standards. As a result, our work and deliverables are not designed or intended to comply with the International Auditing and Assurance Standards Board (IAASB), International Framework for Assurance Engagements (IFAE) and International Standard on Assurance Engagements (ISAE) 3000.

1. Executive summary

Report classification	*Trend*	**Total number of findings**				
			Critical	High	Medium	Low	Advisory
Low Risk	N/A – No prior year reviews for comparison	Control design	-	-	-	-	-
		Operating effectiveness	-	-	2	-	-
		Total	**-**	**-**	**2**	**-**	**-**

Summary of findings

The scope of this audit review was to assess the discharge process in NHS Grampian following the creation of the Integration Joint Boards (IJBs) in Scotland. The review focused specifically on unscheduled care discharges and the process for managing and changing the flow and pathway of patients within and between NHS Grampian and the Moray, Aberdeenshire and Aberdeen City IJBs.

Overall conclusions

The current processes and controls in place are designed with a focus on patient rather than bed management and the provision of excellent patient care. Whilst there are areas for improvement, it is important to note that health and social care integration is relatively new and processes and controls are still being embedded into operations. Furthermore, with increasing demand for health and social care, both primary and acute care sectors are working to develop the necessary efficiencies in ensuring robust unscheduled care discharge processes. This is challenging, particularly with the social care sector, against a backdrop of workforce supply, recruitment and retention challenges with a reducing number in the working age population.

Key findings

In summary we have identified two 'medium' risk findings related to control improvement opportunities resulting in this report being classified as 'low' risk. The findings are:

- NHS Grampian 'Patient Discharge from Hospital Protocol' prepared in September 2016 as a draft document has not been finalised or updated.
- Variances in recording and interpreting Estimated Dates of Discharge (EDDs).

The full details of our findings and the agreed actions can be found in **Section 3** of this report.

Good practice noted

We attended a Monday 12 noon Multi-Disciplinary Team (MDT) meeting in Dr. Gray's hospital on 12 November 2018 in Elgin. It was noted that the multi-disciplinary team (MDT) ran through almost every patient admitted to Dr. Grays and discussed what stage of care they were at and the next stage in their care journey. Clear actions were assigned to individuals to drive forward each patient's care and to help ensure that they are discharged as quickly as possible. Furthermore, specific attention was paid to those patients that were already delayed discharges, for a number of reasons. This meeting involved all necessary individuals from both the acute sector and Moray Health and Social Care Partnership with individuals from social work, occupational therapy, physiotherapy, the Geriatric Consultant from Dr. Grays, hospital operational staff, and senior charge nurses from each ward within Dr Grays were all present.

Whilst Aberdeen Royal Infirmary (ARI) also has site wide MDT meetings we did not attend and observe such a meeting.

Management comments

We are pleased to note that the audit recognises the multi-agency and cross-system participation and as such there are examples of good practice in both Aberdeen Royal Infirmary and Dr Gray's Hospital with their respective Health and Social Care Partnerships.

The EDD process relies upon our systems being embedded, which is a current priority, and we welcome the report highlighting this issue.

General Manager (Acute Sector)

2. Background and scope

Background

The Public Bodies (Joint Working) (Scotland) Act 2014 is the legislative framework for the integration of health and social care services in Scotland. It created a number of new public organisations, known as integration authorities and aims to break down the barriers to joint working between NHS Boards and local authorities. As part of this, the Act requires the integration of the governance, planning and resourcing of adult social care services, adult primary care and community health services and some hospital services.

Improving unscheduled care across Scotland is a key ministerial priority for the Scottish Government.

There are many things which have the potential to cause delay and unnecessarily prolong a patient's stay in hospital. Some of these can be categorised as 'external' (services or resources external to the ward or hospital which may not be available when the patient needs them); however, there may also be internal causes of non-clinical delay, and these can also contribute to poor patient experience. Discharge plans begin on patient admission to acute care. Regardless of the terminology used, a delayed discharge is an interruption of a clear flow through a system of care and support. Such interruptions tend to be symptoms of systems that are not geared to work together. Therefore, discharge performance is a clear performance indicator of the effectiveness of integrated health and social services.

In the Performance Report to the NHS Grampian Board Meeting held on 6 December 2018 it was noted that during September 2018, patients spent 4,023 days in hospital due to delays in discharge in Grampian. The figure for September 2017 was 3,408 so 2018 has seen in increase in delayed discharges of approximately 18%.

Across Scotland patients spent 45,470 days in hospital during September 2018 due to delayed discharges. The national figures for September 2017 was 42,110 so 2018 has seen an increase of delayed discharges of approximately 8%.

Multi-disciplinary Team Planning

Within NHSG a multi-disciplinary team (MDT) aims to meet within twelve hours of a patient being admitted to either Aberdeen Royal Infirmary (ARI) or Dr. Grays hospital in Elgin. The MDT is comprised of a number of health professionals from both the acute sector and the individual Health and Social Care Partnerships. The MDT is made up of professionals or disciplines such as the on-shift consultant, senior charge nurse, staff nurse, social care, occupational therapy and physiotherapy. The MDT will discuss the patient's required treatment, specific pharmacy requirements, possible ongoing, external, care at home or in a community care setting. The MDT will identify each dependent task and will agree when each needs to start and finish to ensure that the patient can be discharged without delay.

Setting and Reviewing an Estimated Date of Discharge (EDD) and Discharge Planning

At the MDT meeting to discuss a patient's treatment and possible ongoing care an estimated date of discharge (EDD) will also be set for that patient. Every patient when entering either ARI or Dr. Grays should be given an EDD. An EDD is the date when the MDT believes the patient can be safely discharged from the acute hospital setting. This may be to home or another place of care. EDDs are input into the electronic patient management system (Trakcare), the data from which feeds through to an individual Wardview system that can be viewed by staff nurses and senior charge nurses. The EDD should be updated regularly and should reflect the ongoing

progress of the patient care journey.

EDDs are fundamental to discharge planning and within NHSG are reviewed daily during ward rounds and at the site-wide system and flow huddles held at 9am, 12 noon and 4pm at both ARI and Dr. Grays. The daily ward rounds are fundamental to daily dynamic discharging. Ward staff will meet to discuss each patient in the ward to agree and prioritise the day's tasks – including any patient who can be discharged before 12 noon or in the evening. Daily dynamic discharging and planning help hospital operational staff plan the bed capacity for the day at each site.

Measurement Framework

NHSG conducts Day of Care Surveys with two surveys completed each year. The surveys are conducted at both acute hospitals within NHSG. These surveys are carried out between 9am and 10:30am across all acute sector wards on the same day. The surveys do not include intensive care, medical and surgical high dependency and coronary care beds. The surveys will review those patients who are found to be appropriately in hospital and those who are not, the age profile of patients, wards with patients not appropriate to be in hospital, NHSG length of stay and will also review the main reasons for patients not being discharged – for example, those patients who are waiting for community beds.

On top of these surveys, there are Delayed Discharge Updates which analyses the delayed discharge performance within each Health and Social Care Partnership. These are specified, formal, six monthly updates on delayed discharge performance which are prepared for each IJB.

Delayed Discharge Performance Reporting and Action Plans

Each individual IJB will report delayed discharge census (number of patients delayed at a specific point in time during the month) and bed days lost each month using government criteria. The information is reported to the Information Services Division of the NHS National Services Scotland. Standard delays and complex delays are reported differently by the IJBs.

The IJBs have actions plans which are put in place to improve delayed discharge performance. These include details of performance and data reporting, discharge pathways and processes, plans to deal with complex delays, services and other resources required to support discharges. The Delayed Discharge Performance and Improvement Programme (the six monthly updates) are linked to each Health and Social Care Partnership strategic risk register. The updates explain plans to mitigate the risks identified in the risk registers.

Scope and limitations of scope

This review therefore concentrated on the five key sub-processes which together help ensure effective discharging. These were:

- **Multi-disciplinary (MDT) team planning.**
- **Setting and reviewing an Estimated Date of Discharge (EDD).**
- **Discharge planning.**
- **Measurement framework for measuring and reporting on patient discharge flow.**

- **Delayed discharge performance reporting and action plans.**

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Further details of the scope, key sub-processes and related control objectives are included in the agreed Terms of Reference set out in **Appendix 2** of this report.

3. Detailed current year findings

3.01 NHSG Patient Discharge from Hospital Protocol – operating effectiveness

Finding

NHSG has a draft 'Patient Discharge from Hospital Protocol' which is dated September 2016. The protocol is to be followed when a patient's needs indicate that they will require support from community health and social care services on discharge into the community. The aim is to provide a consistent co-ordinated approach with multi-disciplinary, multi-agency input while maintaining a patient's interests as central to the discharge planning process.

The protocol states that it is a 'working document and as services and practices develop, it will be reviewed to improve or add to ways of working and to accommodate new service developments'.

The protocol was drafted during the early days following the creation of the Health and Social Care Partnerships and Integration Joint Boards in April 2016. The protocol should be reviewed and updated as necessary to reflect any changes in responsibilities or processes that have arisen as the partnering arrangements have evolved and matured.

Implications

- Risk of ineffective discharge planning or sub-optimal co-ordination between NHS Grampian and the Health and Social Care Partnerships.

Action plan

Finding rating	*Agreed actions*	*Responsible person / title*
Medium	• Management will update and publish an approved Patient Discharge from Hospital Protocol. • Management will ensure the protocol is reviewed on a regular basis and updated as necessary to reflect legislative and regulatory changes, Scottish Government or NHS Scotland guidance and changes in partnering arrangements with the Health and Social Care Partnerships.	General Manager – Acute Sector *Target date:* 30 April 2019 *Reference number:* Unscheduled Care Discharges 3.01 – 18/19

3.02 *Recording, updating and interpreting Estimated Dates of Discharge (EDDs) – operating effectiveness*

Finding

NHS Grampian follows the Scottish Government's 'Daily Dynamic Discharge Approach' aimed at improving the timeliness and quality of patient care by planning and synchronising the day's activities. Under daily dynamic discharging every patient admitted to an acute sector hospital should be given an estimated date of discharge (EDD) as part of the overall discharge planning process. An estimated date of discharge (EDD) is the date when the Multi-Disciplinary Team (MDT) believes the patient can be safely discharged from the acute hospital setting. This may be to home or another place of care. An EDD should be set when the MDT meets within 12 hours of patient admission to an acute setting. It combines a clinical process to estimate and document a date of predicted medical fitness, followed by a MDT view which takes into account primary care requirements, and should be changed to reflect the most recent view of a patient's recovery rate. Through audit interviews and through attending the MDT cross-system huddle of all patients in Dr Grays, it was found that some patients in both ARI and Dr Gray's had no EDD recorded in Trakcare (the electronic patient management system). We observed whilst attending an MDT meeting in Dr Gray's that the senior staff nurse from the ward in which the identified patient was then given an action to go back after the meeting and record an EDD for that patient.

This then led to a discussion with the consultant and with social work staff as to what an EDD actually represents. For the consultant, the EDD represented the date on which the patient was medically fit to leave the hospital. For others, the EDD represented the most-likely, actual, date that the patient will leave the hospital - for example, when transitional issues have been sorted (namely, a community hospital bed, or care package at home). It was stated in the MDT meeting that there was a discrepancy as to what definition for an EDD should be used.

The definition of an EDD (as per NHS Scotland and the Daily Dynamic Discharging Approach Guidance document) combines a medical assessment to assess the likely date that a patient will be ready to leave an acute hospital and a more holistic view of when a patient is able to move from an acute setting to further primary care (complex discharges) which is dependent on the MDT meetings. During discussions with key individuals it was understood that NHSG and Health and Social Care Partnership staff interpret the definition of an EDD differently.

Implications

- Delays to patient discharge arise as the EDD is used to initiate referrals to community health-care providers and social care agencies (normally at least 48 hours prior to discharge)

Action plan

Finding rating	*Recommended action*	*Responsible person / title*
Medium	• Management will provide clear guidance to ensure every patient receives an EDD when admitted to hospital, and guidance for staff in order to set accurate EDDs and to ensure consistency in setting an EDD in full compliance with the Daily Dynamic Discharge Approach.	Acute Director (Nursing & Midwifery) *Target date:* 31 August 2019 *Reference number:*

Unscheduled Care Discharge 3.02 – 18/19

Appendix 1. Basis of our classifications

Individual finding ratings

Finding rating	*Assessment rationale*
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences**;** or • ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences**;** or • ***Significant*** impact on the reputation or brand of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation or brand of the organisation.
Low	A finding that could have a: • ***Minor*** impact on the organisation's operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***Minor*** impact on the reputation of the organisation.
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.

Report classifications

The report classification is determined by allocating points to each of the findings included in the report

Findings rating	Points
Critical	40 points per finding
High	10 points per finding
Medium	3 points per finding
Low	1 point per finding

Report classification	Points
Low risk	6 points or less
Medium risk	7– 15 points
High risk	16– 39 points
Critical risk	40 points and over

Appendix 2. Terms of Reference

Background and audit objectives

Improving unscheduled care across Scotland is a key ministerial priority for Scottish Government. Through the National Unscheduled Care – 6 Essential Actions Improvement Programme the Government aims to improve the timeliness and quality of patient care from arrival to discharge from the hospital and back into the community and aiming to ensure that 95% of patients attending A&E anywhere in Scotland are seen, treated and discharged or admitted with four hours.

The Six Essential actions are:

1) Clinically-focussed and hospital management
2) Realignment of hospital capacity and patient flow
3) Patient rather than bed management – operational performance
4) Medical and surgical processes arranged to take patients from A&E through the acute system
5) Seven-day services targeted to increase weekend and earlier-in-the-day discharges
6) Ensuring patients are cared for in their own homes or a homely setting.
7)

This review will focus on the 'Patient rather than Bed Management – Operational Performance' action.

There are many things which have the potential to cause delay and unnecessarily prolong a patient's stay in hospital, some of which can be categorised as 'external' (services or resources external to the ward or hospital which may not be available when the patient needs then). However, there are also be internal causes of non-clinical delay, and these can also contribute to poor patient experience.
We will review the discharge process considering practices following the creation of the Integration Joint Boards. The review will focus specifically on unscheduled care discharges and the process for managing and changing the flow and pathway of patients within and between services and sectors.

Scope

The sub-processes and related control objectives included in this review are:

Sub-Process	Objectives
Multi-disciplinary team planning	• A multi-disciplinary team gets together within 12 hours of a patient's admission and develops an understanding of the component parts of a patient's discharge plan – what treatment is required, with what – and for how long. • The team also considers other things that need to be done in parallel with the clinical treatment, in order for each patient to be discharged safely onto the next appropriate area of care • There is effective identification of the dependent tasks and agreement on when they each need to start (and finish) to ensure the patient can be discharged without delay.
Setting and reviewing an Estimated Date of Discharge (EDD)	• There is a clinical process to estimate and document an EDD (i.e., when the patient no longer needs medical treatment in hospital. • There is a communication process to document an EDD based on a holistic/multi-disciplinary approach. • The EDD is subject to on-going review and changed to reflect the most recent view of a patient's recovery rate.

Discharge Planning	• Discharge plans are formulated and to record and communicate the tasks that require timely completion for an on-target discharge. • Discharge plans identify external factors such as; communication with family or home support, identification of transport needs, and identification of support needs. • Discharge plans identify internal factors such as the timing of making diagnostic decisions, fulfilment of pharmacy requests and production of discharge letters.
Measurement Framework	• Systems and procedures are in place for measuring and reporting on the performance of the patient admission to discharge flow. • There is an agreed range of performance metrics e.g., average length of stay, number of discharges per day and time, delay (number of patients and number of days), number of discharges pre-noon number of discharges in the evening and number of discharges Saturday and Sunday = Mid-week
Delayed Discharge Performance Reporting and Action Plans	• Discharge performance is reported by NHSG and the IJBs on a regular basis using Government set discharge delay categorisations. • Action plans are formulated and tracked by NHSG and the IJBs that document current initiatives and future plans for improving delayed discharge performance. • Action plans are suitably linked to strategic and operational risk registers so there is a clear view of the risks being mitigated by action plan initiatives.

Appendix 3. Limitations and responsibilities

Limitations inherent to the internal auditor's work

We have undertaken the review of the medicines homecare service, subject to the limitations outlined below.

Internal control

Internal control systems, no matter how well designed and operated, are affected by inherent limitations. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Future periods

Our assessment of controls is for the period specified only. Historic evaluation of effectiveness is not relevant to future periods due to the risk that:

- the design of controls may become inadequate because of changes in operating environment, law, regulation or other; or
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Internal Audit Report 2018/2019

Health & Safety Governance

NHS Grampian

Final (Amended)

April 2019

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For action	Director of Workforce
	Head of Occupational Health & Safety
	Chief Officer, Aberdeen City IJB
	Chief Officer, Aberdeenshire IJB
	Chief Officer, Moray IJB
For information	Audit Committee

This report has been prepared by PwC in accordance with our engagement contract dated 1 August 2017.

Internal audit work was performed in accordance with PwC's Internal Audit methodology which is aligned to the Public Sector Internal Auditing Standards. As a result, our work and deliverables are not designed or intended to comply with the International Auditing and Assurance Standards Board (IAASB), International Framework for Assurance Engagements (IFAE) and International Standard on Assurance Engagements (ISAE) 3000.

1. Executive summary

Report classification	*Trend*	**Total number of findings**				
		Critical	High	Medium	Low	Advisory
Low Risk	N/A – No prior year reviews for comparison					
		Control design	-	-	1	1	-
		Operating effectiveness	-	-	-	-	-
		Total	**-**	**-**	**1**	**1**	**-**

Summary of findings

The objectives of this review were to assess the control design and effectiveness of the Health and Safety governance and oversight structures established by NHS Grampian ('NHSG') and the Health and Social Care Partnerships (HSCPs) and to confirm that the issues identified by the HSE Improvement Notices served on NHSG have been, or are being, effectively managed through to resolution. In addition we reviewed the Health & Safety governance arrangements within NHSG Acute Services.

In summary we have identified one 'medium' risk finding and one 'low' risk finding in relation to control improvement opportunities and these result in this report being classified as 'low' risk overall.

The medium risk finding is as follows:

- Terms of Reference or Constitutions for six committees with Health and Safety governance and oversight responsibilities as part of their remit either exist as draft documents or are overdue for review. This finding spans the three HSCPs and NHSG.

The full details of the above finding, the low risk finding and the agreed actions, can be found in **Section 3**.

Management comment

Management welcomes the report and agrees in principle with the overall findings. Over the past 3 years there has been considerable advancement in the development of Health & Safety governance structures both within NHS Grampian and our Health & Social Care Partners. This report highlights these achievements and further encourages the strengthening of these partnerships in relation to Health & Safety governance and the evolution of safe systems of work Pan-Grampian.

Head of Occupational Health and Health & Safety

2. Background and scope

Background

The objectives of this review were to assess the control design and effectiveness of the governance and oversight structures established by NHSG and the HSCPs and to confirm that the issues identified by the HSE Improvement Notices have been, or are being, effectively managed through to resolution.

We noted the following:

1. **NHS Grampian Health & Safety Governance**

   There are a number of Committees, Teams and Groups with H&S responsibilities that report upwards to the NHS Grampian Board via an established governance hierarchy. Each of these governance bodies functions in accordance with agreed Terms of Reference or a Constitution. Each body is required to maintain appropriate records of meetings in order to demonstrate that it is carrying out the business for which it is responsible according to its remit.

2. **Health and Social Care Partnership Health & Safety Governance**

   NHS Grampian works in partnership with Aberdeen City, Aberdeenshire and Moray Councils to develop and implement arrangements to support health and social care integration. An Integration Joint Board ('IJB') exists for each of the three partnership arrangements to provide strategic leadership for the management and delivery of integrated services. Within each of the Health & Social Care Partnership organisations there are a number of Committees and Groups that report up to the IJBs on matters related to Health & Safety governance. As within NHS Grampian, each of these governance bodies functions in accordance with agree Terms of Reference. Each body is required to maintain appropriate records of meetings in order to demonstrate that it is functioning in accordance with its remit.

   There is collaboration and information sharing on Health and Safety matters between the HSCP committees and the counterpart NHS Grampian committees at all levels.

   As a point of good practice it is important that each Committee within a governance framework includes a standing agenda item to determine if there any issues or reports that require escalation to a higher level Committee. If there are no escalations or referrals then the minutes should confirm so. Alternatively if the meeting determines that escalations or referrals are required then these should be itemized in the minutes. Whilst these arrangements appear to be in place based on our limited sample, we take this opportunity to cite best practice as we cannot be certain that it happens in every case.

3. **Health and Safety Executive Improvement Notices Placed on NHS Grampian**

   In the past 24 months the Health and Safety Executive (HSE) has placed a total of seven Improvement Notices in different areas of NHSG. These related to:

   Falls x 2 Notices

Sharps x 2 Notices

Staff Immunisation x 1 Notice

Skin Health Surveillance x 1 Notice

Ligature Injuries x 1 Notice

Investigation and gap analysis work has been undertaken and documented in order to fully understand the nature of the issues raised by the HSE and to enable the formulation of plans to remediate gaps and resolve the issues. There are remediation plans in place that have been properly documented and approved and there are clearly assigned owns responsible to delivering these plans.

Plan progress is being suitably reported to and overseen by the appropriate groups and committees within the H&S governance structure with headline progress being reported up through the governance hierarchy to the NHSG Board. Policies relating to the areas identified by the HSE have been updated as necessary to ensure changes and improvements in working practices are sustainable and effectively communicated to staff. As at 30 October 2018 five out of the seven notices have been lifted. The other two notices have a timeline set by the HSE of 31 January 2019 (Falls - Manual Handling) and 31 March 2021 (Ligature). We understand that the HSE have ask for a postponement of the 31 January 2019 meeting with regard to the Falls notice with diaries currently being checked with a view to having the meeting at the end of February 2019. NB: The Falls notice was actually lifted on 31 January 2019 so the envisaged postponement was not required.

4. NHS Grampian (Acute Services)

There are health and safety policies and procedures in place and these been communicated to and are accessible to staff within Acute Services. These are kept up to date and reviewed in accordance with the document control procedures. The Board of NHS Grampian is ultimately responsible for ensuring that the organisation keeps up to date with and complies with Health and Satiety legislation. The Operational Group (Acute) in collaboration with the NHSG Health and Safety Expert Group and the NHSG Occupational Health & Safety Committee ensures that policies and procedures within Acute Services are updated appropriately and communicated to Acute Services staff and management. Health and Safety monitoring reviews are conducted within Acute Services and the results reported to NHSG Occupational H&S Committee. Circumstances when risk assessments should be completed are defined and risk assessments are performed by risk owners as required. Mandatory and specialists training are done to ensure that Acute Services staff follow the Health and Safety policies and procedures.

Scope and limitations of scope

Our approach focused on the following four areas:

1. **NHSG Governance**
2. **HSCP Governance**

3. **HSE Improvement Notices**
4. **Acute Services**

The scope of our review is outlined above and will be undertaken on a sample basis.

Internal control, no matter how well designed and operated, can provide only reasonable and not absolute assurance regarding achievement of an organisation's objectives. The likelihood of achievement is affected by limitations inherent in all internal control systems. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Our agreed Terms of Reference are set out at **Appendix 2**.

3. Detailed current year findings

3.01 Terms of Reference for Key Groups and Committees – control design

Finding
Each of the committees with Health & Safety governance and oversight responsibilities within the organisational structures of NHSG and the HSCPs should have a Terms of Reference or Constitution describing the purpose, scope and authority of the committee. It is good practice to review such Terms of Reference at least once a year. We noted that the Terms of Reference for the following committees either exist in draft format and/or have never been formally approved: 1. Aberdeen City HSCP – Staff Governance H&S Committee - July 2016 2. Aberdeen City HSCP H&S Committee Role and Remit - February 2017 (Draft) 3. Moray HSCP – H&S Group – 2018 (Draft) 4. Aberdeenshire – Clinical Health and Social Work Committee – June 2017 (never formally approved). The Terms of Reference or Constitutions for the following committees are overdue for review: 5. NHSG Staff Governance Committee (Constitution) – this is dated November 2015. The document states that there should be an annual review 6. NHSG Occupational H&S Committee (Constitution) – this is dated May 2009 and the document review cycle is stated as being every 3 years 7. NHSG Senior Leadership Team (Terms of Reference) – this is dated June 2016. The document has no stated review frequency.
Implications
• Terms of Reference may be outdated and not fully reflect the purpose and scope of the committee or properly describe the meeting arrangements.

Action plan		
Finding rating	*Agreed actions*	*Responsible person / title*
Medium	• All draft Terms of Reference will be reviewed, updated where necessary, approved and published as final. • All terms of reference that are overdue for review will be reviewed updated as necessary, approved and published as final. • Arrangements will be put in place to ensure that all Terms of Reference are reviewed in accordance with document control requirements set out in the ToRs. Management notes that it is best practice to schedule a ToR review at least once a year.	1.1 Chief Officer, Aberdeen City IJB 1.2 Chief Officer, Aberdeen City IJB 1.3 Chief Officer, Moray IJB 1.4 Chief Officer, Aberdeenshire IJB 1.5 Operational Director of Workforce 1.6 Head of Occupational Health and Health & Safety 1.7 Senior Leadership Team The Board's assurance framework including the role and remit of the Board's Core Governance Committee's (Staff, Clinical, Audit, Performance and Engagement and Participation) will be reviewed following feedback from the national review of governance arrangements currently underway and expected to report in Summer 2019 and internally following further consideration of how the business of these Core Governance Committees may be impacted by the Performance, Assurance, Improvement and Risk arrangements (PAIR) recently agreed by the System Leadership Team and the Board. *Target date:* 1.1 31 July 2019 1.2 31 July 2019 1.3 Completed 1.4 31 August 2019 1.5 Completed

1.6	30 June 2019
1.7	Summer 2019
Reference number:	
HSG / 01	

3.02 Key Groups and Committee's Meeting Arrangements– control design

Finding

We reviewed the meeting arrangements set out in the Terms of Reference for each governance committee with regard to such matters as meeting frequency and location, meeting procedures, quorum, details about agendas and minutes and how these will be distributed.

We noted the following:

- NHSG Senior Leadership Team – The Terms of Reference for the Senior Leadership Team specifies the frequency of meetings as being 'on two occasions each month'. We sample reviewed the records of meetings held for five months (February, March, April, May and June) noted that for May and June 2018 only one meeting was held.

Implications

Governance committees may not achieve their desired level of efficacy if they do not meet at the frequency set out in their Terms of Reference

Action plan

Finding rating	*Agreed action*	*Responsible person / title*
Low	The role and remit of the Senior Leadership Team will be reviewed under the recently agreed Performance, Assurance, Improvement and Risk arrangements (PAIR) agreed for implementation by the SLT and the NHSG Board.	Senior Leadership Team *Target date:* Summer 2019 *Reference number:* HSG / 02

Appendix 1. Basis of our classifications

Individual finding ratings

Finding rating	*Assessment rationale*
Critical	A finding that could have a: • ***Critical*** impact on operational performance; or • ***Critical*** monetary or financial statement impact; or • ***Critical*** breach in laws and regulations that could result in material fines or consequences**;** or • ***Critical*** impact on the reputation or brand of the organisation which could threaten its future viability.
High	A finding that could have a: • ***Significant*** impact on operational performance; or • ***Significant*** monetary or financial statement impact; or • ***Significant*** breach in laws and regulations resulting in significant fines and consequences**;** or • ***Significant*** impact on the reputation or brand of the organisation.
Medium	A finding that could have a: • ***Moderate*** impact on operational performance; or • ***Moderate*** monetary or financial statement impact; or • ***Moderate*** breach in laws and regulations resulting in fines and consequences; or • ***Moderate*** impact on the reputation or brand of the organisation.
Low	A finding that could have a: • ***Minor*** impact on the organisation's operational performance; or • ***Minor*** monetary or financial statement impact; or • ***Minor*** breach in laws and regulations with limited consequences; or • ***Minor*** impact on the reputation of the organisation.
Advisory	A finding that does not have a risk impact but has been raised to highlight areas of inefficiencies or good practice.

Report classifications

The report classification is determined by allocating points to each of the findings included in the report

Findings rating	Points
Critical	40 points per finding
High	10 points per finding
Medium	3 points per finding
Low	1 point per finding

Report classification	Points
Low risk	6 points or less
Medium risk	7– 15 points
High risk	16– 39 points
Critical risk	40 points and over

Appendix 2. Terms of Reference

Background and audit objectives

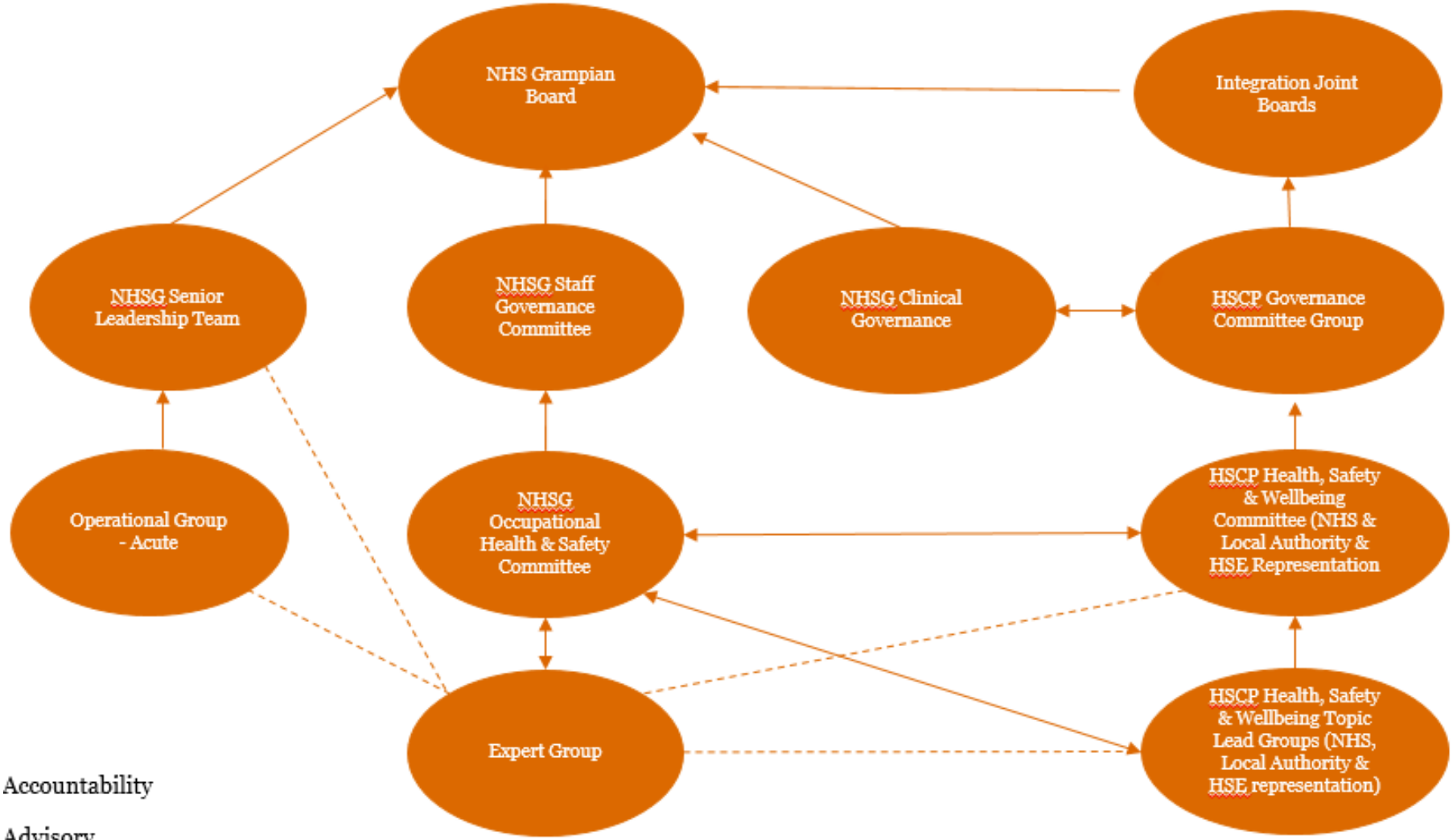
Health and Safety within the workplace refers to preventing accidents and injuries to employees, contractors, patients and visitors. Failing to efficiently and effectively manage Health and Safety risks through appropriate policies and controls can be extremely costly both at a financial and a reputational level. As an employer, NHS Grampian ('NHSG') has a responsibility to ensure that all of its sites adhere to the Health and Safety policies, standards and controls as implemented throughout the Health Board.

Crucial for the delivery of an effective health, safety and welfare strategy is the existence of adequate arrangements for governance, oversight and consultation on health, safety and wellbeing process and performance across NHSG and the three regional Health and Social Care Partnerships (HSCPs). On the slide overleaf we show the structure of the Group and Committees that have been established to provide this governance and oversight and who will take action as necessary to rectify and areas of concern.

During the past two years the Health and Safety Executive (HSE) have placed a total of seven Improvement Notices across various areas of NHSG and these have required NHSG to undertake gap analyses and develop and implement action plans in order to remediate the issues raised by the HSE and to strengthen the Health and Safety management regime across NHSG.

The objectives of this review are to assess the control design and effectiveness of the governance and oversight structures established by NHSG and the HSCPs and to confirm that the issues identified by the HSE Improvement Notices have been, or are being, effectively managed through to resolution.

Governance Structure



Scope

We will review the Health and Safety governance arrangements, including actions arising from HSE notices issued. The primary focus of the review will be governance arrangements in acute services but the review will also consider overall H&S governance at the IJB level.
The sub-processes, related control objectives included in this review are:

Sub-Process	Objectives
NHSG Governance	• There is a clearly defined and communicated governance structure. • Each Board, Committee and Group (hereinafter referred to as 'governance fora' within the structure has clearly defined roles and responsibilities and these are set out in approved Terms of Reference. • There is auditable evidence that each governance forum is functioning in accordance with its Terms of Reference with regard to such matters as frequency of meetings, attendance, agenda content, meeting conduct, inputs to and outputs from meetings including minutes and action lists. • There is effective escalation upwards through the governance hierarchy of reports, management information and other such information e.g., risk registers that needs to flow from the lower level governance fora up to the NHSG and Integration Joint Boards and between these Boards.
HSCP Governance	• There is a clearly defined and communicated governance structure within each HSCP. • Each Committee and Group within the structure has clearly defined roles and responsibilities and these are set out in approved Terms of Reference • There is auditable evidence that each governance forum is functioning in accordance with its Terms of Reference with regard to such matters as frequency of meetings, attendance, agenda content, meeting conduct, inputs to and outputs from meetings including minutes and action lists. • There is effective escalation upwards through the governance hierarchy of reports, management information and other such information e.g., risk registers that needs to flow from the lower level governance fora within the HSCPs up to the Integration Joint Boards and between comparable/collaborative forums across the NHSG and HSCP organisations.
HSE Improvement Notices	• Roles and responsibilities for responding to and addressing the issues raised by the HSE have been clearly allocated. • Appropriate investigations and gap analysis work have been undertaken and documented in order to fully understand the nature of the issues raised by the HSE and to enable the formulation of plans needed to remediate the gaps and resolve the issued. • Remediation plans have been properly documented and approved and have clearly defined owners. • Progress against remediation plans is being properly overseen by and reported to the appropriate governance fora with headline progress being reported up to the NHSG Board. • Requirements for external reporting on progress to the HSE are being properly fulfilled. • Policies, procedures and standard are updated where necessary to ensure that the actions taken in remediation of HSE are permanent and sustainable as required.

Acute Services	• Relevant health and safety policies and procedures are in place and have been communicated to staff within acute services. These are kept up to date and reviewed regularly. • Responsibility for keeping up to date with legislation and communicating changes has been assigned and policies and procedures are updated appropriately and communicated to acute services staff. • Health and Safety monitoring reviews are conducted within acute services and the results reported. • Circumstances when risk assessments should be completed are identified and risk assessments are performed by risk owners as required. • Action are taken to ensure that acute staff follow the Health and Safety policies and procedures, such as communication of responsibilities and providing up to date training for employees.

Appendix 3. Limitations and responsibilities

Limitations inherent to the internal auditor's work

We have undertaken the review of the health and safety governance, subject to the limitations outlined below.

Internal control

Internal control systems, no matter how well designed and operated, are affected by inherent limitations. These include the possibility of poor judgment in decision-making, human error, control processes being deliberately circumvented by employees and others, management overriding controls and the occurrence of unforeseeable circumstances.

Future periods

Our assessment of controls is for the period specified only. Historic evaluation of effectiveness is not relevant to future periods due to the risk that:

- the design of controls may become inadequate because of changes in operating environment, law, regulation or other; or
- the degree of compliance with policies and procedures may deteriorate.

Responsibilities of management and internal auditors

It is management's responsibility to develop and maintain sound systems of risk management, internal control and governance and for the prevention and detection of irregularities and fraud. Internal audit work should not be seen as a substitute for management's responsibilities for the design and operation of these systems.

We endeavour to plan our work so that we have a reasonable expectation of detecting significant control weaknesses and, if detected, we shall carry out additional work directed towards identification of consequent fraud or other irregularities. However, internal audit procedures alone, even when carried out with due professional care, do not guarantee that fraud will be detected.

Accordingly, our examinations as internal auditors should not be relied upon solely to disclose fraud, defalcations or other irregularities which may exist.

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Aberdeen City Health & Social Care Partnership
A caring partnership

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Date of Meeting	28.05.199
Report Title	Audit Scotland Reports
Report Number	HSCP.19.013
Lead Officer	Alex Stephen, Chief Finance Officer
Report Author Details	Alex Stephen, Chief Finance Officer
Consultation Checklist Completed	*Yes*
Appendices	a) Local Government in Scotland – Challenges and Performance 2019 b) Safe Guarding Public Money: Are you Getting it Right?

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 Reports 'Local Government in Scotland – Challenges and Performance 2019' and 'Safeguarding Public Money: Are You Getting It Right?',

2. Recommendations

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

a) Reviews, discusses and comments on the reports "Local Government in Scotland – Challenges and Performance 2019', as attached at Appendix A and 'Safeguarding Public Money: Are You Getting It Right?" as attached at Appendix B.

3. Summary of Key Information

Local Government in Scotland – Challenges and Performance 2019

3.1. This report highlights that councils must continue to change to address the gap between demand and resources.

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

3.2. It emphasises how Scotland's councils are managing to improve and maintain most services. But Scottish Government funding to councils is likely to reduce in future; this, combined with increased demand and less flexibility over spending decisions, means councils need to think differently about how they deliver services to the public.

3.3. The Local Government Overview 2019 report by the Accounts Commission, the local authority watchdog, says some services are beginning to show signs of pressure and change is needed to tackle a growing gap between demand and resources.

3.4. Nearly 70 per cent of councils' spending is on social care and education, and more money is being committed to Scottish Government priorities. This leaves councils less flexibility in where to spend and where to save.

3.5. At the same time councils are facing increased demand. All councils will see a continued rise in the number of people aged 65 and over, and ten councils an increase in the number of children under 15.

Safe Guarding Public Money

3.6. This report aims to reinforce the importance of councils having effective internal controls.

3.7. Although these may have a low profile, they are fundamental to maintaining a council's finances; securing its core values; safeguarding public money; and minimising the reputational impact on a council if things go wrong. In places, anonymised, real-life case studies illustrate the importance of internal controls and the consequences if they fail.

3.8. The report highlights that there are signs from councils' internal auditors and the work of councils' external auditors that standards of internal controls may be strained. Some recurring weaknesses are becoming apparent among councils and the consequences could be serious, including the loss of significant amounts of public money, impacts on services and reputational damage.

3.9. Checklists are featured to help councillors and officers assess their council's situation and, where necessary, to identify and plan improvements.

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

4. Implications for IJB

Whilst the reports do not directly relate to the Integration Joint Board, as Aberdeen City Council is one of our key partners, it is important to have an understanding of the local authority's performance, challenges and how we can influence these. Many learning opportunities identified in the report are applicable to the 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.

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

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.

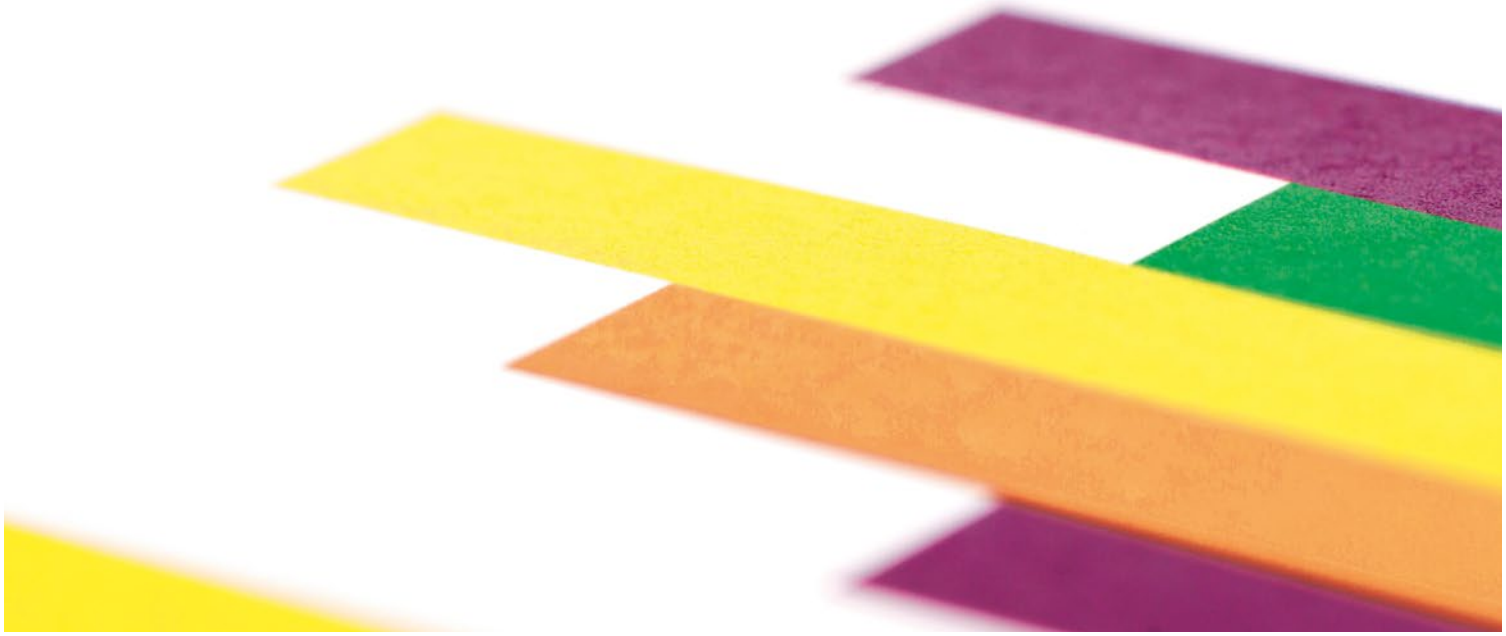
6.2. **Link to risks on strategic or operational risk register:** Strategic Risk 2

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 assurance that it is learning from best practice.

Local government in Scotland

Challenges and performance 2019



ACCOUNTS COMMISSION

Prepared by Audit Scotland
March 2019

The Accounts Commission

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

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

Our work includes:

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

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

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

Information box

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.

These question mark icons appear throughout this report and represent questions for councillors.

Audit team

The core audit team consisted of: Carol Calder, Kathrine Sibbald, Ashleigh Madjitey and Ruth Azzam, with support from other colleagues and under the direction of Claire Sweeney.

Chair's introduction

Councils have an increasingly challenging role. They need to respond to the changing needs of their local population. At the same time, they have a pivotal role in helping to deliver a range of key national priorities for Scotland. This is at a time when the outlook is for finances to tighten further and for demand for services to continue to increase, as populations change and there are more people living in poverty.

The important role councils play is clear, but there are many uncertainties, which makes planning for the future more challenging as it becomes more critical than ever. The UK's withdrawal from the EU is imminent as I write this introduction, but the process and implications remain unclear. The medium to longer-term impact of changes to the Scottish Government's financial powers and the details surrounding the local governance review are also still unknown.

However, we find that councils across Scotland have continued to work hard to maintain services to their communities, despite the increasing challenges and pressures. They have stepped up and have continued to improve how they use their resources. But, in many councils the change and improvement work has focused on efficiencies. To address the growing gap between demand and resources, more fundamental, transformational changes are needed in service provision, and the pace of change needs to improve in some councils. Transformational change is about more than just efficiency. There needs to be a focus on how services are best delivered to communities and, in particular, how councils protect and empower the most vulnerable members of those communities.

Objective and relevant data are essential. Nationally, across councils, data are fundamental for the assessment of performance, benchmarking and improvement. Locally, data should support the redesign and change of processes and services. It is important for councils to have good-quality workforce data to inform organisation-wide workforce planning that supports the shape of future operations.

The pressure on council budgets has led to the exploration of alternative approaches to increasing income such as extending fees and charging schemes and the options for introducing local taxes. This is a development of interest to the Commission that we will monitor and consider in future overview reports.

We published an update report *Health and social care integration* in November 2018, which found that although integration authorities have made some progress they must overcome significant barriers to speed up change. The Commission will continue to have a close interest in the progress of integration authorities and in their financial management.

I hope you find this overview useful and I would welcome any feedback you may have.

Graham Sharp
Chair of the Accounts Commission

Summary

Key messages

1 Councils face an increasingly complex, changing and uncertain environment which places different demands and expectations on them. Councils are also central to delivering many high-level public sector objectives, such as the integration of health and care services and involving citizens more in decisions about public services.

2 These reforms require councils to collaborate with partners, with the third sector and with communities, to think differently about how they deliver and fund services. Thinking differently about services is important to meet the growing and changing needs of their communities in the coming years. New ways of working can lead to increasingly complicated lines of accountability.

3 Scottish Government revenue funding to councils has reduced in real terms between 2013/14 and 2019/20, while national policy initiatives continue to make up an increasing proportion of council budgets. This reduces the flexibility councils have for deciding how they plan to use funding. At the same time, demands for council services are increasing from a changing population profile. All councils expect an increase in the proportion of people aged over 65 and almost a third of councils expect an increase in the proportion of children under 15.

4 Councils have made good progress in developing medium-term financial planning and continue to manage their funding gaps through savings and use of reserves. All councils increased council tax to the maximum three per cent in 2018/19 and many increased their fees and charges to raise income. Some councils are looking at other options to raise income.

5 Councils need to ensure they have the staff, skills and leaders to deliver change. This requires effective workforce planning, but the quality of planning is inconsistent across councils. An increasing proportion of the workforce is nearing retirement. If there is insufficient succession planning, skills and knowledge will be lost as these people retire. Recruitment into some service areas is becoming increasingly difficult, but national workforce data is insufficient to clearly understand how individual services areas are affected.

6 Despite reducing funding and increasing demands, across local government most performance indicators are improving or being maintained, although some service areas show more strain. There remains performance variation among councils that cannot be readily explained by differences in context or spend. Better use of data and benchmarking could lead to further improvement and efficiencies.

Recommendations

While councils have continued to find ways to manage funding gaps and have made good progress with medium-term financial planning, they face an increasingly complex, changing and uncertain time ahead. To continue to improve the outcomes for their communities within this context, councils need to be open to transformational change and implement new ways of working.

To make effective progress councils should:

- assure themselves that they have adequate leadership and management capacity in place. This should include development arrangements that prepare and support councillors and senior managers to respond to the challenging and changing local and national demands
- undertake long-term financial planning to set out how they will deliver national policy commitments, while continuing to sustain local services with reducing budgets and increasing demands
- continue to seek and implement innovative ways of working and collaborate with communities, partners and the third sector to drive transformational change
- improve data to:
  - help inform the difficult decisions councils have to make
  - support benchmarking, learning and sharing of experience and effective practice with others that will contribute to improving service quality, efficiency and outcomes for communities
- ensure they have workforce planning that is clear about the workforce needed now and in the future, where the gaps are and what training or other action is needed to fill them. This should be supported by better workforce data
- be able to demonstrate how spending decisions and priorities have impacted on service delivery and the outcomes of residents, as well as how they are delivering against the national performance framework.

About this report

1. This report provides a high-level, independent view of the challenges facing councils in Scotland, how councils are responding to tightening budgets and how this has affected services. It draws on findings from *Local government in Scotland: Financial overview 2017/18*, published performance data and local government audit work in 2018. This includes annual audits, Best Value Assurance Reports (BVARs) and national performance audits. All national and individual council audit reports are available on our website.

2. The report highlights key challenges councils face and looks at some of the main ways councils are responding to increasing demand and reduced funding. Where specific examples of council activities or circumstances are referenced, this is not intended to imply that the named councils are the only ones engaging in these activities or experiencing these circumstances. The report aims to inform the public and its representatives and, in particular, local government councillors and senior council officers to support them in their complex and demanding roles. It covers three areas:

- The current and future challenges facing councils.
- How councils are responding to these challenges.
- The impact on performance in key service areas and public satisfaction.

3. To help councillors, we have produced the following supplements to accompany this report:

- *A scrutiny tool* with examples of questions that councillors could ask to help them understand their council's position, scrutinise performance and assist in making difficult decisions. Councillors should feel they fully understand, and are satisfied with, the answers to the questions that are most relevant to them in their role within the council.
- An online tool that shows how councils are performing. It is designed to allow councillors, officers and members of the public to better understand how their council is performing compared to others.

4. We draw on a range of sources of evidence for this report. Financial information is taken from the Local Government Financial Circulars,[1] Local Government finance statistics,[2] the Scottish Government's provisional outturn and budget estimates[3] and councils' annual accounts. Performance information is gathered from the Local Government Benchmarking Framework (LGBF),[4] the National Performance Framework (NPF) indicators[5] and relevant reports from other scrutiny bodies, such as Education Scotland and the Care Inspectorate.

5. To make financial information clear and comparable in the report we:

- Refer to real terms changes, this means we have adjusted the figures to take account of inflation. Our analysis of local government funding adjusts figures into 2018/19 prices to reflect the current year.

- Look at historical trends in financial data using data from 2013/14 where possible. National police and fire services were established in 2013 and so were not included in local government accounts from 2013/14. It is not always possible to use 2013/14 as some information is only available for more recent years.

- Adjusted figures to 2017/18 costs where the report comments on council performance in 2017/18.

Part 1

The context for councils

Councils must respond to an increasingly complex policy agenda while dealing with a high degree of uncertainty

6. Councils have a responsibility to provide a wide range of services to their residents and communities. These include educating children, looking after the elderly, collecting bins, maintaining local roads and ensuring buildings meet safety standards. Councils' work is influenced by the wider economic and political environment, UK and Scottish Government policy and demographics.

7. The context that councils are working in has become characterised by reducing budgets (paragraphs 25–36), increasing demand for services (paragraphs 37–41) and the delivery of an increasingly complex range of national policies. Within this challenging context, councils need to continue to work towards local priorities and improving outcomes for their communities. Exhibit 1 (page 11) illustrates some of the major current examples of policy and legislative change.

8. Some policy changes by the UK and Scottish governments increase expectations on councils, many come with financial implications and others increase uncertainty. Significant current issues include:

- Withdrawal from the European Union (EU) – At the time of writing this report, it is planned that on 29 March 2019, the UK will leave the EU. As the process is still on-going there is a high level of uncertainty about what this will mean for councils, which makes planning difficult. This is an area which is fast changing and will have a long-term impact on councils.

- Scotland's new financial and social security powers – The 2012 and 2016 Scotland Acts introduced new financial and social security powers. As a result, Scotland's budget is influenced by Scottish ministers' tax decisions and how well the Scottish economy performs compared to the rest of the UK. This means the Scottish budget is likely to become more variable than it has been through the block grant from the UK Government. In its five-year strategy, the Scottish Government estimates that the Scottish budget could vary by up to six per cent by 2022/23.[6] If the Scottish budget varies, funding to local government through the Scottish Government settlement will also be affected, in particular, services that are not financially protected as Scottish Government priorities.

- Local governance review – In 2018, the Scottish Government and COSLA launched a review of how powers and responsibilities are shared across national and local government and with communities. The aim of the review is to give local communities more say in how public services in their area are run. The Scottish Government and COSLA plan to continue consulting with stakeholders through 2019 as legislation is developed. It is not yet clear how this review will affect councils and how it will affect partnership working with other organisations, such as the NHS.

Have you considered how policy and legislative change will affect how your council operates?

What scenario planning has your council done for events such as EU withdrawal and increasing budget uncertainty?

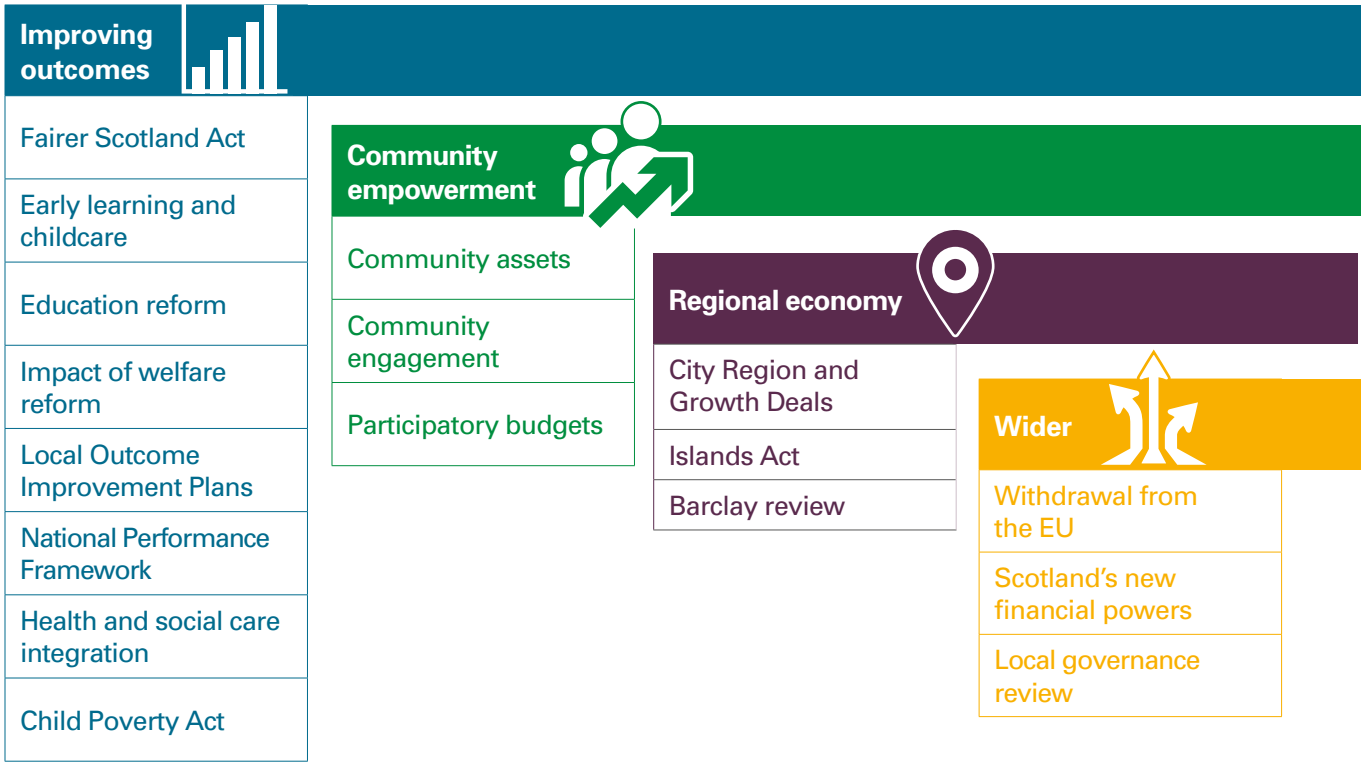
Audit Scotland published a briefing paper on the *EU withdrawal* in October 2018 highlighting the risks including workforce, funding and financial implications.

Audit Scotland has produced a policy briefing on *new financial powers*

Exhibit 1

Current major policy and legislative changes affecting local government

Many of the changes in national policy are interdependent.



Source: Audit Scotland

9. This context makes it difficult for councils to know how they will need to respond in the future and makes longer-term financial planning challenging but even more vital. With increased uncertainty, scenario planning within medium and longer-term planning becomes increasingly important. We will continue to monitor national developments, councils' preparations and their responses to these issues through our audit work.

10. The examples in Exhibit 1 contribute to a complex picture of interacting policy initiatives. Many of the policy changes and initiatives are interdependent and will influence each other. For example, good community empowerment (giving people more influence over how services are planned) should contribute to a range of initiatives and activities that improve outcomes. This complex picture means that:

- Councillors and senior officers need to have a wide and current understanding of policy issues and how these relate to local priorities and needs, to plan and make complex decisions locally. This can be challenging where capacity is already stretched.
- It is more important than ever for councils to plan for different scenarios in terms of funding and demand for services. This includes finding different ways to deliver services efficiently and effectively.
- There is an increasing need for effective partnership working with other public, private and third-sector organisations and their communities.

Are you clear what Community Empowerment involves and what it means for your council?

Improving outcomes is a priority both at a local and national level but reporting arrangements still need to develop

11. In June 2018, the Scottish Government and COSLA launched their revised National Performance Framework (NPF).[7] All councils signed up to the priorities and vision for Scotland it sets out. There is a strong focus on increased wellbeing, improving outcomes, and economic growth that is sustainable and benefits all sections of society.

12. Councils are key contributors to delivering this vision to improve the outcomes for the people of Scotland, alongside their community planning partners. Councils and their partners need to have regard to the NPF and consider how this framework fits with local decision-making, local outcome priorities and measures. A significant amount of council activity is already focused on themes that reflect those of the NPF. For example, most councils have a strategic focus on reducing inequality within their communities.

13. Councils also have a role in delivering a range of national initiatives that will contribute to the themes of the NPF, such as:

- Delivering 1,140 hours of free childcare to all three-year olds and eligible two-year olds.
- Improving educational outcomes, especially for the most deprived pupils, through the Pupil Equity Fund (extra money to some schools with children from poorer backgrounds) and a commitment to maintain teacher numbers.
- Contributing to the delivery of 50,000 affordable homes including 35,000 for social rent.
- Implementing the requirements of the Fairer Scotland Duty which places a legal responsibility on public bodies in Scotland, including councils, to actively consider how they can reduce inequalities caused by socioeconomic disadvantage, when making strategic decisions.

Although there is ongoing work that will contribute, it is not yet clear what role councils are expected to have in achieving all of the NPF aims, what that would mean for councils' resources or how progress and targets will be monitored and reported on.

Councils cannot deliver their priorities alone

14. Councils have a long history of working closely with other organisations. This includes delivering some services through the third and private sectors and through arm's-length external organisations (ALEOs). This also includes local partnership working with other public sector bodies, such as the NHS, the third sector and other local and national organisations through local partnership activities, including Community Planning Partnerships. Councils need to build on their partnership working experience to respond to the changing context.

15. Councils face a difficult balance of a move towards more regional working and collaboration, and a need to maintain a focus on local priorities, local decision-making and local accountability. Many of the national policies introduced in recent years have involved some elements of working with partners, for example in regional partnerships to deliver economic development or through the health and social care integration joint boards.

Councils and the Scottish Government are focused on improving outcomes across Scotland. Examples of these include improving employment opportunities, reducing anti-social behaviour, giving children the best start in life and helping people live longer and healthier lives.

Do you know if your council's governance and accountability structures are fit for purpose, given increasingly complex ways of working?

If you sit on a board, do you fully understand your responsibilities to that board and the council?

Regional economic developments mean more collaborative and partnership working

16. Councils are pursuing City Region Deals and Growth Deals as ways to drive local economic growth. These involve significant partnership working. The Scottish Government has committed to all areas in Scotland being part of a deal:

- There are four signed City Region Deals in Scotland, involving 17 councils and various other partners.
- A further six councils are developing two City Region Deals.
- The remaining councils are working on alternative investment proposals, such as Growth Deals and Island Deals.

City Region and Growth Deals are long-term agreements between the Scottish Government, the UK Government and councils to improve regional economies.

17. Councils work with their partners to propose projects to include in their deal, based on the anticipated benefits to their regional economies. The Scottish and UK governments then decide which projects to fund, typically over a ten to 20-year period. To date, the governments have jointly committed £2.1 billion to the four signed City Region Deals. This is supported by around £1.6 billion committed by councils and other partners. Most of the funding for the four signed deals has been allocated to infrastructure projects, such as roads and buildings. However, deals also include innovation, employability and skills, technology, housing and digital projects such as improved broadband. The Scottish Government expects that councils and partners signed up to deals will form Regional Economic Partnerships to work together on regional issues.

18. We are carrying out an audit of City Region and Growth deals which will be reported towards the end of 2019.

The Community Empowerment Act gives citizens a greater role and this requires a change in how councils operate

19. The Community Empowerment (Scotland) Act 2015 gives people more influence over how their councils and their partners plan services. It is intended that councils will devolve power to communities to make a difference to their local areas through:

- Community asset transfers – where communities can take responsibility for land and buildings.
- Participation requests – where people can ask to take part in decisions about council services.
- Participatory budgeting – where communities can have a say in how the council should spend public money locally.

20. As part of the Act, local authorities also have statutory oversight of community councils and are required by statute to consult community councils about planning applications and licensing matters.

21. Councils are considering how they balance an increase in community involvement with a responsibility and accountability for the sustainability of services delivered to their citizens. Some progress is being made with community empowerment, particularly with ensuring formal arrangements are in place. We consider this further in Part 2 (paragraphs 70–78).

Accountability is increasingly complex

22. A result of a more collaborative way of working is an increasingly complex governance and accountability landscape. This has implications for councils:

- Councillors now sit on more boards than before. In our May 2018 report, *Councils' use of arm's-length external organisations* (ALEOs) we noted that this can make it difficult for small councils to manage potential conflicts of interest.
- There can be disagreements around shared governance arrangements. In our *Health and social care integration update* report we noted that a lack of collaborative leadership and different cultures in councils and health boards were affecting the pace of change.
- Councils still have a responsibility to track performance management and provide scrutiny proportionate to the risk involved. The roles of councillors and officers in overseeing collaborative activities needs to be clear.
- There is a duty to ensure that communities are involved in decision-making processes where appropriate. This may be more difficult to manage with more complex governance structures.

23. The discussion and decision-making on some issues is moving further from councils themselves, but councils retain the overall accountability to the local community. It is increasingly important that councillors and officers have an appropriate understanding of their roles and skills, including in governance and leadership, when leading work delivered through complex partnerships, boards and other mechanisms.

24. Formal governance arrangements must be kept current to cover local decisions made about representation, delegation, scope of responsibilities and reporting. Councils, and their partners, should ensure arrangements meet their needs but take care to minimise additional complexity of governance arrangements as new ways of working are adopted.

Scottish Government funding to councils has reduced in real terms since 2013/14 but increased slightly between 2018/19 and 2019/20

25. Councils need to continue to deliver on the increasingly complex range of local and national priorities and initiatives, despite several years of reducing funding and increasing demands on services. Between 2013/14 and 2019/20, total revenue funding has fallen six per cent in real terms. Scottish Government funding to councils is forecast to continue to reduce in the medium-term.

26. Scottish Government funding is the largest source of income for councils. Overall, total revenue funding will increase by 1.1 per cent in real terms between 2018/19 and 2019/20 (Exhibit 2, page 15).

Governance describes the structures, systems, processes, controls and behaviours for managing activities.

Accountability is the way individuals or groups are held responsible for managing and planning how resources are used and how well performance aims are achieved. For example, chief executives in councils are accountable to councillors.

Revenue funding is funding from Scottish Government to councils for day-to- day services.

Total revenue funding consists of general resource grants, specific revenue grants and non-domestic rates income (NDR).

Core revenue funding includes the general resource grant and non-domestic rate income, and reflects the funding councils have control over to provide services.

Exhibit 2

Funding from Scottish Government to councils

Total revenue funding increased slightly between 2018/19 and 2019/20.

Cash				Change 17/18 to 18/19		Change 18/19 to 19/20		Change 17/18 to 19/20	
	2017/18 (£m)	2018/19 (£m)	2019/20 (£m)	Cash (%)	Real (%)	Cash (%)	Real (%)	Cash (%)	Real (%)
General Resource Grant	6,808	6,885	6,718	1.1	-0.7	-2.4	-4.2	-1.3	-4.8
Non-domestic rate income	2,666	2,636	2,853	-1.1	-2.9	8.2	6.3	7.0	3.3
Core revenue funding	**9,474**	**9,521**	**9,571**	**0.5**	**-1.3**	**0.5**	**-1.2**	**1.0**	**-2.5**
Specific revenue grants	211	274	508	29.7	27.4	85.5	82.3	140.6	132.2
Total revenue funding	**9,685**	**9,795**	**10,078**	**1.1**	**-0.7**	**2.9**	**1.1**	**4.1**	**0.4**

Note: We have used the most current information available. This means we have used 2019/20 budgeted funding and compared this with 2017/18 and 2018/19 outturn funding. This does not include £355 million allocated in 2018/19 and 2019/20 from the Scottish Government's health budget to Integration Authorities. The additional funding of £34.5 million is included in the 2017/18 cash funding column above.

Source: Audit Scotland; Scottish Budget 2019/20; Local Government finance circulars 04/2018, 08/2018, 02/2019

27. On 28 March 2018, the Scottish Government paid £34.5 million of additional funding to councils. Although this was funded from Scottish Government underspends and paid in 2017/18, it was shown as 2018/19 funding in the local government settlement:

- By recognising the £34.5 million as 2018/19 funding the Scottish Government showed an increase in funding to local government of 1.7 per cent in cash terms and 0.2 per cent in real terms compared to 2017/18.[8]
- In the 2019/20 settlement, the 2018/19 total revenue funding figures no longer include the £34.5 million. The settlement makes no reference to this adjustment or that it is included in 2017/18 funding. Taking this adjustment into account, between 2017/18 and 2018/19, the Scottish Government's total revenue funding to councils increased by 1.1 per in cash terms but this was a 0.7 per cent decrease in real terms. Our figures now include the £34.5 million as 2017/18 income.

28. The presentation of the £34.5 million within the annual settlements, and failure to refer to the change or how it has been treated, has made it harder to compare annual changes in local government funding. It is important that funding allocations are transparent and consistently applied across years to allow public bodies to plan and manage their finances effectively and support parliamentary scrutiny.

National policy initiatives make up an increasing amount of council budgets

29. A growing proportion of Scottish Government total revenue funding to councils is protected to support Scottish Government priorities. Our analysis shows that revenue funding to support specific Scottish Government policies has increased from 6.6 per cent of total revenue funding (£643 million) in 2018/19, to 12.1 per cent (£1.2 billion) in 2019/20 (Exhibit 3, page 17). This is because:

- The Scottish Government funding that must be spent on specific policy initiatives (specific revenue grants), such as the Pupil Equity Fund, now makes up an increasing proportion of total revenue funding. In 2018/19, this represented 2.8 per cent of total revenue funding and in 2019/20 will increase to five per cent.

- Alongside the specific revenue funding set out in the settlement, several of the Scottish Government's policy initiatives have funding attached to them. Although these are not explicitly ring-fenced, if the council does not meet the objectives it may lose out on the funding. These have grown from 3.8 per cent of total revenue funding in 2018/19 to 7.1 per cent in 2019/20 and are predominantly for education and social care services.

If these funding obligations are excluded from councils' total revenue funding, the amount remaining was £9.2 billion in 2018/19 and £8.9 billion in 2019/20. This is a decrease of £449 million in real terms, five per cent of 2019/20 total revenue funding.

30. Councils face other obligations which limit where they can make savings, for example:

- Councils must make repayments on their debt. In 2018/19 they budgeted to spend £1.2 billion, ten per cent of their budgeted net revenue expenditure, on debt repayments.

- In December 2018, COSLA made a pay offer for a three-year settlement for 2018/19 to 2020/21. The offer included an increase of 3.5 per cent for 2018/19 (capped at £80,000) and a three per cent increase in each of the following years. Any settlement that is accepted will need to be funded from revenue funds.

- In February 2019, Glasgow City Council approved the settlement of its equal pay claim. It has agreed to make payments of around £548 million (44 per cent of its 2019/20 revenue funding from Scottish Government and council tax) in 2019/20. Our auditors will monitor this as part of the annual audit work.

- In 2019/20, councils can only reduce their allocations to Integration Authorities by 2.2 per cent compared to 2018/19.

31. Social care and education make up a large proportion of councils' budgets. In 2018/19 councils budgeted to spend £3.3 billion on social care and £5.2 billion on education. This includes £2.4 billion on primary and secondary teachers' salaries. Together, this represents 69 per cent of their net revenue expenditure. Although it is possible for councils to make savings in these areas, national priorities, statutory obligations and demand for services make this challenging.

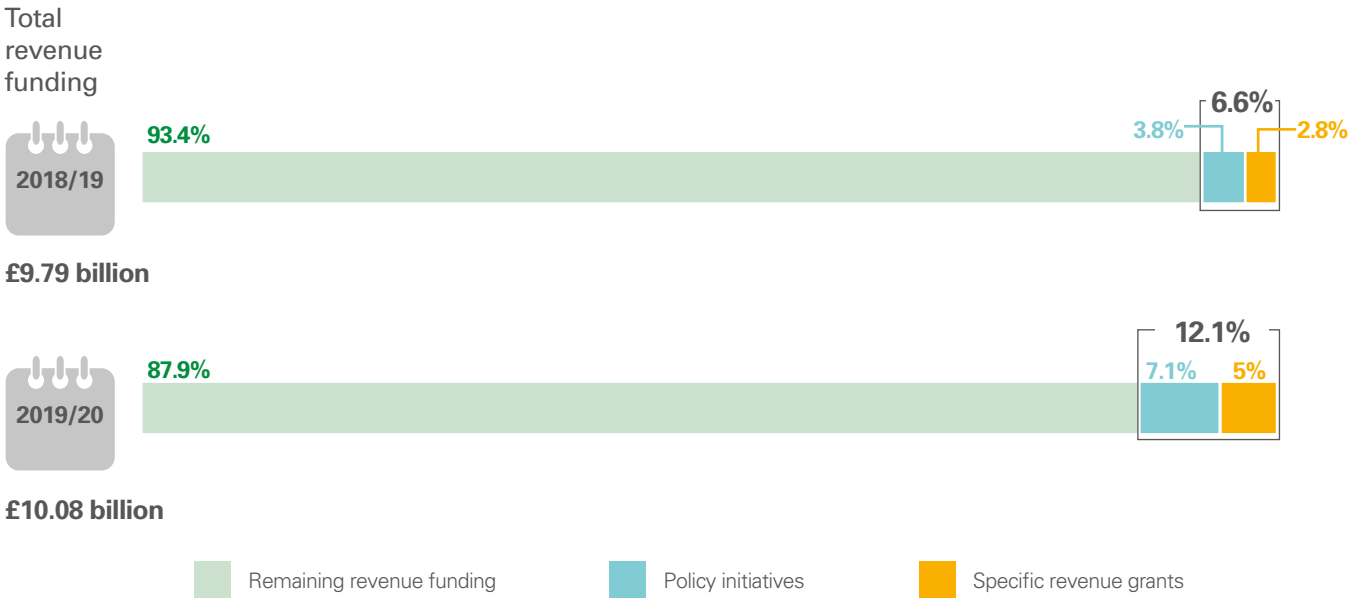
Net revenue expenditure is financed through Scottish Government funding, council tax and the use of reserves.

Individual revenue allocation consists of Total revenue funding and assumed council tax contribution.

Exhibit 3

Spend on national priorities in 2018/19 and 2019/20

In 2019/20 councils will spend 12.1 per cent of their revenue funding meeting national priorities.



Source: Audit Scotland, Local Government finance circular 2/2019, Scottish Budget 2019/20

32. As a result, as we have previously reported, councils have made larger reductions to services other than education and social work. These include economic development, waste management and planning services, which are still important for maintaining the health, safety and wellbeing of residents. Between 2013/14 and 2017/18 spending was reduced as follows:

- planning and development services (28 per cent)
- cultural and related services (14 per cent)
- roads and transport (seven per cent).

33. The Commission recognises that councils cannot be expected to deliver continuous performance improvement across all services in the current financial climate. Councils should set their priorities and invest in line with them. However, it is more difficult to do if increasing amounts of their budgets are protected. There is a risk that these budget reductions will have an impact on the sustainability of services as they are currently delivered. Councils need to continue to seek innovative ways to improve the efficiency of how they deliver all services and be clear about the anticipated impact on performance and service scope.

Some council service areas can expect further funding reductions

34. The Scottish Government's five-year strategy sets out its spending priorities to 2022/23; these are health, police, early learning and childcare, secondary school attainment, higher education and social security. Council services outside

education and early years are not identified as Scottish Government priorities and so will be disproportionately affected by any reductions to the Scottish budget. We calculated that other services outside the Scottish Government's priorities could face between one and 16 per cent real terms reduction to their budgets.[9]

Councils are managing reducing budgets despite local challenges

35. We have previously reported that councils will have their own social and demographic circumstances to manage alongside funding reductions. An ageing population increases demand for social care services, rurality can make it more difficult to deliver services cost-effectively, and deprivation and poverty have wide-ranging impacts which can affect council services. However, the majority of revenue funding is allocated according to the size of the council's population. Other factors are not always as clearly reflected in the funding allocations (Exhibit 4, page 19). For example:

- Eilean Siar and Argyll and Bute have seen some of the largest reductions in their funding allocations since 2013/14 due to a declining population but are also two of the most rural areas and have growing elderly populations.

- Some of the councils with high levels of deprivation, including Inverclyde, Glasgow and West Dunbartonshire, have also seen higher than average reductions to their core budgets.

36. Medium and long-term scenario planning will help councils understand what the likely implications are for them which will in turn help inform how best to provide services in the future.

Population change is affecting demand for services.

37. Demographic pressures, including an ageing population continue to increase the demands on council services. Over the period 2016 to 2041, ten councils expect an increase in both the over-65 population and the under-15 population. The Improvement Service estimates that, because of changing demographics, demand for services will increase by 2.6 per cent between 2018/19 and 2019/20. This represents an additional £248 million of spend for councils.[10]

38. All councils are projected to have an increase in the number of people over 65 by 2041. West Lothian council has a projected 45 per cent increase in the over-65 age group, the highest in Scotland. An ageing population represents a significant challenge for councils especially in delivering social care services:

- The Institute for Fiscal Studies estimates that over the next 15 years, social care funding in the UK will need to increase by 3.9 per cent in real terms each year to meet the needs of an ageing population and more younger adults living with disabilities.[11]

- The Scottish Government estimates an additional £683 million will be required by 2023/24 to meet additional social care demand.[12]

39. Ten councils are expected to see an increase in the proportion of people aged under 15 during the period 2016 to 2041, while 22 expect a decrease. For example, East Lothian Council expects its under 15-year-old population to increase three times faster than the Scottish average between 2016 and 2026. This increase means the council will need to fund:

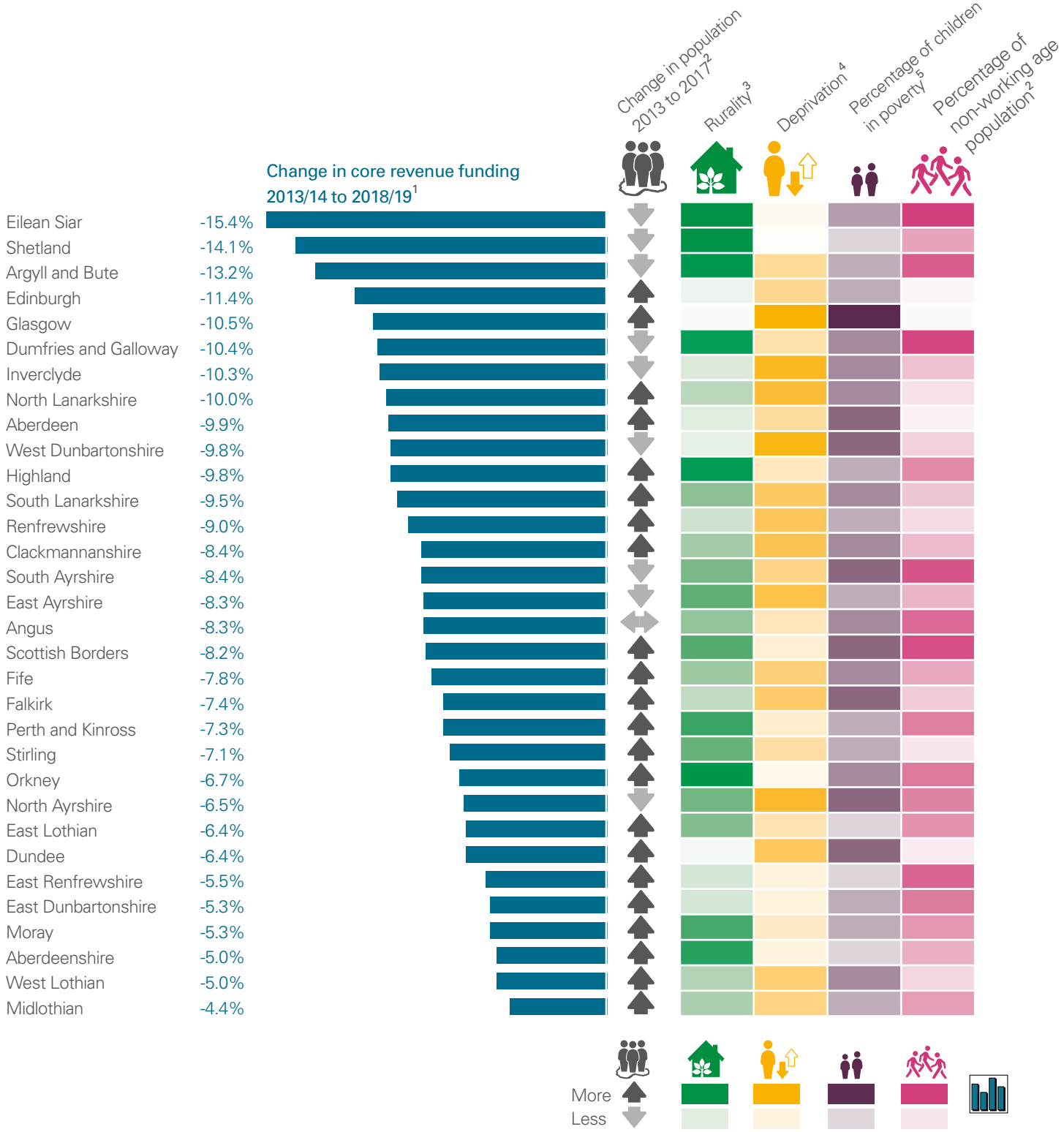
Do you have a clear understanding of the demographic circumstances within your council area?

Do you know how effectively your council uses this information to decide how to provide services in the future?

Exhibit 4

Changes to council core revenue funding in real terms between 2013/14 and 2018/19, illustrated with socio-demographic factors that can impact on service demand and costs

Demographic change, rurality and deprivation will all have implications for council services. The majority of core revenue funding is allocated based on population factors so funding reductions largely follow population change.



Note: The darker the colour the more significant an issue it may be to that council, Rurality can make it more difficult to deliver services cost effectively, an ageing population increases demand for services and deprivation and poverty can have wide ranging impact on residents and councils (Paragraph 41).

Sources: 1. Scottish Government financial circulars 2013, 2014 and 2019. 2. National Records Scotland mid-year population estimates 2013 and 2017. 3. Scottish Government Urban Rural Classification 2016. 4. Scottish Index of Multiple Deprivation 2016. 5. Children in families with limited resources across Scotland 2014-16, Scottish Government, 2017.

- the capital cost of building four new primary schools and a secondary school
- the costs of developing the roads and utilities to these developments
- the day-to-day costs of running and staffing the schools.

The number of people living in poverty has increased, putting additional pressure on council services

40. The Scottish Government reports that relative poverty rates are slowly increasing and that since the period 2012 to 2015, there has been a rise in income inequality. Between 2013 and 2016, the top ten per cent of the population in Scotland had 21 per cent more income than the bottom 40 per cent; in 2014 to 2017 this increased to 24 per cent more income.[13] The Joseph Rowntree Foundation also reported an increase in child poverty rates during this period.[14]

41. There are implications for councils from more residents living in poverty, as they are more likely to need support from their council or have difficulty paying their council tax or rent:

- As part of the Child Poverty Act, councils are expected to produce an annual joint report with the NHS on their activities to address child poverty at a local level. It is not clear what resources councils will choose to allocate to their child poverty duties and reporting arrangements, but it may be substantial for those councils with high or growing rates of child poverty.
- Libraries now help people apply for benefits using their computers but a survey by Citizen's Advice found that people from the most deprived areas were less likely to be able to use a computer than those from the least deprived areas. It also found that of people seeking benefits advice, 25 per cent would need help and 27 per cent would not be able to manage at all.[15]
- There is also evidence to suggest that individuals' levels of debt have increased, and this could affect councils in council tax collection or rent arrears. The Joseph Rowntree Foundation found that in the UK six per cent of adults in the most deprived areas had council tax debt compared to 0.1 per cent in the least deprived.[16]
- Council accounts show that rent arrears have increased by nine per cent between 2016/17 and 2017/18; as councils have different procedures for managing and writing off rent arrears the level varies by council. The National Audit Office (NAO) found that local authorities in England reported higher rent arrears following the introduction of Universal Credit.[17]
- Homelessness applications have increased by one per cent between 2016/17 and 2017/18. During this period 17 councils saw an increase in the number of applications. Of those assessed as homeless or threatened with homelessness, 47 per cent had at least one additional support need, such as mental health problems, compared to 34 per cent in 2012/13.[18]

Part 2

How councils are responding

42. In Part 1 we described the complex financial, policy and legislative challenges that councils face. Effectively led councils are clear about how these issues impact locally. They also recognise that the financial and demand pressures mean that planning and implementing changes to find efficiencies alone is no longer enough and the redesign of service delivery is needed. Part 2 focuses on some of the main considerations for councils and how they are responding to this need.

Transformational change requires strategic leadership, planning and good governance

43. Councils have worked hard to make efficiency savings. These have mostly focused on service review and improvement activity, property rationalisation, and improvements in back office functions such as human resources, payroll and finance systems. In many councils, these activities are unlikely to be sufficient to address the growing gap between demand and resources, and more fundamental changes are needed.

44. In making more fundamental changes councils have different approaches; many have a transformation programme, although it is not always called this, whereas some integrate service redesign work into mainstream council management and improvement activity. Transformation activity does not have to change everything at once; it can deliver change incrementally.

45. Making change through transformation to the services and functions of the council requires effective leadership and good governance arrangements. Transformation and change initiatives should contribute to the council's strategic and outcome priorities. It should also be a consideration in strategic planning. This includes decisions relating to arrangements such as:

- implementing digital approaches
- financial planning and funding approaches
- working in partnership
- community empowerment activity
- workforce planning and development.

These issues are all linked, and their interdependence needs to be understood by councillors and senior management.

Do you understand how your council's approach to transformational change will improve services and save money?

How will you monitor and scrutinise progress of transformational projects?

What is your council's risk appetite for transformational change? Are risks properly monitored?

Do you know what the financial repercussions will be if your council's transformation activity fails to meet its savings targets?

46. To make good decisions about opportunities and options for change, councils need to ensure that they make effective use of good-quality information and data. This includes benchmarking with other councils and using performance information to identify and understand why performance varies across councils and where this offers opportunities to improve. Part 3 of this report sets out an overview of current performance across councils and some notable variances.

Is your council's transformation activity supported by good governance arrangements and robust management?

Do you know if the governance arrangements factor in time needed to ensure projects are properly scoped?

Good transformation is well scoped, addresses the needs of people who use services and should have proportionate governance structures.

47. The aim of transformational change is to improve outcomes for service users by making services to communities more efficient and effective. Transformation requires moving away from established ways of delivering services and this can bring considerable challenges. Successful projects dedicate time at the start to fully understand the issues that need to be addressed. To deliver transformative change, councils should:

- Adopt a holistic approach to service design. Transformation benefits from different departments working together to find the best solutions to improving services.
- Engage with service users and staff from the outset, to make the right decisions about where problems and opportunities lie, and what needs to change.
- Allow time for staff involved in transformation to properly scope and appraise options before committing to savings estimates.

To do this councils will have to consider how to incorporate some flexibility and freedom into their change and improvement arrangements, to allow some of the early thinking and design work to take place. This is difficult when budgets are reducing.

48. Good governance arrangements and effective management are essential in enabling the successful delivery of transformation activity. Councils report that they are adopting some key elements of good governance. Almost all councils have specific planning, decision-making and reporting arrangements in place for transformational or change activities. Over two-thirds show evidence of using options appraisals and around half have a dedicated team of staff to support change and transformation.

49. Good transformation should result in a service that better meets the needs of the people that use it, as well as being more efficient. There is scope for councils and other public bodies to share examples of successful transformation activity and learn from each other. Examples include:

- NHS Highland and partners have adapted homes in the 'FitHome' village in Dalmore to enable residents, who are elderly or have physical disabilities, to live safely and independently. The adaptations include sensor equipment that captures data as residents move around their homes and can be used to predict and prevent events such as falls. The first 14 residents moved into their new homes in Summer 2018.
- Glasgow City Council's family group decision making aims to allow children to remain within their wider family group rather than being taken into care.

Children and their families are involved in creating a plan to meet the child's needs. There are more than 1,300 children looked after by extended family or close friends, known as Kinship Care, in Glasgow. They are supported by 1,017 Kinship Carers with an annual budget of £8.1 million.

There are examples of digital approaches being used to drive improvement

50. Thirty-one councils are involved in the Digital Office (DO) for Scottish local government, a collaborative organisation created to improve the core digital skills held by council workers, digital leadership, and digital services within councils. All councils play an active role in delivering the projects that the DO runs by taking the lead on projects where their officers have expertise. This approach:

- pools in-demand skills and expertise
- shares best practice amongst councils
- fosters a strong culture of collaborative support.

51. Through the DO, councils are sharing their experience of using digital technology to improve service delivery. Some examples include:

- The E-sgoil programme in Eilean Siar uses technology to allow pupils to access teachers, classes or resources from any school within the council or elsewhere in Scotland. Previously a lack of teachers restricted the range of subjects the council could offer. The programme has been offered to other schools and is being used by some other councils. Comhairle nan Eilean Siar is now considering whether it could raise income by extending the programme's reach to other groups from outside the council area.
- City of Edinburgh Council has been working with a private company on its tram systems, using artificial intelligence to identify potentially hazardous situations and ensure that they are avoided.
- Glasgow City Council used data to change its approach to tracking and allocating school clothing grants in Glasgow. It was able to identify those eligible for a grant by analysing data it had already collected. This allowed them to identify 5,000 families who were entitled to funding but had not previously claimed.

Digital technology:

Technologies used by councils to deliver services and change the way that residents and staff interact with the council.

There are specific challenges that councils need to recognise to successfully deliver digital transformation

52. People increasingly expect to be able to access services online, and digital provides many options for transformation within a council. However, digital approaches will often be only part of the solution. In many cases, digital can improve services and make them more efficient, but more complex or unusual tasks may require other approaches. Digital transformation also has specific features that councils need to consider:

- Not all service users will be able to access digital services. It is often the most vulnerable within society who have the greatest need for council services but who are least able to access them digitally. They include people living in poverty, the elderly, people living in remote rural locations,

and people living with mental and physical disabilities. By enabling digital access to services for those who are able to use them, staff and funding can be redirected to provide other options, such as face to face or telephone contact, for those who struggle to engage through digital platforms or have more complex problems.

- Procurement of digital-enabled projects may be different to other things the council buys; so its existing arrangements may not be appropriate. Councils should understand that potential savings may not be immediately quantifiable, that investing for the future may be necessary, and that 'agile' management (where projects are broken down into small stages and adapted frequently), may be the best option. For this approach, councils need to invest in training staff and leaders.

- Digital projects can bring significant cultural change to councils. Those leading and managing change need to be sensitive to the potential for disruption in the working environment and for individuals in particular roles. Councils need to ensure that their workforce is included and informed at every stage of a digital change programme.

- Digital projects need to be led and staffed by officers with the right skills in the relevant areas. These skills can be difficult to find in the wider workforce and come at a high cost. The DO has been working with councils to develop these skills.

- The failure of digital projects can open a council up to the risk of losing data or of data being accessed and exploited by external groups. The internal mishandling of data could also leave councils vulnerable to being penalised for General Data Protection Regulation non-compliance.

53. Before embarking on digital transformation activity, councils should understand these challenges and the complexity of what they are trying to do. Our *Principles for a digital future* briefing sets out five principles that should be considered when planning and delivering digital programmes. We will be carrying out an audit on digital progress in local government in 2020/21 which will consider councils' digital activity in greater detail.

Good progress has been made with medium-term financial planning

54. The Commission has previously commented on the importance of medium and long-term financial planning, particularly in the context of the increasing financial challenges and wider demands on services.

Does your council have medium and long-term financial planning in place?

55. Funding settlements from the Scottish Government to councils continue to be provided on an annual basis. This makes it challenging for councils to plan and budget effectively for the medium term, given such a significant proportion of their income comes from Scottish Government funding.

56. In 2018/19, councils reported a funding gap of £0.3 billion (two per cent of expenditure), £0.1 billion less than in 2017/18. Councils planned to address this through making savings, using reserves and increasing fees and charges.

57. The need to find and deliver savings is expected to continue. We emphasise the increasing importance of medium and long-term planning to manage these

financial challenges and to make well-informed decisions which are aligned to council priorities. Medium-term financial planning has been adopted by almost all councils, but less than half have significant long-term plans. Of those councils with longer-term plans, only five consider the impact of population and demand change on their services. The Commission encourages all councils to continue to develop and refine their medium and long-term planning and the use of scenario planning to support both.

Councils are under pressure to find different ways to increase income

All councils increased council tax by the maximum allowable three per cent in 2018/19 for the first time since the council tax freeze was lifted

58. As revenue funding has fallen in real terms, council tax represents an increasingly large proportion of the total funding available to councils, from 16 per cent in 2013/14 to 18 per cent in 2018/19. In the 2017/18 budget, the Scottish Government announced the end of the nine-year council tax freeze, but capped the amount councils could increase it by to three per cent:

- In 2017/18, 24 councils increased their council tax, including 21 that increased rates by the maximum allowed.
- In 2018/19, all councils increased council tax by three per cent.

In 2019/20, the Scottish Government increased the cap to 4.8 per cent in cash terms, or three per cent in real terms. Twelve councils decided to increase council tax by the full amount. Thirteen councils increased it by three percent and the other seven by between 3.9 and 4.5 per cent.

59. In 2017/18, an estimated additional £110 million was raised through council tax reforms, these included a change to higher rate council tax bands and an end to council tax relief on second homes.

Councils have looked for other ways to increase income

60. We reported in our *Local government in Scotland: Financial overview 2017/18* that there is variation in how councils approach increases to charges. Some councils are making increases to all charges, some are making significant increases to certain charges such as commercial waste and some are introducing new charges, for example for garden waste and public toilets.

61. From information provided by auditors, we found that councils had increased 11 types of charges by more than inflation between 2016/17 and 2018/19. The highest increases were in relation to burials. The cost of a burial plot increased by an average of 20 per cent (22 councils responded) and the cost for burial services increased by 12 per cent (23 councils responded).

62. COSLA and some councils are seeking opportunities to raise local taxes.

- City of Edinburgh Council is the first council to propose a transient visitor levy or 'tourist tax' to raise funds to manage and promote tourism in their local area. In February 2019, the council approved plans for a £2 or two per cent per room per night charge which it expects will raise up to £14.6 million.[19] It now requires legislation from the Scottish Government to implement the tax. The Scottish Government committed to a consultation on the tourist tax in January 2019.

Does your council link budgets to plans and outcomes and report on these?

Do you know what options your council is considering to maximise income?

How is your council considering the impact that these changes might have on equalities?

If your council is considering generating commercial income, do you know how it plans to mitigate the risks?

- In the 2019/20 budget the Scottish Government agreed to support an amendment from the Scottish Green Party to the Transport (Scotland) Bill that would give powers to councils to introduce a workplace levy. This means employers would pay the council a tax for any car parking spaces they offered.

Councils are considering development of commercial services, but risks need to be well managed

63. As part of longer-term financial planning, councils are considering how they can develop approaches to generate commercial income, beyond local fees and charges for current services. If councils choose to do this they need to consider; whether they have the skills and staff numbers to deliver it, the impact it may have on the local economy, and how they will mitigate the risks of investing public money in the commercial market.

64. Given that there has been more development of commercial arrangements in England, it is useful to consider the learning from this. Councils in England have experienced very significant reductions in funding (funding to local government has fallen by 49 per cent between 2010/11 and 2017/18) and have used several commercial approaches to support their finances in response.[20] The NAO reported that between 2013/14 and 2016/17, there had been a 31 per cent increase in external interest payments and a 16 per cent increase in trading profits.[21] Some councils have borrowed money to invest in property from which they then earn an income or profit. The UK Government reports that:

- spending on trading services has increased from £323 million in 2014/15 to £2.9 billion in 2017/18
- land and buildings acquisitions increased by 43 per cent in the last year to £4 billion in 2017/18.[22]

65. The Chartered Institute of Public Finance and Accountancy (CIPFA) is concerned by the level of borrowing by councils and is producing guidance for those considering this route; it has cautioned councils against:

- becoming dependent on commercial income
- taking out too much debt relative to their total spending
- taking on debt to finance commercial investments, such as shopping malls or office blocks.[23]

Good partnership working is critical if councils are to deliver priorities and improved outcomes for communities

66. The Commission has consistently highlighted the increasing importance of good partnership working in the Scottish public sector. Working well with local partners in the public, private and third sectors is becoming increasingly important as councils try to deliver more for less. Given the significance and the potential efficiencies, both financial and non-financial, that collaborative working in the public sector can achieve, this will continue to be an area the Commission will have an interest in over future years.

Does your council consider sharing services in options appraisals and change programmes?

Do you know if there are processes in place in your council to facilitate collaborative working on a local, regional or national basis?

67. Shared services are one potential approach to partnership working. Through our audit work, we have seen only a limited number of examples of councils sharing services. These include:

- East and South Ayrshire work together to deliver roads-related services through the Ayrshire Roads Alliance
- East and West Dunbartonshire share an IT data centre
- Renfrewshire, East Renfrewshire, Inverclyde and West Dunbartonshire are part of a joint emergency planning service.

Do you know how your council is ensuring the good governance and financial sustainability of its Integration Authority?

Do you know what your council is doing to ensure that it works with partners to be more open and realistic about changes needed?

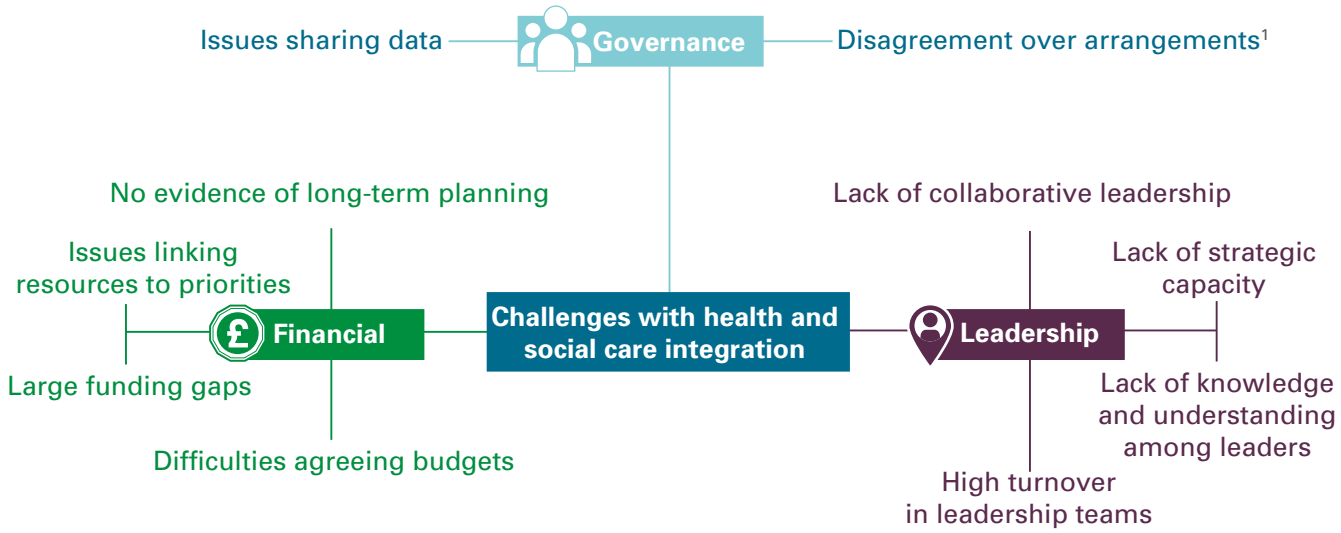
Although integration authorities have made some improvements they must overcome several significant barriers to speed up change and improve outcomes

68. The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) established 31 integration authorities (IAs) which are partnerships between NHS boards and councils. They are responsible for directing almost £9 billion for the delivery of adult health and social care, and in some council areas, for other services, such as children's services. Our report *Health and social care integration* and our *Local government in Scotland: Financial overview*, both published in November 2018, found that although progress has been made there are significant challenges to overcome (Exhibit 5).

Exhibit 5

Challenges to health and social care integration in Scotland

There are significant changes required if integration is going to make a meaningful difference to the people of Scotland.



Note: 1. Disagreements are often due to differing views on responsibility, especially about who is responsible for service performance and quality of care and when accountability for a decision rests with individuals who are no longer responsible for taking them.

Source: *Health and social care: update on progress*, Audit Scotland, November 2018

69. Performance of IAs in terms of the outcomes experienced by patients is discussed further in Part 3 (paragraphs 114–118).

The Community Empowerment Act fundamentally changes the relationship between council and communities

70. Councils are committed to community empowerment and most are beginning to implement their arrangements at a local level. Effective use of community empowerment can contribute to change and transformation by generating ideas and by involving communities in the difficult decisions that need to be made about priorities and options.

71. Our work shows that some councils:

- have well-established arrangements in place to empower communities (Case study 1)
- are providing training to elected members and officers to enhance their knowledge of community empowerment
- are working to develop community capacity, including providing information and training to communities on how to deliver a service and support through the community asset transfer process.

Case study 1

East Ayrshire Council's 'Vibrant Communities' approach

The Vibrant Communities approach is to work 'with people' rather than 'for people'. It focuses on two areas:

- Early intervention and prevention – acting as soon as possible to tackle problems for children, families and vulnerable people.
- Sustainable communities – empowering and enabling communities to get more involved where they live.

Communities discuss their local needs and priorities and then agree actions to improve their local area. Since 2014, the council has supported 19 communities to develop and implement community action plans through their Vibrant Communities approach. Community workers support community representatives in developing and implementing their plans. Once the plans are established community representative groups monitor progress.

Vibrant Communities has a dedicated community asset transfer team to offer legal, planning and business advice, and advise on alternative funding streams for communities applying for an asset transfer.

Sources: *Best Value Assurance Report: East Ayrshire*, Accounts Commission, May 2018, East Ayrshire Council

Audit Scotland produced a briefing paper in April 2018 *What is integration*

Does your council engage with communities on decisions about services, budget proposals and priorities?

Are you clear on what community empowerment involves what it means for your council?

What is your council doing to implement community empowerment arrangements at a local level?

Does the Local Outcome Improvement Plan focus on areas where the Community Planning Partnership can make the biggest impact?

Do you know what your council is doing to reach out to 'seldom heard' and disadvantaged groups?

72. While we have seen examples of good progress, some councils still need to do more to meet their obligations under the Act and ensure communities are empowered by building their capacity further.

73. The Act also places a duty on each Community Planning Partnership (CPP) to develop a local outcomes improvement plan (LOIP). LOIPs set out local outcomes that the CPP will prioritise for improvement. Audit Scotland, the Improvement Service and NHS Health Scotland conducted a review of LOIPs in 2018. We found that:

- the scale and scope of LOIPs varies across Scotland, however progress is being made against the expectations of the Act and associated guidance
- LOIPs need to be more focused on areas where the CPP can make the biggest impact
- there are genuine attempts to enhance community engagement and participation
- there is a lack of clarity around how CPPs are reaching those who are under-represented in council decisions, or the most disadvantaged communities.

Councils are engaging with communities but there is less evidence of successful engagement with people from deprived areas

74. Consultation with communities continues to take place mostly through citizens' panels, residents' surveys and council webpages. Our auditors reported that 26 councils involve communities in decisions about services, budget proposals and priorities and nine councils had either a dedicated team or staff member to support community engagement. Some examples of good practice include:

- Argyll and Bute Council carries out an annual consultation exercise on its budget for the coming financial year. It collates and analyses responses and publicly reports the impact of residents' feedback on decisions.
- East Lothian Council has established six local area partnerships to enable community engagement for the CPP. Each partnership is chaired by a member of the community and is made up of elected members, local bodies, interest groups and residents. Locality plans for each area partnership outline their priorities for improvement and help focus budgets around local priorities.

75. The Scottish Household Survey results suggest that councils are less successful in engaging with people from deprived areas. The percentage of all people surveyed who felt they could influence local decisions was 23 per cent in both 2016 and 2017, whereas for people living in deprived areas the figure was 21 per cent in 2016 and 19 per cent in 2017.

Although councils are responding to the requirements of the Act, they need to do more

76. Participatory budgeting is part of the Community Empowerment Act. It gives residents the opportunity to vote on how local money is spent and to have a say on issues important to them. Councils benefit from a better understanding of their residents' needs and communities feel more engaged and empowered. Dumfries and Galloway Council used its participatory budgeting exercise to focus on reducing inequality (Case study 2, page 30). Councils should also consider

The Community Empowerment Act (Scotland) 2015 requires that councils ensure communities are actively involved in deciding how public services are planned and provided and seeks to empower community bodies through transferring ownership of land and buildings.

As part of the Act, local authorities have statutory oversight of community councils and are required by statute to consult community councils about planning applications and licencing matters.

What is your council doing to ensure that one per cent of revenue budgets is allocated through participatory budgeting by 2020/21?

whether their approach to participatory budgeting is inclusive of a range of groups within their area, including disadvantaged and hard-to-reach groups, and the impact on improving outcomes.

Case study 2

Dumfries and Galloway Council's tackling poverty participatory budgeting exercise

Dumfries and Galloway Council allocated £240,000 from its Tackling Poverty fund towards a participatory budgeting exercise, 0.08 per cent of its total revenue funding. Sixty-three projects from across the region progressed to public voting events. Successful projects were focused on alleviating different aspects of poverty. Examples of successful projects included provision of:

- emergency power payments, sanitary products and essential toiletries (low income and financial poverty)
- school holiday breakfast and lunch clubs for low income families (food poverty)
- transport for access to services and activities (fuel poverty, rurality and isolation)
- ICT learning activities for those who require access to benefits and who are seeking employment (access to information and educational activities/opportunities).

The council evaluated the project and used feedback to identify how the process could be improved in the future, such as increasing the number of voting events and improving communications to build awareness and generate interest.

Sources: *Best Value Assurance Report: Dumfries and Galloway Council*, Accounts Commission, November 2018. *Participatory Budgeting Evaluation Report*, Dumfries and Galloway Council, 2018

77. We are aware of 13 councils that have held participatory budgeting exercises; however, they remain small in scale. COSLA is supporting councils' work towards the Scottish Government's target of allocating one per cent of revenue budgets to participatory budgeting by 2020/21. For example, Dundee City Council held a participatory budgeting exercise in 2017/18 where 11,000 people voted on which priority projects should be allocated a share of £1.2 million (0.3 per cent of the council's £343 million revenue funding). Communities, existing representative groups and elected members were involved in the selection of projects and the council held a community conference to shape ideas. Feedback on the exercise was positive and the council will use learning to shape future exercises.

78. The Accounts Commission has a continuing interest in community empowerment, and will consider the pace and level of progress in future Best Value work and performance audits.

Workforce reductions have changed how councils are structured and the skills available, but the quality of workforce planning is inconsistent

79. Councils spend a substantial part of their revenue budgets on their staff. They directly employ around 243,000 people, around 197,500 full-time equivalent (FTE) staff. This is 48 per cent of the public-sector workforce, meaning councils are the largest employer in the Scottish public sector. Reducing the workforce is one of the main ways councils have made savings. For example, in Dumfries and Galloway the council saved £60 million in the past five years partly through reducing its workforce by 11.3 per cent.[24] Councils need to do more to ensure they understand in detail the profile and capacity of the management and workforce they currently have and need in the future. This is fundamental for being able to effectively respond to the challenging context and deliver effective change.

80. The Scottish Government reports quarterly on total local government staff and every year on social workers and teacher numbers.

- Between September 2017 and September 2018, there has been a small decrease, 0.2 per cent, in FTE staff numbers within councils. Since 2013, staff numbers have fallen by almost 5,000, a decrease of two per cent.[25]
- In the past five years there has been a 0.1 per cent reduction in social workers and a 1.6 per cent increase in teachers compared to a two per cent reduction for total council workforce.

Therefore, teachers and social workers now make up an increasing proportion of council employees, 29 per cent in 2017 compared to 27 per cent in 2013.

The quality of workforce planning varies across councils

81. The Commission believes that integrated workforce planning is essential for robust medium and long-term planning and effective transformation. This should include an analysis of what the council will need in the future, where the gaps lie and how to address them, either through training, recruitment, restructuring current resources, shared arrangements with other organisations, or procuring specialist skills.

82. Workforce planning is an area where progress is mixed across councils. Glasgow City, as an example, has a coordinated approach to workforce planning. Each service has a workforce plan which forecasts its requirements. Quarterly updates are collated centrally to identify gaps and surpluses which are then used to develop budgeting and resourcing plans including redeployment and retraining opportunities. However, there are other councils where it is not clear what the workforce will look like in terms of numbers and skills in the medium or long term.

Councils need to plan to ensure they have the staff, skills and leaders to deliver change, but there is no national data on workforce by service

83. Effective leadership is fundamental to the successful implementation of change in a complex and changing policy landscape. Councils need to ensure they have the best possible political and management leadership. This means ensuring there is appropriate training and development to support both councillors and management. For senior management this also means building the best strategic team possible and ensuring there is enough capacity to lead change and wider responsibilities. The Commission considers that this means recruitment

What is your council doing to ensure that it has the right capacity, skills and leadership in its workforce?

What training does your council make available to officers and councillors to ensure they have the skills to deliver services in the future?

to chief executive posts should include open competition to secure the best possible pool of candidates. Unless there is a clear rationale, which should be articulated in public council papers, key senior management positions, such as director and head of service level posts, should also be advertised externally.

84. There is a lack of national data on workforce by service. This makes it difficult to be able to determine what is needed in terms of skills or training for staff across Scotland, how services have been affected by the overall reduction in workforce and to inform benchmarking and sharing good practice. Other available data indicates reductions in some services, for example:

- The Royal Institute of Town Planners report a 23 per cent reduction in the planning workforce in Scotland from 2009 to 2016.[26]
- The Society of Chief Officers of Environmental Health in Scotland report that the number of professionally and technically qualified environmental health staff has decreased by 12 per cent from 2016 to 2018.[27]
- The number of librarians has fallen by 22 per cent and the number of library staff by seven per cent between 2014 and 2018.[28]

85. Councils continue to report staff shortages in key service areas:

- Two-thirds of councils reported a shortfall in mental health officers, the additional hours needed per week to make up this shortfall is equivalent to 41 full-time officers.[29]
- Care Inspectorate reports for Eilean Siar and Renfrewshire observed the continued difficulties in recruitment and retention of social care workers and the impact this has on services.

86. The UK's withdrawal from the EU could exacerbate problems of staff shortages as it could result in a loss of non-UK EU nationals from the workforce or difficulty recruiting from Europe. The Scottish Government estimates that there are 9,830 non-UK EU nationals working in social care in Scotland, 5.6 per cent of the workforce.

87. Councils are competing with other organisations for the same skills, for example digital, project management, planning and engineering expertise. Difficulties with recruitment and retention are compounded by an ageing workforce within councils and with a smaller working age population to recruit from. Also, many of the reductions in the workforce are from those approaching retirement, meaning that their skills and experience are lost to the organisation. For example, in Dumfries and Galloway Council 44 per cent of staff are over 50 years old.

88. Councils need to ensure there is sufficient training for their staff to allow them to respond to the changing and more pressured environment. There is no national data on skills training programmes; however, in our BVAR reports we have highlighted how some councils have approached this:

- In West Dunbartonshire Council, staff have a skills passport which sets out mandatory learning for staff at various career milestones. This allows them to plan for their ongoing development and encourages continuous learning.

Does the training you are offered meet your needs? If not, do you know who to speak to?

Does your council have an organisation-wide workforce plan? Does it contain information about the numbers, costs and skills of the actual and desired workforce?

- Dumfries and Galloway Council's 'Grow your Own' scheme retrains staff in areas where there are recruitment issues. As a result, it has been successful in filling teacher vacancies.

Councils should consider the impact of change on their staff

89. Savings programmes and staff reductions mean some uncertainty for council staff. Unless managed well, this could have an impact on the morale of the workforce and individual staff's wellbeing. Surveys carried out by Unison found that in 2018:

- 75 per cent of Environmental Health and 70 per cent of Trading Standards employees interviewed reported that morale in their organisation was low
- 90 per cent and 78 per cent respectively said that workload was higher than five years ago.[30]

Do you know how your council is ensuring changes to staff numbers and working practices do not have a negative impact on morale and wellbeing?

90. Councils should be aware of the impact savings programmes are having on their workforce and put measures in place to address any issues. Many councils do this through staff surveys. Common findings from staff surveys indicated people not feeling valued for what they do, not being asked for their views on change and feeling that working for the council had worsened in recent years due to workload.

91. The average number of sickness days for non-teaching staff has increased from 10.9 days in 2016/17 to 11.4 days in 2017/18. There is significant variation among councils, from an average of 16.8 days in Clackmannanshire to 8.4 days in East Ayrshire. For teachers, the average number of sickness days has fallen slightly from 6.1 days in 2016/17 to 5.9 days in 2017/18, varying from 9.1 days in Clackmannanshire to 4.2 days in East Ayrshire.

92. We have calculated in previous reports that if councils reduced sickness absence they could improve their productivity. If councils with higher rates of sickness absence levels reduced these in line with the top eight performing councils, they would gain the equivalent of 619 non-teaching staff across Scotland, and 248 teaching staff.

Part 3

Council performance and the impact on communities

Councils understand the challenges facing their communities, but resources need to be better linked to their vision and priorities

93. Our audit work shows that councils continue to clearly set out their strategic priorities and plans. Councils understand the local context of their communities and have a strategic focus on improving social inequality, particularly in areas of high deprivation.

94. Over half of councils clearly link their budget setting to their strategic priorities or plans. This should be evident in all councils. More also needs to be done to demonstrate how spending is linked to outcomes and performance. A positive example that contributes to clearer links is evident at North Ayrshire Council. Officers include information on what outcomes could be achieved for each level of investment when presenting strategic investment options. This allows councillors to consider whether the impact on the council's priorities would be significant enough to warrant the investment.

Does your council clearly link its budget setting to its strategic priorities and plans?

Are you assured that performance reporting by your council is accurate and accessible?

Can your council demonstrate progress in delivering its key outcome priorities?

Councils are focused on performance management and improvement

95. Our Best Value assurance reports to date indicate councils have improved their approaches to managing performance and improvement. Good performance management should link to the council's strategic priorities and be able to demonstrate a link between spend and outcomes.

96. A good council is self-aware, understands its own performance and uses that to make improvements. Our auditors reported evidence of self-evaluation in 14 councils in their 2017/18 Annual Audit Reports. For example, North Lanarkshire Council reviewed its position against the Best Value characteristics and the recommendations in previous Best Value assurance reports to help develop its rolling programme of reviews. Many councils have structured self-evaluation programmes. These can include corporate level and service level assessment tools, for example in West Lothian Council all services complete a bespoke assessment model and attend an officer-led scrutiny panel once in a three-year cycle to provide challenge to the service and promote improvement.

Councils need to show they are delivering against their high-level outcomes

97. As part of setting its *2018 Statutory Performance Information Direction*, the Commission reviewed performance information available on council websites. It found that:

- Auditors in 20 councils concluded that performance information was satisfactory.
- 90 per cent of councils published an annual performance report and 80 per cent published service level performance information.

- There are large amounts of performance information online, however websites could be easier to navigate, and the information was sometimes out of date. Councils may also want to consider whether having fewer, but better focused, performance indicators would allow them to demonstrate performance against their key priorities more clearly and effectively to the public.

- While 90 per cent of councils report performance against their priorities, few outlined progress against outcomes.

98. It is important that councils clearly report their performance to local citizens and the community. Good performance reporting includes clearly stating how performance and spend are linked to the council's priorities; local indicators which demonstrate quality of service; public satisfaction levels; and an overall assessment of the council's performance against outcomes.

Most national indicators have improved or been maintained but performance varies between councils.

Despite funding reductions, councils have maintained performance against several national indicators

99. The National Performance Framework measures progress across 81 indicators, although some of these are still in development and some do not have the data to allow trend analysis. We have selected 16 of the available indicators, these show that many outcomes have improved across Scotland in the last five years (Exhibit 6, page 36). However, there has been less progress with health outcomes.

100. Many of the NPF indicators are not available at a local level but the Improvement Service has developed a Community Planning Outcomes Profile (CPOP) tool which tracks performance against a set of identified measures at a CPP level. There is a helpful interactive tool on the Improvement Service website which allows communities and councils to drill into the data and to compare performance between CPPs, councils and over time. Analysis of the CPOP data shows that the majority of outcome measures have improved over the last five years.

101. There are limitations with the availability of both the NPF and CPOP data. Better data would allow councils to understand differences in demand and performance, report how well they are delivering against their outcomes and enable more informed decisions.

Since 2010/11 performance against most Local Government Benchmarking Framework indicators has been maintained or improved

102. The Local Government Benchmarking Framework (LGBF) is produced by the Improvement Service in partnership with councils. Since 2010/11 it has produced comparative performance information for councils to help them improve. The LGBF contains over 70 indicators covering a broad range of service areas. In previous years and in our BVARs we report on a sample of eight measures to give an indication of council performance.[31] Over the past seven years performance for these indicators has improved slightly or remained stable (Exhibit 7, page 37). This year, the LGBF reports that across all indicators there is some evidence that performance improvement is slowing down for the first time since 2010/11.[32]

Does your council make use of LGBF data to consider where and how it might make improvements to service delivery?

Have you considered what lessons your council can learn from other councils who are delivering services well?

Exhibit 6

Changes in performance measures for Scotland's outcomes between 2013 and 2017

Performance against many outcome measures has improved but there has been less progress with health outcomes.

Children, young people and education	Percentage of settings providing funded early learning childcare achieving good or better across all themes	-0.5%
	Proportion of adults aged 16-64 with low or no qualifications (SCQF level 4 or below)	-1.8%
Satisfaction	Percentage of adults who rate their neighbourhood as a very good place to live	2%
	Percentage of respondents who are fairly or very satisfied with the quality of local services (local health services, local schools and public transport)	-8.2%
	Percentage of people who agree with the statement 'I can influence decisions affecting my local area'	0.7%
	Percentage of households who report being either 'very satisfied' or 'fairly satisfied' with their house or flat	2%
Culture and leisure	Percentage of adults who have participated in a cultural activity in the last 12 months	-0.2%
	Proportion of adults making one or more visits to the outdoors per week	6%
Environment	Percentage of energy consumption which is renewable energy	7.1%
	Household waste (million tonnes)	4.2%
Fair work and business	The total number of private sector enterprises in Scotland per 10,000 adults	8%
	Percentage of workers earning less than the living wage	0.1%
	The difference between male and female full-time earnings, expressed as a percentage of male full-time hourly earnings	-3.4%
Health	Average Mental Wellbeing Score[1]	-0.2%
	Percentage of adults with two or more health risk behaviours (current smoker, harmful drinking, low physical activity, obesity)	1%
	Proportion of adults usually travelling to work by public or active transport	-0.6%
	European Age Standardised mortality rates per 100,000 for people under 75 in Scotland	-2.8%

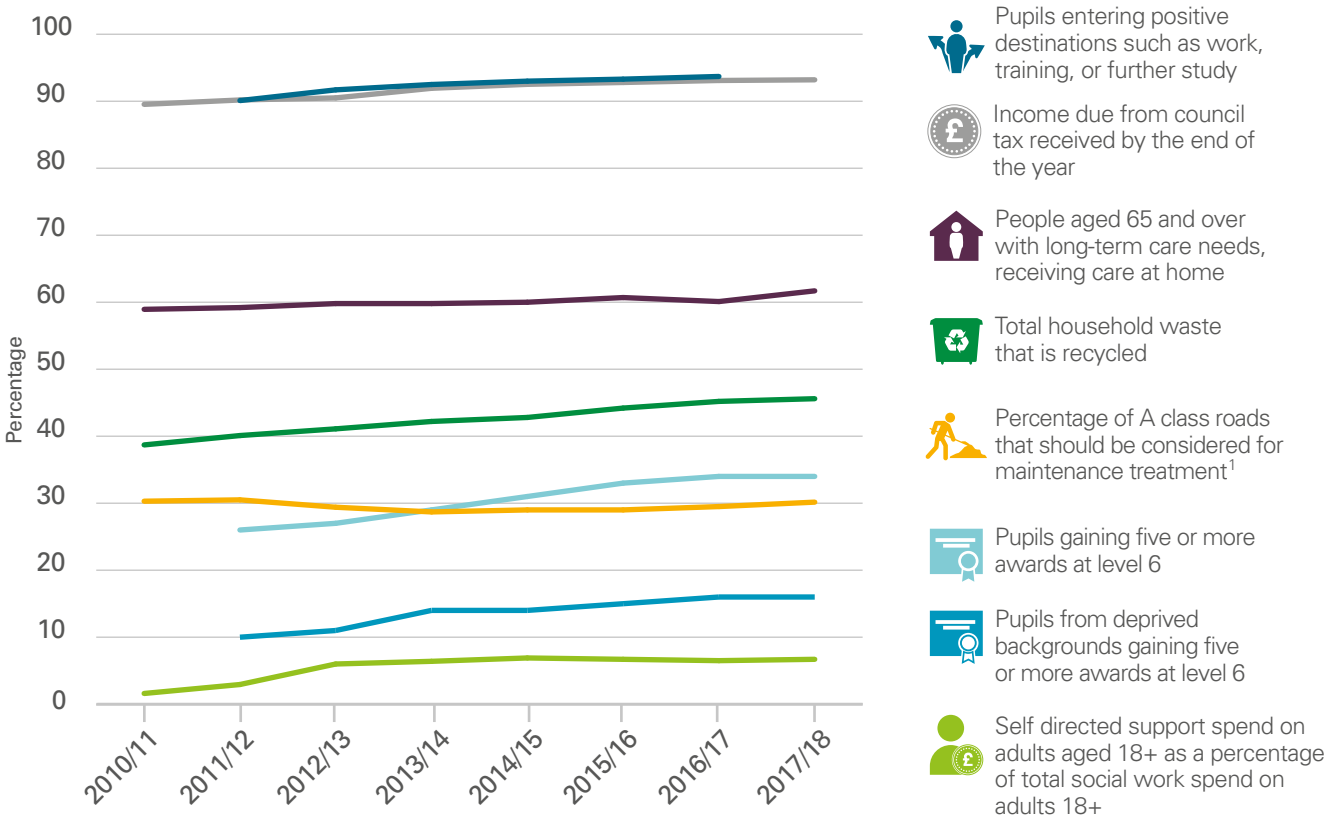
Note: 1. Warwick-Edinburgh Mental Wellbeing Score.

Source: National Performance Framework

Exhibit 7

Performance against selected indicators, 2010/11 to 2017/18

Performance has been maintained or improved.



Note: 1. Roads maintenance is measured in two-year time periods therefore 2009-11 is reported in 2010-11.

Source: Local Government Benchmarking Framework, 2017/18

103. We have also analysed council spending against indicators to see the impact that funding reductions have had on performance at a national level. This shows that since 2010/11 most services have been maintained or improved despite reducing budgets (Exhibit 8, pages 38-39). However, in the past year the data shows that some services are beginning to spend more or have had a decline in performance, for example, the number of library visits has fallen by eight per cent.

Performance variation is expected as councils have different local priorities, but it can also provide opportunities for identifying efficiencies.

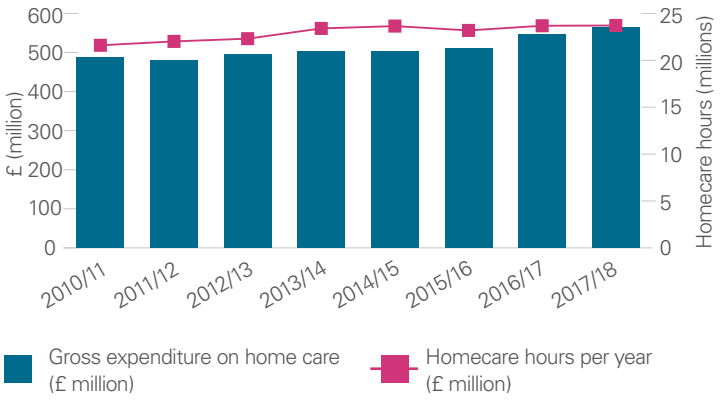
104. The Accounts Commission is clear that 'It is for councils to make choices in where they focus their improvement work, but they need to be able to show how they have arrived at such choices'.[33] As such performance against the indicators will vary depending on both local factors and policy decisions.

105. Councils should use the LGBF and other benchmarking tools to understand where councils with similar circumstances are performing better or spending less to provide the same service. Exhibit 9 (page 40) shows that there is a wide variation in both performance and unit costs between councils. There could be several reasons behind this, but it provides an opportunity to share learning and experiences to improve services.

Exhibit 8

Performance and spend in key areas, 2010/11 to 2017/18

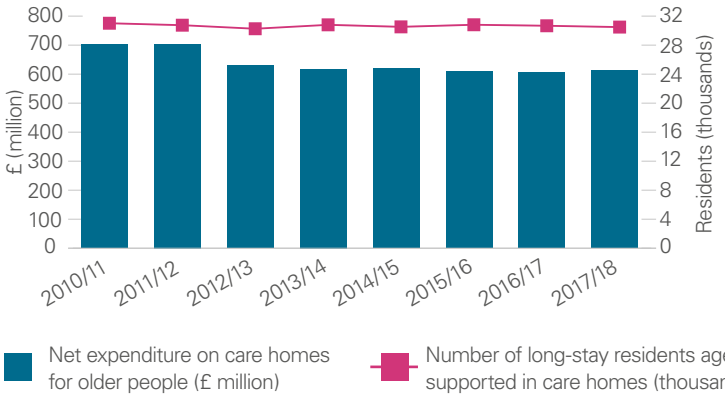
There has been a significant increase in expenditure on home care, while the number of hours provided has increased at a lower rate.



Local variations

Clackmannanshire, Perth and Kinross and Stirling councils have the lowest costs per hour of homecare. The island councils have higher cost per hour of homecare than other councils. Midlothian Council's costs are higher than other mainland councils.

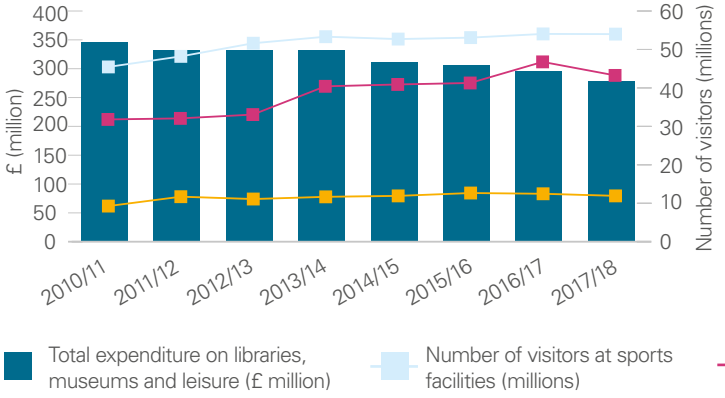
Spending on residential care and the number of residents has stayed relatively constant in recent years.[1]



Local variations

Shetland Islands Council spends more than three times the Scottish average per week on their care home residents, £1,349 compared to £386; while Dumfries and Galloway Council spends just over half of the Scottish average (£195).

Spending on culture and leisure continues to fall but visitor numbers to sports facilities, museums, and libraries all decreased in 2017/18.



Local variations

The City of Edinburgh Council had the highest number of library visits in 2017/18 and some of the lowest costs per visit. Glasgow City Council had the highest number of museum visitors and average costs per museum visit.

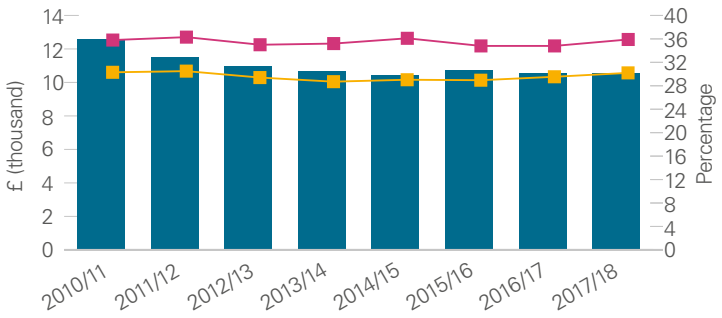
Interactive data map available on our website

Cont.

Exhibit 8 (continued)

Performance and spend in key areas, 2010/11 to 2017/18

Spend on roads has reduced since 2010/11, although it has remained relatively stable in recent years. The percentage of roads classified as needing maintenance increased slightly between 2016/17 and 2017/18.[2]



Cost of maintenance per kilometre of roads (£ thousand)

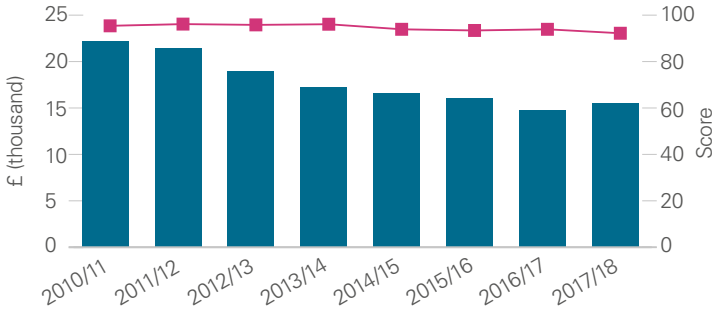
Percentage of A class roads that should be considered for maintenance treatment

Percentage of B class roads that should be considered for maintenance treatment

Local variations

Dundee City Council has the lowest percentage of roads in need of maintenance and is in the top 25 per cent of cost of roads per km. Argyll and Bute Council has the most roads in need of maintenance and is in the bottom 25 per cent for cost of roads per km.[3]

For the first time since 2010/11 expenditure on street cleaning increased, by six per cent, but the cleanliness score continues to fall slightly.



Net cost of street cleaning per 1,000 population(£ thousand)

Street cleanliness score

Local variations

In 2017/18, Glasgow City Council spent the most per 1,000 of population on street cleaning, more than double the Scottish average, but had one of the worst street cleanliness scores. Scottish Borders Council has one of the highest street cleanliness scores and spends roughly two-thirds the Scottish average.

Interactive data available on our website

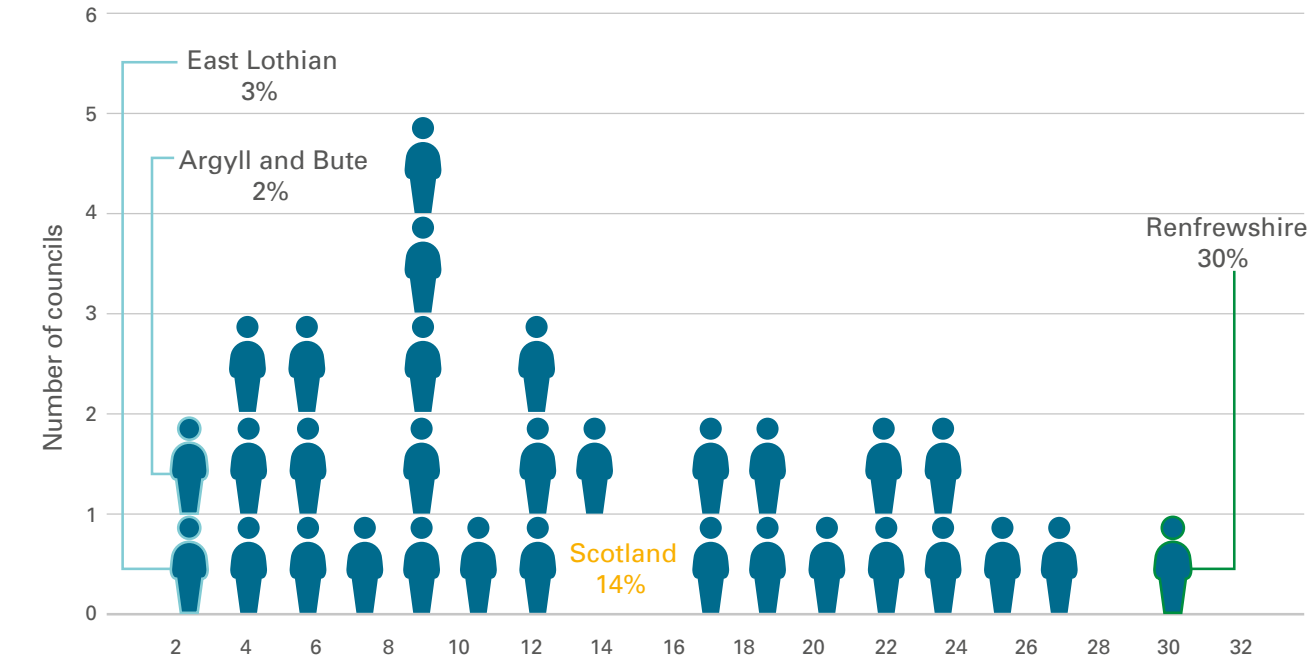
Notes:
1. 2010/11 and 2011/12 expenditure includes support costs so is not directly comparable to later years.
2. The percentage of roads that should be considered for maintenance treatment indicator is measured over two-year periods, for example 2009-11 is plotted as 2010/11.
3. The cost of roads per km includes both revenue and capital expenditure.

Source: Audit Scotland; and Local Government Benchmarking Framework 2017/18, Improvement Service

Exhibit 9

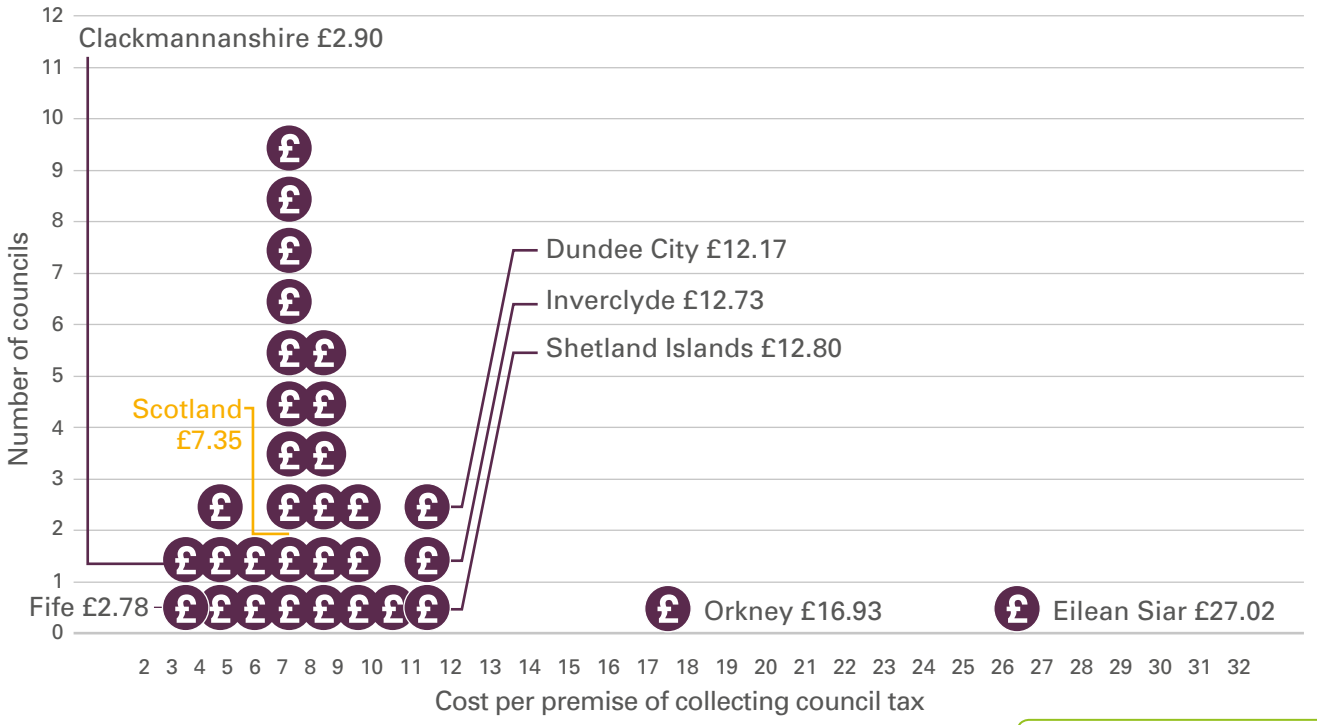
Variation between councils 2017/18

The percentage of unemployed people helped into work by a council employment scheme varied from two per cent in Argyll and Bute to 30 per cent in Renfrewshire.



Note: There is no data for employability in Shetland in 2017/18.

The cost of council tax collection is significantly higher in the island councils.



Interactive data available on our website

Note: Scotland figures are the Scottish average.

Source: Local Government Benchmarking Framework 2017/18

- The percentage of unemployed people helped into work through a council operated or funded employability programme ranged from two per cent in Argyll and Bute to 30 per cent in Renfrewshire. We calculated that if all councils could increase their number to the Scottish average of 14 per cent, an additional 3,500 people would have been helped into employment in 2017/18.

- The cost of council tax collection is significantly higher in the island councils; it costs £27 per property to collect council tax in Eilean Siar and £17 per property in Orkney Island compared to the Scottish average of £7. Clackmannanshire and Fife councils spend less than £3 per premise to collect council tax. We calculated that if the 16 mainland councils who spend more than the Scottish average reduced costs to that level they would save £1.7 million and if the Eilean Siar and Orkney reduced their costs to those of Shetland Islands, they would save £209,000 and £46,000 respectively.

Education performance has improved since 2011, but progress slowed in 2017/18 and the attainment gap between the most and least deprived pupils has widened in the last year

106. Education is the largest area of council spend, and the focus of considerable national policy attention. In 2017/18, councils spent £3.9 billion on schools, and a further £0.4 billion on pre-schools. This is a one per cent and three per cent respective real terms increase on the previous year. Spending on schools has reduced by two per cent since 2011/12, but has been increasing since 2015/16, when the Scottish Government introduced its Scottish Attainment Challenge.[34]

107. Nationally pupil attainment has been improving. Across Scotland, there has been a 16 per cent improvement in average tariff score since 2011/12. However, 2017/18 data shows that:

- For the first time there has been no change in the percentage of pupils gaining five or more awards at level 6 and the proportion of pupils gaining five or more awards at level 5 has increased at a slower rate than previous years.

- The gap between average tariff scores of the most deprived pupils and the least deprived pupils increased from 2016/17 to 2017/18. In 2017/18, pupils from the most deprived areas saw a 1.1 per cent reduction in their tariff scores while those in the least deprived saw a 0.9 per cent increase. This increased the gap between the most and least deprived by three per cent since 2016/17.[35]

108. Performance in exams is not the only way to measure attainment. The LGBF also reports on the percentage of 16 to 19 year-olds in work, training or learning which has increased year on year since first measured in 2015/16.

Average Tariff Score

Is an overall measure of secondary attainment, taking account of all qualifications a pupil earns from age 14 until leaving school.

Tariff scores strongly reflect the total number of subjects studied which may not reflect curriculum decisions taken by the council.

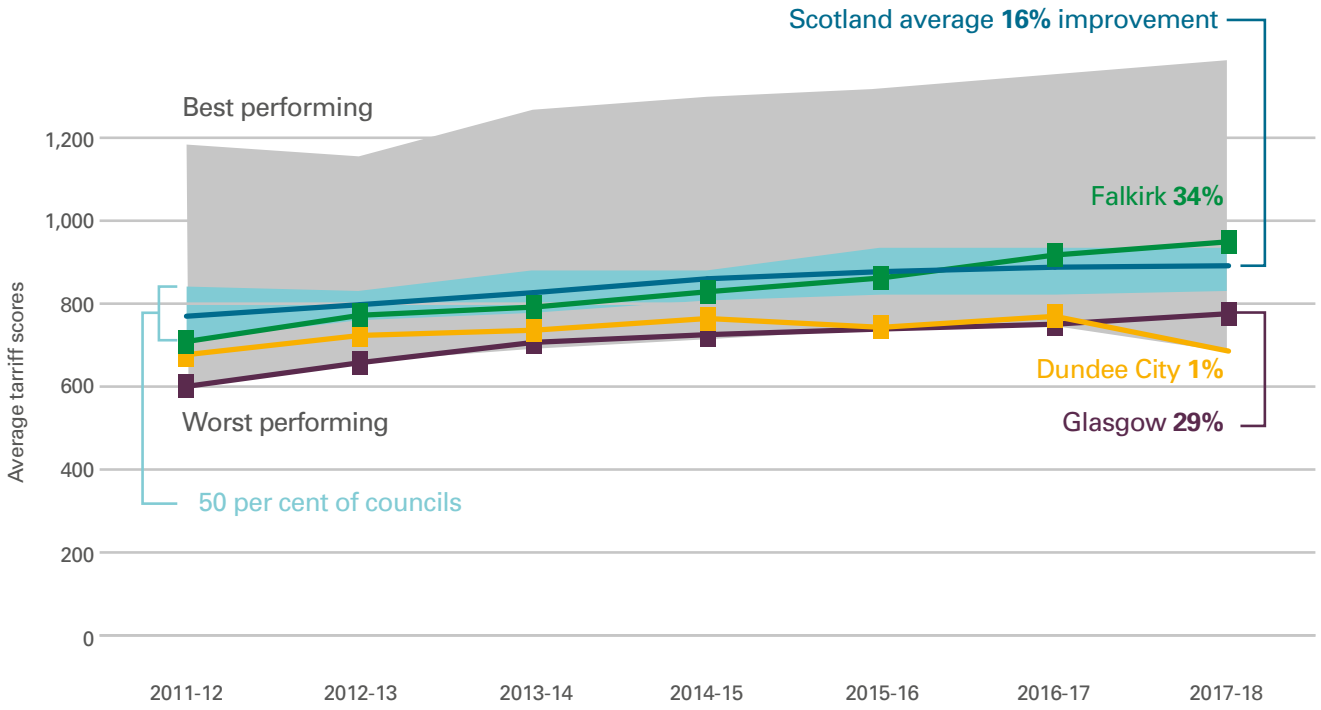
Some councils have done well to improve attainment

109. We reported last year that there is variation in education performance that cannot be explained by deprivation. This is still the case. This year we have considered how councils' performance has changed since 2011/12. All councils have improved their performance despite a reduction in spend. But some councils have improved considerably faster than others and the gap between the best and worst performing council has widened (Exhibit 10, page 42):

Exhibit 10

Improvement in average tariff score 2011/12 to 2017/18

All councils have seen an improvement to their overall tariff scores despite reducing budgets but the gap between best and worst performing has increased.



Note: As leaver information is not available when the LGBF publishes its data, the LGBF uses data based on the year pupils are expected to leave school rather than the actual year they left. This means there are some small differences between it and data published by the Scottish Government later in the year.

Source: Local Government Benchmarking Framework 2017/18

- Falkirk Council's attainment has improved by 34 per cent since 2011/12. It is now in the top quartile for attainment, whereas in 2011/12 it was in the bottom quartile.
- Glasgow City Council has seen a 29 per cent improvement in their tariff scores although it remains in the bottom quartile.
- Dundee City Council has seen only a one per cent improvement in its tariff scores since 2011/12. It had a ten per cent drop in tariff score in 2016/17 which affected the overall trend. It has been in the bottom quartile since 2011/12.

110. The reasons behind why Glasgow and Falkirk have seen big improvements in attainment and Dundee has not, cannot be explained simply by the amount spent on education nor levels of deprivation:

- Dundee City Council spends more than the Scottish average per secondary pupil while Falkirk and Glasgow spend less.
- Both Dundee and Glasgow City councils have reduced their spend per secondary pupil by five per cent since 2011/12, a bigger reduction than the

Scottish average of one per cent. Falkirk Council has reduced spend per pupil by one per cent.

- All three councils have high levels of children living in families with limited resources compared to the Scottish average of 20 per cent. Dundee City and Falkirk have similar levels, 26 per cent and 27 per cent respectively. Forty-one per cent of children in Glasgow live in families with limited resources.[36, 37]

- Dundee City Council reports that the drop in tariff scores in 2017/18 is due primarily to a higher than usual number of children leaving school at S4 in 2015/16.

111. This variation provides an opportunity for councils such as Glasgow and Falkirk to share what has helped them make these improvements. Our Best Value work, engagement with scrutiny partners and 2014 report on *School education* suggest that the leadership and culture of the organisations have a part to play:

- We highlighted in our 2015 Best Value report on *Falkirk Council* that it had good performance management arrangements and a strong improvement culture embedded in its education department.

- Our *Best Value Assurance Report: Glasgow City Council* reported that targeted actions have helped improve attainment through the Glasgow Improvement Challenge. The Care Inspectorate and Education Scotland's 2017 inspection of young people's services in Glasgow found that 'strong leadership is driving an ambitious vision to improve life chances for all children and young people in Glasgow'.[38]

- During engagement with scrutiny partners for Dundee City Council, Education Scotland highlighted that the council will need to move from incremental to transformational change to improve attainment.[39] In its 2018 inspection of Dundee's Attainment Challenge progress, Education Scotland found that strong leadership and higher aspirations are beginning to improve the pace of change. It also highlighted strong use of data and collaboration with Dundee University to help understand the pupils' needs and improve attainment.[40]

112. In February 2019, Education Scotland rated Renfrewshire Council excellent in its inspection of the Scottish Attainment Challenge. It found that highly effective leadership and governance and evidence-based interventions had led to significant year-on-year improvements in closing the gap between attainment of the most and least deprived pupils.

113. We will be carrying out an audit on educational outcomes in 2019/20 which will consider the reasons for variation in attainment.

There is evidence that spending reductions and increasing demand are impacting on some services

Social care services continue to struggle to meet demand

114. Adult social care remains one of the largest areas of spend for councils and the demand for services will continue to increase as the population ages. Older

Do you know the impact of spending reductions on the services your council provides?

people in need of support are either cared for in their home by visiting care workers or in a residential care home. This care is given by a range of different providers. In 2017:

- Most care home residents were cared for by the private sector, 80 per cent, while the NHS and councils cared for 11 per cent of residents and the third sector nine per cent.[41]

- The private sector also provided most homecare hours, 42 per cent, councils provided 41 per cent, the third sector six per cent and a mixture of providers 11 per cent.[42]

115. We continue to see signs that services are struggling to meet the demand for care. We reported in December 2018, that there has not yet been enough progress to address the scale of challenges with social work in Scotland and there are some outstanding areas where action is needed. In 2017/18, the number of hours of personal care at home is at the highest level since 2010/11. Between 2016/17 and 2017/18, councils have spent more on both home care and residential care, this has increased at a faster rate than the people who are cared for. This is in part due to those receiving care having increasing levels of need, as well as the payment of the living wage and overnight allowances to social care workers.

- Total spending on homecare has increased by 3.1 per cent despite only a 0.1 per cent increase in the number of hours of homecare.

- Net spending on residential care homes increased by 1.2 per cent despite a 0.6 per cent reduction in the number of residents.

116. Both satisfaction indicators in the LGBF data show a substantial drop in satisfaction with social care services. Eighty per cent of adults who receive care are satisfied with it and feel it improves or maintains their quality of life. This is down from 84 and 85 per cent respectively and is the lowest since it was first recorded in 2014/15.

117. We reported last year that local inspections raised concerns about the ability of the City of Edinburgh and Scottish Borders councils to meet the demand from older people and the quality of care provided. A progress review of the City of Edinburgh Council's services for older people found that limited progress had been made towards improving the outcomes for many older people. They and their carers were unable to get help even when their needs were critical, and often had to wait lengthy periods for the care they needed. In April 2018, there were 1,500 people in the community waiting for an assessment, waiting an average of 50 days.

118. The Care Inspectorate has also carried out follow-up inspections of Eilean Siar and Aberdeen City Councils and a full inspection of Renfrewshire Council's adult services. It found that progress has been made but observed issues around staff recruitment and retention in Eilean Siar and Renfrewshire and the capacity of care services in Aberdeen.

How is your council adjusting to meet changing demands for care services?

How is this reflected in the performance data?

Public satisfaction is falling

119. The Scottish Household Survey reported that in 2017 public satisfaction has fallen for another year:

- 52 per cent of adults were satisfied with three public services – local health, schools and transport. This is the lowest since first measured in 2007 (57 per cent) and a reduction of four per cent since 2016.
- Satisfaction amongst schools had dropped from 79 per cent in 2007 to 70 per cent in 2017.
- Satisfaction with service users was higher than the whole population, people who had children at local schools reported 87 per cent satisfaction.

120. Less than half of councils have published a residents' or citizens' survey between 2016 and 2018. Of these, five reported a reduction in satisfaction levels compared to previous years. In their surveys many councils asked satisfaction questions about specific services or aspects of service delivery. The most frequent service-specific surveys were in relation to social care, schools and education, housing, building standards and planning, children and families services and school meals. Overall, the picture varies significantly with both increases and decreases in satisfaction levels being reported for the same service across the country.

Do you know what your council is doing to understand how satisfaction with different services is changing?

Some councils are not meeting their statutory duties in terms of homelessness.

121. The number of homeless applications increased for the first time in nine years in 2017/18, from 34,570 households in 2016/17 to 34,972 households in 2017/18. Councils have a statutory duty to provide temporary and settled accommodation to households assessed as homeless. However, some councils have been unable to meet this obligation.

- The Scottish Housing Regulator reported in March 2018 that Glasgow City Council had failed to offer temporary or emergency accommodation to 40 per cent of the 5,377 applications it had for assistance in 2016/17. It had also provided settled accommodation to just over half of the households it had a duty to provide to.[43]
- The Local Government and Communities Committee took evidence from the Legal Services Agency who reported up to ten cases a week where households had approached them for legal help with councils who had been unable to offer temporary accommodation.[44]

122. When providing accommodation, councils must ensure that households with children or a pregnant woman do not stay in unsuitable accommodation for more than seven days. In 2017/18, there were 400 cases where the household stayed longer than this time, 280 of these were in Edinburgh, 65 in West Lothian and 20 in East Dunbartonshire.

123. Councils use temporary accommodation when a permanent home is not immediately available. Temporary accommodation is more expensive for councils to provide, impacts on existing housing stock and is not the best place for people to stay long term. However, there has been an increase in the use of temporary accommodation in recent years. In 2017/18:

Is your council meeting its statutory duty to provide temporary and settled accommodation to households assessed as homeless?

- there were 10,933 households in temporary accommodation, one per cent more than in 2016/17 and 6,615 children, nine per cent more than 2016/17
- the average time spent in temporary accommodation is 204 days for families and 161 for households without children
- over 13 per cent of households in temporary accommodation spent more than a year there. In Shetland, the average time spent in temporary accommodation was over a year.

124. Homelessness is a complex problem that is often the symptom of a range of different challenges. Shelter believes that the increase in homeless applications is due to the impact of welfare reform, a lack of affordable housing, an increase in people with complex needs who do not receive the support they need, and insufficient and inconsistent prevention work.[45] The Scottish Government has an objective to end homelessness, this will require a multi-agency approach. We will be reporting further on affordable housing in 2019/20 and will consider homelessness as part of the scope of this audit.

Endnotes

1 Local Government Finance Circulars are letters from the Scottish Government to councils. We use the letters which set out the annual funding settlement. All circulars can be found on the Scottish Government's website: https://www.gov.scot/publications/local-government-finance-circulars-index/.

2 Local Government Finance Statistics are annual statistics on council spend from returns from councils. We have not audited the information in them. They can be found on the Scottish Government's website: https://www2.gov.scot/Topics/Statistics/Browse/Local-Government-Finance/PubScottishLGFStats.

3 Provisional outturn and budget estimates contain initial outturn and budget information provided by councils. We have not audited the information in them. They can be found on the Scottish Government's website: https://www2.gov.scot/Topics/Statistics/Browse/Local-Government-Finance/POBEStats.

4 The LGBF is published by the Improvement Service and contains over 70 cost and performance indicators for local government. It can be found here: http://www.improvementservice.org.uk/benchmarking/explore-the-data.html.

5 National Performance Framework indicators are used to measure progress against the NPF. They can be found here https://nationalperformance.gov.scot/measuring-progress/national-indicator-performance.

6 Scotland's Fiscal Outlook, Scottish Government, May 2018.

7 The 2018 National Performance Framework is set out at: https://nationalperformance.gov.scot/

8 *Local government in Scotland: Financial overview 2017/18*, Audit Scotland, November 2018.

9 *Scotland's new financial powers briefing paper*, Audit Scotland, October 2018.

10 Projected cost pressures for Scottish local government, Improvement Service, 2018.

11 *Securing the future of health and social care to the 2030s*, Institute of Fiscal Studies, May 2018.

12 *Health and Social care medium term financial framework*, Scottish Government, October 2018.

13 *Poverty and inequality in Scotland: 2014-2017*, Scottish Government, March 2018.

14 *Poverty in Scotland 2018*, Joseph Rowntree Foundation.

15 Citizens Advice, Disconnected, 2018.

16 UK Poverty 2018, Joseph Rowntree Foundation.

17 *Rolling out Universal Credit*, Comptroller and Auditor General, HC 1123, June 2018.

18 *Homelessness in Scotland 2017-18,* Scottish Government.

19 City of Edinburgh, Council papers, 7 February 2019.

20 *Financial sustainability of local authorities 2018*, Comptroller and Auditor General, HC 834, March 2018.

21 Ibid.

22 Local Authority Capital Expenditure and Receipts, England: 2017-18 Final Outturn, Ministry of Housing, Communities and Local Government.

23 Statement from Rob Whiteman and Richard Paver on borrowing to invest, CIPFA, October 2018.

24 *Workforce strategy and metrics update 2018*, Dumfries and Galloway Council, November 2018.

25 These figures do not include staff who are employed by arm's-length external organisations.

26 Royal Institute of Town Planners written submission to Local Government and Communities Committee, 2018.

27 Data provided by Society of Chief Officers of Environmental Health, 2019.

28 Public library statistics, CIPFA, 2014 and 2017/18.

29 *Social work in Scotland - Impact report*, Account Commission, December 2018.

30 *Tipping point*, Unison, November 2018 and *Trading safety*, Unison, May 2018. Both are reports on surveys carried out by UNISON of their members. For environmental health workers, members from 21 councils responded, for trading standards members from 29 councils. The overall number of respondents is not stated.

31 The full range of indicators includes unit cost and public satisfaction. These are available on the improvement services website: www.improvementservice.org.uk/benchmarking.

32 *National benchmarking overview report 2017-18*, LGBF, 2019.

33 *Accounts Commission Strategy and annual action plan 2018-23*, Accounts Commission, June 2018.

34 LGBF included educational attainment information for the first time in 2011/12.

35 As leaver information is not available when the LGBF publishes its data, the LGBF uses data based on the year pupils are expected to leave school rather than the actual year they left. This means there are some small differences between it and data published by the Scottish Government later in the year.

36 *Children in families with limited resources across Scotland 2014-2016*, The Scottish Government.

37 The Scottish Government, through its Attainment Challenge provides additional funding to the councils it defined as having the highest concentration of deprivation. Glasgow and Dundee are challenge authorities. The other authorities are Clackmannanshire, East Ayrshire, Inverclyde, North Ayrshire, North Lanarkshire, Renfrewshire and West Dunbartonshire.

38 Joint inspection of services for children and young people in Glasgow, May 2017.

39 *Dundee City Council Local Scrutiny Plan 2018/19*, Audit Scotland, April 2018.

40 *How well is Dundee City Council improving learning, raising attainment and closing the poverty-related attainment gap?* Education Scotland, June 2018.

41 Care home census for adults in Scotland, 2018, NHS Scotland.

42 Social Care Services, Scotland, 2017, Scottish Government.

43 Scottish Housing Regulator, March 2018.

44 Local government and communities committee, Report on homelessness, February 2018.

45 Briefing for Scottish Government debate on ending homelessness together, Shelter, November 2018.

Local government in Scotland

Challenges and performance 2019

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ISBN 978 1 911494 81 2

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How councils work:
an improvement series for councillors and officers

Safeguarding public money: are you getting it right?

ACCOUNTS COMMISSION

Prepared by Audit Scotland
April 2019

The Accounts Commission

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

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

Our work includes:

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

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

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

Audit team

The core audit team consisted of Carol Calder and Douglas Black, with support from other colleagues, under the general direction of Antony Clark.

Links

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Key messages

Councils provide valuable public services but face a complex, uncertain environment that places evolving demands and expectations on them. Increasingly, councils deliver services through multi-faceted partnership working across organisational, functional and geographical boundaries – such as for the provision of health and social care services.

It is challenging for councils to prioritise how they use their finite resources. Councils' decreasing budgets contrast with rising demands on many of their services, including care of vulnerable elderly people. This means that effective risk management and strong internal controls are more important now than ever before.

1 An effective system of internal controls and risk management helps councils to safeguard their finances; ensures they implement their policies; and helps them to deliver high-quality services. Controls include procedures for paying the right sum of money to the right person at the right time; keeping confidential data secure; and minimising a council's exposure to fraud and corruption.

2 There are signs from councils' internal auditors and the work of councils' external auditors that standards of internal controls may be strained. Some recurring weaknesses are becoming apparent among councils and the consequences could be serious, including the loss of significant amounts of public money, impacts on services and reputational damage.

3 Ultimately, councillors are accountable for scrutinising a council's use of public money. Senior officers have the primary responsibility for ensuring internal controls and risk management operate effectively and that a council's internal auditing function provides a valuable and objective view.

4 Councillors should seek assurances from officers that a rigorous system of internal controls is in place. Scrutiny and audit committees have leading roles, but every committee and councillor has a scrutiny role too.

About this report

1. The Accounts Commission aims to help councils improve their use of public money, alongside its role as the local government public spending watchdog. Our *How councils work* (HCW) reports support councils' drive for continuous improvement. We select topics from recurring themes in our Best Value assurance reports; performance audits; the work of councils' external auditors; and our annual overview of local government.

2. Our previous HCW reports have examined:

- The roles, responsibilities and working relationships of councillors and council officers in achieving Best Value (2010); and a follow-up (2016).
- The relationships between councils and their arm's-length external organisations (ALEOs) (2011).
- The value of good-quality cost information in making informed policy decisions and scrutinising performance (2012).
- The importance of effective performance management systems (2012).
- Good practice in managing councils' major capital investments (2013).
- Charging for council services (2013).
- Options appraisal (2014).

3. Scotland's councils face complex, challenging financial pressures. Rising demand for many of the diverse services councils provide must be met despite tightening budgets for numerous services, and significant uncertainty stemming from external factors including the UK's planned withdrawal from the EU.

4. In 2017/18, councils' net revenue expenditure totalled £12.4 billion.[1] If councils could save one per cent by improving their financial management, risk management and internal controls, they could potentially free-up an extra £124 million for providing public services.

5. Scotland's 1,227 councillors have multi-faceted responsibilities and constantly make difficult decisions when prioritising and allocating their council's finite resources.[2] With so much at stake, it is more important than ever that the impact of their decisions on communities and individuals is transparent and clearly understood. This requires an organisational culture that is open to candid discussions about risks and recognises the importance of scrutinising decisions.[3]

6. This report aims to reinforce the importance of councils having effective internal controls. Although these may have a low profile, they are fundamental to maintaining a council's finances; securing its core values; safeguarding public money; and minimising the reputational impact on a council if things go wrong. In places, anonymised, real-life case studies illustrate the importance of internal controls and the consequences if they fail. Checklists are featured to help councillors and officers assess their council's situation and, where necessary, to identify and plan improvements.

7. The Accounts Commission expects councillors to use this report to ensure that they:

- have a good understanding of the main risks facing their council and how well these risks are being managed
- are assured that appropriate internal controls are in place and, where weaknesses have been identified, effective action is being taken to address them
- are kept aware of the outcome of any significant risk occurring; the failure of internal controls; and what remedial actions are being taken.

Part 1

Internal controls help councils to manage risk

Councils can use internal controls to manage risks

A control is an action taken by management … to manage risk and increase the likelihood that established objectives and goals will be achieved.[4]

8. A council is responsible for having an effective system of internal controls to safeguard public funds and help secure value for money. A system of internal controls has five main components (Exhibit 1).

Exhibit 1

Internal control components

The five main components are interdependent.

Control environment

The overall attitude, awareness and actions of councillors and senior officers to control activities and their importance in the council. This includes the high-level structures, culture and values across the council to provide a basis for carrying out internal controls.

Risk assessment process

Risk assessments should be carried out regularly. By identifying and evaluating risks, the council can assess the need for control activities.

Information systems

Councils use these systems (manual and computerised) to record financial transactions and non-financial data; and maintain accountability for related assets, liabilities and equity.

Control activities

Policies and procedures that senior management apply to ensure that their decisions and instructions are implemented; and risks are mitigated (treated) to achieve their objectives.

Monitoring of activities

Ongoing assessment by management of the control system's performance. Communication helps to monitor progress against the council's objectives.

Source: Financial Reporting Council

9. Control activities help to ensure council policy is applied, and they can generate feedback on whether intended actions were implemented and achieved their desired objectives. They comprise policies that establish what should be done, and procedures to implement these policies. In addition to the component arrangements for handling risk, five control categories are identified in the International Standards on Auditing, regarding the sorts of areas where risks occur:

- Authorisation
  - Officers handle only those processes and transactions that fall within the scope of their role.
- Physical
  - The physical security of assets, including adequate safeguards such as secured access to premises and records.
  - The authorisation for access to computer programs and data files.
  - The periodic counting and comparison with amounts shown on control records (for example, comparing the results of cash, security and inventory counts with accounting records).
- Information processing
  - Allow data to be processed in a specific way.
  - Application controls, which apply to the processing of individual tasks. Examples include checking the arithmetical accuracy of records, and manual follow-up of computer-generated exception reports.
  - General ICT controls, which are policies and procedures relating to many applications, such as controls that restrict access to computer systems which could change financial information without leaving an audit trail.
- Performance reviews
  - Monitoring performance versus budgets, forecasts, and prior period performance; and reviews comparing different data sets.
- Segregation of duties
  - Assigning different people the responsibilities of authorising transactions, recording transactions, and maintaining custody of assets. This is intended to reduce opportunities for someone to both perpetrate and conceal errors or fraud.[5]

10. It is the responsibility of officers to develop, implement and maintain reliable controls. Accounting regulations require a council to review, at least annually, the effectiveness of its system of internal controls. The findings from such a review must be considered by the audit committee (or equivalent) before it approves the council's annual governance statement, which is included in its published annual accounts.[6] The governance statement is where a council reports publicly on the extent to which it complies with its own code of governance, which in turn should be consistent with good governance principles. It should include:

- an acknowledgement of responsibility for ensuring that there is a sound system of governance (incorporating the system of internal control) and reference to the council's code of governance

- reference to, and assessment of, the effectiveness of key elements of the governance framework and the role of those responsible for the development and maintenance of the governance environment
- an opinion on the level of assurance that the governance arrangements can provide and that the arrangements continue to be regarded as fit for purpose in accordance with the governance framework
- an agreed action plan showing actions taken, or proposed, to deal with significant governance issues
- reference to how issues raised in the previous year's annual governance statement have been resolved
- a conclusion – a commitment to monitoring implementation as part of the next annual review.

11. A council's external auditor is required to express a separate opinion in their independent auditor's report on whether:

- the information given in the council's annual governance statement is consistent with its financial statements
- the annual governance statement has been prepared in accordance with the *Delivering good governance in local government: framework 2016*.[7]

Risk management helps to safeguard public money

Risk management is about identifying risks; assessing the impact they will have if they come to pass; the likelihood of that happening and making plans to mitigate, or 'treat', those risks.[8]

12. A council needs to understand its risks before it can manage them, and each council will have its own set of local circumstances, risks and challenges. Councils have some risks in common but their level and how they manifest themselves vary from place to place and over time. Risks can arise or change owing to factors such as: changes in the regulatory or operating environment; recruiting new staff and staff turnover; implementing revamped or new information systems; adopting new technologies; and organisational restructuring. Understanding and proactively acting on risks reduces the likelihood of a council being impacted by adverse events; suffering a policy or service failure; or omitting to benefit from opportunities.

13. The impact of risks can be categorised in various ways and here is one approach for illustration:

- Compliance – with laws, regulations and good practice.
- Finance – risks to the funding available for providing quality services; and to the council's ongoing financial sustainability.
- People – risks to employees' health, safety, wellbeing and morale; and to the organisational culture within services and the council overall.
- Reputation – risks to a council overall, its values, councillors and officers.

- Change – including risks with major construction projects and a council's organisational transformation plans.
- Impact – including the consequences of bad weather for services, and a council's responsibility to champion and demonstrate good practice concerning its social responsibilities.

14. A council is responsible for having an effective and appropriate risk-management function.[9] A good practice approach consistently integrates planning and risk management at corporate and service levels, and helps a council to:

- set and achieve its strategic objectives
- comply with its legal and policy obligations
- ensure the rigour of its decision-making
- prioritise the allocation and use of its finite resources
- deliver high-quality services.

15. A risk management cycle typically has seven steps (Exhibit 2). An underlying principle is to identify risks and their root causes at the earliest opportunity; assess risks' potential impact; introduce controls to mitigate (treat) those risks; and continually review the council's position.

Exhibit 2

Risk management aspects

There are seven key steps.

1		**Identify** the risks to the council
2		**Assess** the impact of the results
3		**Assess** the likelihood of the risks occurring
4		**Prioritise** all risks, assessing the principal risks
5		**Identify** how controls can be put in place to help mitigate risks
6		**Monitor** risks and the effectiveness of controls
7		**Report** regularly to senior officers and to councillors

Source: Audit Scotland

A council needs to use one or more risk registers

A risk register is a key document which, together with service performance data and financial information, equips senior officers and councillors with an assessment of a set of issues.[10]

16. A risk register supports the identification, assessment and monitoring of risk. It can inform the understanding of trends; drive action planning; and help in sharing good practice across the council. A large, complex organisation like a council is likely to need a strategic, corporate-level risk register; and a more operationally focused risk register for each service and major programme of change or development – such as improvements to the school estate or a major new ICT programme. A risk register can capture where key risks sit and:

- the ownership and responsibility for how each risk will be managed
- the regularity of reports to officers and councillors on the handling of risk
- the basis for periodically updating the council's approach to risk.

17. Once a risk is identified, its significance is assessed in terms of the likelihood of it occurring and, if it occurred, what the consequences would be. Typically, likelihood is categorised on a numerical scale such as one to five, with one being rare and five almost certain. Impact will also be assessed on a similar scale, with one being insignificant and five being severe. Likelihood and impact are multiplied to obtain a single overall risk score between one and 25.

18. Few risks can be avoided altogether but an effective, self-aware risk culture enables councillors and officers consciously to take the right risks in an informed, responsible way. A council that is consistently risk-averse may not be well-placed to benefit from new opportunities. How acceptable a risk is deemed to be will depend on the type of risk involved; may vary among council services; and be influenced by factors such as the sums of money involved, or the potential consequences should the risk materialise.

19. It is for each council to have a clear approach to managing risk and articulating its risk appetite in ways that balance risk and opportunity and reflect the specific and varied nature of risks across different service and policy areas. For example, a council's risk appetite could range between being risk-averse (where the avoidance of risk and uncertainty is a key organisational objective) and risk-hungry (where the council is eager to be innovative and to choose options offering potentially higher rewards, despite greater inherent risk).

20. A council must monitor and control risks. It is important to evaluate each risk's score before and after mitigating action to curb it. Based on a risk's score, there are four options. In picking one, factors to consider include costs, feasibility, probability, and potential impact.

- Terminate – avoid the risk altogether by deciding not to proceed with an activity. For example, if a project is very high-risk, it may be prudent to cancel the project altogether or handle it differently.
- Transfer – to another person or organisation that bears all or part of the risk. This could mean moving some work to a different type of organisation; working in partnership to share the risk; or taking out insurance.

- Mitigate – identify measures to reduce the risk. Risks should be monitored regularly to ensure mitigation measures remain effective.

- Tolerate – it is sometimes appropriate to accept and live with a risk, for instance if the cost of mitigating it exceeds the potential benefits.

Internal controls and risk management are increasingly important

21. The outlook is that reductions in funding for councils may increase financial pressures on them, especially in services that are unprotected by funding dedicated to their sole use – such as road maintenance, waste disposal and 'back-office' functions such as finance, personnel and ICT services.

22. Further savings will become progressively more important to councils' financial sustainability but could be increasingly difficult to achieve.[11] Sound internal controls are therefore essential for ensuring councils can extract the maximum possible value from their budgets within a tolerable level of risk. Risk is often unavoidable, but it always needs managed actively. The rewards in a well-managed situation can outweigh the risks for individuals, councils and for residents.

Councillor checklist 1

Internal controls and risk management

The following questions may help you to think about internal controls and risk management in your council.

Is the answer Yes, Maybe/Partly, or No? Is action required? If so, what action and who by?

Internal controls

- Do internal controls link with key corporate and service-level risks?
- Do internal controls apply to both financial and non-financial risks?
- Has the council identified the weakest internal controls?
- Are officers improving weak internal controls and minimising the risks they pose?
- Does internal auditing evaluate controls' effectiveness, and report to the audit committee?
- Does the audit committee take appropriate action?
- Does the council publicly review its system of internal controls annually?

Risk management

- Is risk management actively led, supported and promoted by councillors and senior officers?
- Does the council have an up-to-date, corporate-level, risk management strategy?
- Does the corporate risk management strategy address the council's risk appetite?
- Does the council have up-to-date corporate-level and service-related risk registers?
- Is risk management embedded in business practices at both corporate and service levels?
- Does systematic evaluation and prioritisation of risks and opportunities lead to timely action?
- Are key risks and action to mitigate them monitored and reported on throughout the year?
- Do officers' reports to committees cover both financial and non-financial risks?
- Is there sufficient, timely training and ongoing support on controls and risk for you and relevant officers?

Part 2

Weak controls can have serious consequences

There are signs that standards of internal controls may be strained

23. An effective system of internal controls works to prevent foreseeable problems from happening in the first place. When things do go wrong, symptoms of significant weaknesses in controls can include:

- Major financial transactions are not appropriately scrutinised by councillors.
- Fraud is not prevented by the council's internal controls.
- A risk assessment process is absent, where it would ordinarily be expected.
- The council's risk management process does not identify where risk assessment is ineffective, such as a failure to identify a risk of material misstatement in the annual accounts.
- There is an ineffective response to identified significant risks (for example, an absence of controls over such a risk).
- Previously issued financial statements have had to be reissued to correct a material misstatement due to error or fraud.[12]

24. However, developing and implementing an internal control is not cost-free and implementing increasing numbers of controls may not be helpful or sustainable. Consequently, there are balanced judgements to be struck. The challenge is to consolidate only the most suitable controls into systems and operations.

External auditors report their concerns about controls

25. Through their audit reports and plans, councils' external auditors flag concerns about councils' internal controls as a result, for example, of the trend in reduction of finance staff. Recurring weaknesses are becoming apparent with certain types of controls, particularly those relating to:

- information processing controls, such as for key financial systems
- performance reviews, such as making effective use of computer-generated reports that usefully highlight patterns and exceptions
- segregation of duties, including ensuring that a council officer cannot perform both Human Resources (HR) and payroll functions, and so create fictitious employees; and ensuring an officer cannot both make a purchase from a supplier and arrange the payment for it.

26. Case studies in Exhibit 3 (page 16) illustrate a range of situations where:

- controls worked well
- controls were weak, but problems were averted
- weak controls enabled a problem to occur, but corrective action was taken.

The failure of internal controls can cause numerous problems

Public money can be lost

27. Even where a council's controls are theoretically robust, risks can arise if they are implemented weakly (Case study 1). Controls need to be applied:

- consistently – by all relevant parts of the council and its various services
- responsively – in good time, such as when one part of the council relies on being supplied with information by another council function or service
- sustainably – without intermittent interruptions in their use.

Case study 1

Overpayments to current and former employees cost a council £21,000

Between April 2015 and February 2018, the council made over 800 salary overpayments totalling approximately £812,000 to a combination of actual and former employees. An eighth of former employees were still paid after leaving the council, usually due to a delay in a department notifying Payroll Services staff that someone had left. Six overpayments exceeded £10,000 and the highest was £15,500. At the time of the external audit, there were no documented procedures for preventing or recovering payroll overpayments. In March 2018, the council issued a Payroll Overpayment Process Guide, which outlined the steps to recover an overpayment of salaries/wages. In April 2018, in conjunction with HR, Payroll Services also issued procedural guidance to managers on avoiding salary overpayments. By March 2018, the council had:

- Recovered around £351,400 of overpayments, taking an average of 101 days, and written off £21,000.
- Recovered 58 per cent of overpayments from actual employees and 27 per cent from former employees.

Source: Audit Scotland

Exhibit 3

Control activity case studies

There are five categories of control activities.

Control activity	Controls worked well
Authorisation controls Officers handle only those processes and transactions that fall within the scope of their role. For example: • The purchasing manager evidences authorisation of a purchase requisition through their signature. • The head of HR reviews and signs off the payroll before payments are made to employees.	**Authorisation controls** Journal entries are raised and approved by different officers, as appropriate. Each journal entry is supported with back-up detail that enables the authoriser to know the journal entry is correct.
Physical controls Controls over access to files ensure that data is restricted to authorised users; and only changed if permitted. For example: • Buildings are secured by keycard locks. • Safes are locked routinely. • Fire and burglar alarms are maintained. • Access to computer servers is restricted.	**Physical controls** An officer's access rights to the council's IT network are automatically removed at midnight on the day s/he leaves the council. The system is linked to leaving dates held in the HR and payroll systems. The same process automatically removes access to third parties who have been granted temporary access to the council network. Additionally, inactive computer accounts are automatically disabled after 30 days.
Information processing controls Allow specific data to be processed in a specific way. For example: • Application Controls typically apply to the processing of specific types of transactions, such as invoicing customers or paying suppliers. • IT General Controls help ensure the secure, continuing operation of information systems.	**Information processing controls** The council purposely tolerates low reported levels of Blue (disabled parking) Badge misuse because pursuing the return of a badge when its holder dies could be insensitive. Instead, the council's Blue Badge team receives updates on deceased customers through the UK-wide 'Tell Us Once' scheme. A person's badge is cancelled through the national Blue Badge system and the local Parking Unit is informed.
Performance reviews Allow management to review information to highlight any exceptions. For example: • Senior officers regularly use computer-generated reports that show exceptions to normal patterns. • There are regular reviews of debtors. • Actual spend is compared to the original budget.	**Performance reviews** A comprehensive compliance system produces weekly reports on processing activity and accuracy. Reports detail trends in processing errors detected through the quality procedures in place and they report on bank amendment reviews. Reports are also reviewed monthly by the director and the head of accountancy. This approach allows senior management to identify issues with individuals; spot trends, and target staff training.
Segregation of duties Mitigates a risk that people could commit a fraud or error and conceal it. For example: • Access to payments and supplier accounts is controlled. • HR staff cannot also access the payroll function.	**Segregation of duties** The council introduced a new computer system that integrated the management of HR, payroll, and financial management functions. The risk of fraud was minimised by consulting internal audit at the design stage, and ensuring that officers could not access multiple parts of the computer system, and so arrange to create and pay a fictitious employee.

continued...

Exhibit 3 (continued)

Controls were weak, but problems were averted	Weak controls enabled a problem to occur
Authorisation controls Documents setting out the council's financial management and governance arrangements referred to superseded structures and roles. Differences between obsolete written procedures and the processes actually being followed meant that controls were weakened, or not fully complied with. The council brought its Scheme of Delegation into line with its revised structure and strengthened its related controls.	**Authorisation controls** The council approved a new Scheme of Governance including refreshed Financial Regulations. These required purchase orders to contain a contract reference number. Orders for £50,000 or over should be approved by an officer at Head of Service level or above. In one year, 117 orders for £50,000 or over were raised through the council's procurement system. Of these, 73 per cent had neither head of service nor committee approval because of weak application of the control.
Physical controls There was no formal communication process to ensure access to IT systems was removed promptly when an employee left the council. This generated a risk of fraud or manipulation of systems by former employees. Arrangements are now in place that automatically remove access rights to the council IT network at midnight on the day someone leaves the council. This is linked to leaving dates held by HR and the payroll system.	**Physical controls** Mobile telephones worth £5,400 were stolen from a council store. The door entry system's code was widely known among employees; fire exits were left open; and the phones were not recorded on the council's asset tagging system on delivery. An internal audit review introduced improved controls, including periodic changes to door entry codes, closing fire doors, regular physical checks of stock, and applying the council's asset tagging system.
Information processing controls Information from a third party suggested an adviser of a consortium delivering a project had falsified claim evidence. This consisted of emails about client activities, which the adviser could edit. Evidence of eligibility of benefits and identification was tampered with. The investigation by the internal audit section prevented payment on the ineligible claims. The adviser resigned. Controls and evidence standards have been tightened, and consortium supervisors have been trained about tampered evidence.	**Information processing controls** Confidential tax forms containing personal data on around 900 actual or former employees were sent to the wrong people. The council apologised to affected people, and reported the breach to the Information Commissioner's Office. The internal audit section found procedures had been in place, but human error had occurred. Remedial actions comprised revised procedures with additional quality assurance.
Performance reviews An exercise to check payroll data with service managers was two years old. Dated and incomplete checks risked undetected payroll errors. Personnel conducted a full verification exercise, but services responded on only 79 per cent of staff. The council further improved its verification of payroll data. Overall, overpayments are now a small percentage of the paybill and are pursued to ensure repayment.	**Performance reviews** An officer diverted £6,000 of school fund income, triggering an internal audit investigation. The fraud was possible because reconciliations and spot checks on accounts and cash balances were not made. The employee denied theft but admitted failing to bank school fund income. A report was made to the Procurator Fiscal. Regular checks and bank reconciliations, signed off by the headteacher, have been introduced by the council to deter a recurrence.
Segregation of duties Five council officers had access to both the HR and payroll areas of the council's computer system, potentially enabling them to create – and pay – a fictitious new employee. The council is undertaking a comprehensive review and implementing a new 'people manager module' to change some HR staff's access permissions to computer systems.	**Segregation of duties** A £1.1 million fraud spanning over five years was detected when year-end procedures found that an invoice for £7,000 lacked supporting evidence. A payment had been made to an officer who could insert fake invoices and suppliers' details. Internal audit and Police Scotland found fundamental control weaknesses. The officer was jailed for over five years. All but £19,000 is being recovered, and controls have been improved to help avoid further anomalous payments.

Source: Audit Scotland

Public money can be lost through corruption or fraud

28. Fraud and corruption can be perpetrated in various ways that can include, for example, fraud or corruption by a council officer or a councillor; a resident attempting to exploit a service; or a fraudster acting alone or in a wider plot. Councils' internal auditing functions routinely share intelligence on actual or potential frauds, enabling them quickly to review the suitability of their own controls. Some councils have teams of officers dedicated to counter-fraud work, and others rely primarily on officers within the internal audit section alone.

29. The National Fraud Initiative (NFI) is a UK-wide, counter-fraud exercise that is conducted every second year and is coordinated in Scotland by Audit Scotland. It uses computerised tools to compare information on people held by different public bodies and on different financial systems. The NFI identifies potential inconsistencies, called 'matches', that suggest potential fraud or error. Examples include matching council tax records to the electoral register, to spot unreported changes affecting a resident's eligibility for a council tax discount.

30. The most recent NFI exercise, on 2016/17, identified £18.6 million of 'outcomes' in Scotland including around £11.9 million among councils (Exhibit 4, page 19).[13] An NFI outcome describes the overall amounts for fraud, overpayments and error that are detected by the NFI exercise and an estimate of future losses that it prevents. Examples include housing benefits being stopped or reduced; council tax discounts being reduced or removed; and 'Blue Badges' for parking being stopped or flagged for future checks. High levels of outcomes could be due to increased fraud and error in the system, better detection of fraud and error or poor internal controls. Once an overpayment has been identified, a council can consider how to recover the money involved. The NFI also has an important deterrent effect that cannot be measured.

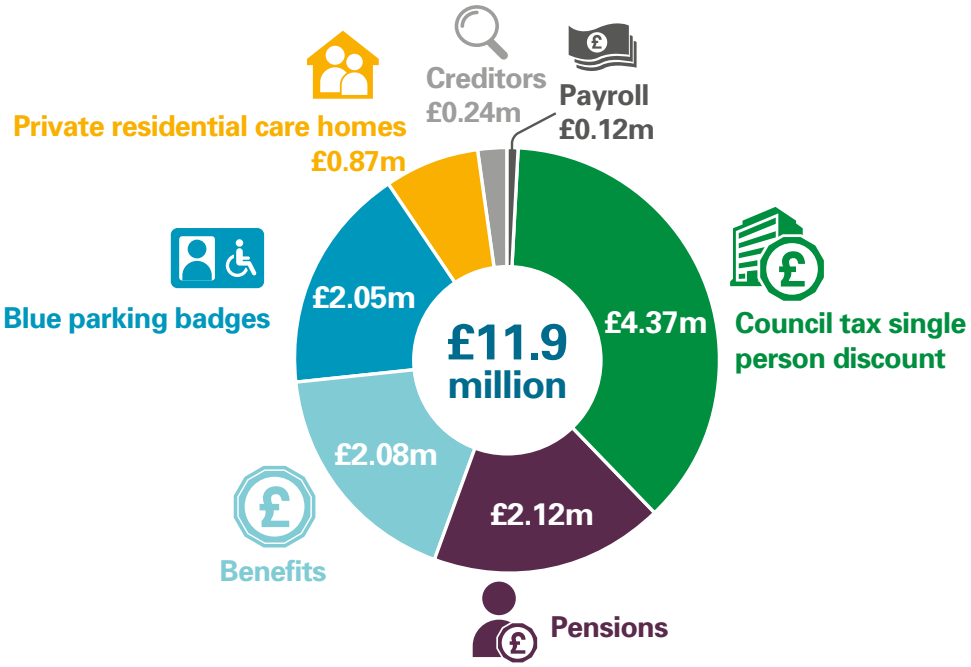
31. Most public bodies take advantage of opportunities provided by the NFI, and Audit Scotland disseminates information on instances of fraud in its quarterly technical bulletins. The frauds they cover have all been facilitated by people exploiting weaknesses in internal controls. Councils could use the NFI and these bulletins to consider promptly whether the same weaknesses apply in their own systems and what the necessary remedial actions may be for them.

32. Councils should ensure they have sufficient capacity in place to prevent frauds; investigate suspicious matches or other problems; and correct errors. It is more cost-effective to invest staff time in deterring or preventing fraud using good internal controls than to take remedial action afterwards. Investigating a fraud can cost a great deal of staff time and prosecuting a fraudster can incur substantial legal costs with no guarantee that the money lost will be recovered. It is for each council to decide how to organise, resource and pursue its fraud work.

Exhibit 4

The results of the 2016/17 National Fraud Initiative in Scottish councils

The NFI identified £11.9 million of 'outcomes' among councils.



These four aspects jointly accounted for 90 per cent of the NFI savings identified in councils

Council tax
People living on their own, or with no countable adults in the household, are eligible for a 25 per cent Single Person Discount.

Pensions
The NFI provides councils that administer pensions with an efficient and effective way of checking that they are paying the right pension to the right people; are not paying pensions to retirees who have died; and take account of people who retired but later returned to work.

Benefits
The NFI helps councils and the UK's Department for Work and Pensions to identify benefit frauds and errors – often caused by undeclared occupational pensions and undeclared public sector employment.

Blue parking badges
People with mobility problems can park for free in certain circumstances. Sometimes, a badge is used or renewed after the badge holder has died. Councils do not always try to recover a deceased person's badge to avoid distressing their family. But councils can ensure a badge is not renewed incorrectly.

These three aspects jointly accounted for ten per cent of the NFI savings identified in councils

Housing
This includes continuing to make payments to a care home for a resident after the person has died.

Creditors
The NFI helps to identify duplicate payments and ensure payments are made only to appropriate creditors.

Payroll
For example, legitimate employees may be in breach of their conditions of service or European Union working time limits; some employees could be working illegally in the UK; a council could inadvertently continue paying a former employee, or overpay a current employee.

Note: Some figures include late outcomes from the 2014/15 NFI work.
Source: Audit Scotland

Weak controls can have many other consequences

33. These can include an impact on:

- confidence in the council's integrity and reliability, including among residents, other public bodies and the council's business partners
- compliance with legislation and regulation, with the potential for costly and time-consuming legal action, such as on public liability matters
- the security of confidential financial, commercial and personal data
- the funding available for providing public services
- specific individuals – for example, if their confidential information is inadvertently published, or their personal safety is jeopardised
- additional external audit work.

Councils have duties to whistleblowers

Whistleblowing is about ensuring that if someone sees something wrong in their workplace, they are able to raise this within their organisation, to a regulator, or wider.

34. The Public Interest Disclosure Act protects employees and other workers who raise concerns about wrongdoing they believe is occurring. An employee must have a genuine and reasonable belief that the wrongdoing is taking place, and also that the disclosure is a matter in the public interest.[14] Where the statutory conditions are met, the employee should be protected from detrimental treatment. Every council should have a whistleblowing policy which complies with the legislation and the Whistleblowing Code of Practice.[15] A council that does not provide a safe whistleblowing route for its officers could discourage employees from raising legitimate concerns, and miss an opportunity to address a problem before it becomes a crisis.

Controls regarding cyber-security are increasingly important

35. Digital technology is becoming central to the way public services are delivered, with scope to improve and transform services and how users interact with public bodies. Citizens' expectations of public bodies' digital services are also rising. However, there is the potential for inadvertent data breaches, and also for malicious cyber-attacks to access and abuse sensitive information on a huge scale. Councils are required to meet high standards of information security and few serious issues have arisen among councils.[16, 17] Nonetheless, effective internal controls on access to information and its uses remain vital. If a council suffered a serious cyber-attack, the impact could be damaging, sustained, and include:

- interruptions to the provision of public services
- exposure of citizens' money and confidential data to theft and abuse
- financial damage to the council and its commercial partners
- costly remedial work to restore and re-secure computer systems.

Councillor checklist 2

Fraud and corruption

The following questions may help you to think about fraud and corruption in your council.

Is the answer Yes, Maybe/Partly, or No? Is action required? If so, what action and who by?

- Does the council have a fraud and corruption strategy for all its business, including its partnerships?
- Have cases of fraud and corruption been identified in each recent year?
- Have there been successful prosecutions for fraud or other criminal behaviour?
- Of the money lost to fraud/corruption, what percentage has been successfully recovered?
- Is the whistleblowing policy monitored for take-up; and are concerns acted upon?
- Are staff and other resources for fraud investigation proportionate to risks that the council faces?
- Are all allegations of fraud or corruption risk-assessed, and investigated accordingly?
- Are fraud alerts and good practice shared among council services in a timely way?
- Are there cost-effective measures for recovering money lost to fraud and corruption?
- Does the council actively take part in the National Fraud Initiative and act on its findings?
- Is comprehensive information on fraud and corruption reported to a relevant committee?
- Is there sufficient timely training and ongoing support for officers and councillors, including you?

Councillor checklist 3

Consequences of weak controls

The following questions may help you to think about how your council deals with weak controls.

Is the answer Yes, Maybe/Partly, or No? Is action required? If so, what action and who by?

- Which services have been most affected by weak controls, and why?
- Has internal auditing tracked, assessed and reported to a committee on weak controls' impacts?
- Have consequences of weak controls for ongoing service delivery been assessed?
- Could the council do more to anticipate longer-term risk trends, such as cyber-crime?
- Is there sufficient timely training and ongoing support for officers and councillors, including you?

Controls have practical limitations

36. Since a council constantly evolves, its officers need a programmed approach that updates existing controls and creates new ones as and when required. Internal controls operate within practical constraints, such as when the cost of introducing and enforcing a control would probably outweigh the impact of something going wrong (Exhibit 5).

37. The more senior an officer is, the more authority and opportunity s/he is likely to have for inappropriately overriding well-intentioned controls without being detected. However, the annual audit reports on the 2016/17 external audits of councils found no evidence of inappropriate management override of controls.

Exhibit 5

Internal controls

Numerous factors can limit the system of internal controls.

Relevance/obsolescence

Control-related activities or processes can become irrelevant over time as technologies and business needs change. Changes in key personnel could also cause a control to become obsolete.

Cost

Beyond a certain point, the cost of installing or improving a control could outweigh the benefits likely to be gained from applying it.

Collusion

Two or more officers work together to circumvent existing controls for their own purposes. If officers collude to perpetrate a fraud, typically by overriding management controls, it can be difficult for management to detect it.

Human error

There is always a risk of people making genuine mistakes, including in the operation of control activities themselves. The risk can be exacerbated by factors such as a lack of adequate motivation or training, time pressure, an adverse working environment, or excessive workloads.

Unusual or infrequent transactions

Control activities may be less suited to unusual and/or infrequent types of transactions.

Management override

Many processes have a facility to permit a management override function, so there is a risk that this facility could be abused; for example, by inflating reported figures to boost an officer's reputation.

Source: Financial Reporting Council

Councils' external auditors evaluate their internal controls annually

In determining whether the auditor has identified one or more deficiencies in internal control, the auditor may discuss the relevant facts and circumstances of their findings with the appropriate level of council management. This discussion provides an opportunity to alert management on a timely basis to deficiencies they may not have been aware of.[18]

38. International auditing standards require a council's external auditors to report significant deficiencies in internal controls to its audit committee, regardless of whether the deficiencies have been resolved by council management. This is part of the external auditor's responsibility for assessing the suitability and effectiveness of a council's corporate governance and it includes reporting on whether a council:

- has arrangements to ensure systems of internal control work effectively
- can demonstrate the effectiveness of budgetary controls in communicating accurate and timely financial performance information
- has established appropriate and effective arrangements for preventing and detecting fraud and corruption.[19]

39. Councils have sound, reliable systems of internal control that work well most of the time but can have weaknesses that could be damaging. It is in a council's interest to invest in internal controls that help reduce the risk of problems materialising and safeguard the resources it can devote to public services.

Part 3

Officers and councillors both have important roles

Councillors are ultimately accountable for councils' use of public money

Councillors and council officers have distinct but complementary roles

40. The full council (comprising all elected councillors) is the governing body of the council and determines the council's policy direction. It is ultimately responsible for ensuring that suitable services are delivered by officers. Councillors are elected to determine policy, and the role of officers is to implement these through day-to-day management of services. Officers advise and serve the whole council, and councillors have a right to expect officers to provide them with advice which is expert, impartial and candid.

41. In practice, councillors' responsibilities include:

- oversight of risk and the system of internal controls
- ensuring public money is spent on the council's intended purposes
- protecting public money from misuse, including fraud and corruption
- ensuring public spending is clearly accounted for, and publicly reported on
- scrutinising the council's operation and performance.

Culture and behaviours are important

42. A national code of conduct applies to all councillors. The Ethical Standards in Public Life etc (Scotland) Act 2000 introduced a framework which required Scottish ministers to issue a code of conduct for councillors. The latest version was introduced in July 2018 by the Standards Commission for Scotland. It sets out a range of principles that councillors must follow, including leadership, honesty, objectivity, stewardship and accountability.[20]

43. It is important that:

- full council, cabinet, committee and board meetings are held regularly
- there is trust between councillors and senior officers
- councillors and officers recognise and respect their distinct roles
- a culture of openness to challenge helps councillors and officers to recognise the importance of scrutiny; be open to candid discussions about risks and related controls; and promote this culture across the council and the partnerships it is involved in.

Scrutiny works best when officers provide councillors with timely, good-quality information

44. A council should be transparent about its decisions and the quality of the services it provides, so that the public and the council's partners can be confident it is making informed decisions; and safeguarding public money. This involves the council's leadership being open to scrutiny and accountable for their plans and performance. Every councillor – not just those who sit on the council's audit committee, scrutiny committee, or equivalent committees – has a valuable scrutiny role to play at corporate, local area and electoral ward levels.

45. Officers are responsible for providing committees with timely, good-quality reports that inform transparent decision-making by councillors. If a significant issue arises in a long gap between committee meetings, it may be helpful for officers to provide councillors with additional, intervening briefings on material developments. Similarly, councillors may need to be proactive in seeking out further information from officers to assure themselves that they have sufficient knowledge to hand before making a difficult decision.

46. Good councillor-officer working relationships are vitally important. It is mutually beneficial for councillors and officers, especially those in the corporate management team, to nurture constructive working relationships. Coalition and minority administrations are now more common and bring a different dimension to communication within councils. They may require a more nuanced approach that balances different political interests and involves compromises across party lines.[21]

The audit committee has an important role

47. This committee (or the equivalent committee that performs this role) provides the council with independent assurance on the adequacy of the council's governance arrangements; risk management framework; internal control system; and the integrity of financial and non-financial performance reporting.

48. An audit committee must have clear terms of reference that set out its members' independent role in scrutinising the council's decisions, performance and risks.[22] The Accounts Commission believes that effective, transparent scrutiny is best achieved when the chair of the committee is not a member of the administration. The chair should provide leadership and critical thinking, and work well with other committee members in scrutinising and challenging the council's work and performance. Committee members need the necessary skills and training to do their job, with ongoing support by officers and access to independent advice.

49. The core functions of an audit committee should include:

- Being satisfied that the council's annual governance statement properly reflects the risk environment and any actions required to improve it, and demonstrates how governance helps achieve the council's objectives.
- Considering the effectiveness of the council's risk management arrangements and its control environment.
- Considering the reports and recommendations of external audit and inspection agencies, along with their implications for governance, risk management or control.

- Reviewing the council's financial statements, the external auditor's opinions and reports to councillors.[23]

50. The audit committee's role in relation to internal audit is to:

- oversee its independence, objectivity, performance and professionalism
- support the effectiveness of its auditing processes
- promote its effective use within the council's assurance framework.[24]

Councillor checklist 4

Audit committee

The following questions may help you to think about the audit committee in your council.

Is the answer Yes, Maybe/Partly, or No? Is action required? If so, what action and who by?

- Do audit committee councillors have a clear remit that addresses the latest guidance by the Chartered Institute of Public Finance and Accountancy (CIPFA)?
- Does the chair of the committee manage committee meetings effectively?
- Does the chair routinely liaise with the head of internal audit before committee meetings?
- Do the committee's councillors attend routinely, prepare well and challenge officers appropriately?
- Does the committee approve internal audit's annual workplan and reports?
- Can internal audit report to senior officers and the audit committee without fear or favour?
- Do officers provide committee members with timely, well-written and useful reports?
- Do internal audit reports set out comprehensively and clearly what needs to improve, and how?
- Does the committee endorse and track improvements proposed by internal audit?
- Has the committee identified the top five risks to the council?
- Is there sufficient timely training and ongoing support for officers and councillors, including you?

Councillors should scrutinise risks from partnership working

51. Councils have extensive experience of working closely with diverse organisations. This includes delivering some services through the third and private sectors; and through arm's-length external organisations (ALEOs). It involves partnership working with other public sector bodies such as the NHS and community councils, which have a statutory basis in a council's partnership working too.

52. Changing models of service delivery are bringing more numerous and more complicated partnerships, collaborative ways of working and generating an increasingly complex governance and accountability landscape. On some issues, the centre of gravity in discussion and decision-making is moving away from councils themselves, yet councillors must remain sighted on their duties to their council and their council remains accountable to the local communities it serves.

53. It is therefore increasingly important that councillors and officers have an appropriate level of understanding of their roles and the necessary skills, and are alert to the potential for conflicts of interest. Councillors should expect officers to report to them on the activities, finances and performance of each partnership in achieving its intended outcomes.

Community Planning Partnership

54. Community planning is the process by which councils and other public bodies work with local communities, businesses and voluntary groups to plan and deliver better services and improve the lives of residents. The process is led by 32 Community Planning Partnerships (CPPs), each covering a council's geographical area. Governance and accountability arrangements in CPPs are complex given the range of partners involved, all of whom are accountable to different bodies and are not formally accountable to the CPP board.[25] The Local Government in Scotland Act 2003 provided the initial statutory basis for community planning.[26] It aimed to:

- enable public bodies to work together to deal with complex, long-term challenges that a single organisation cannot deal with, for example inequalities in health, employability and levels of crime
- involve local communities more in decisions that affect people's lives.[27]

Community Planning Partnership (CPP)

A statutory forum for the council, NHS and other public and third sector bodies, such as charities and voluntary groups, to work with local communities to plan and deliver better services.

55. The Community Empowerment (Scotland) Act 2015 introduced new statutory duties for community planning alongside other changes intended to give local people more say in how public services are planned and run.[28] The Scottish Government's statutory guidance on community planning places local communities at the heart of public service delivery and clarifies expectations of CPPs.

56. The act compelled councils to work with their statutory community planning partners to produce a jointly owned Local Outcome Improvement Plan (LOIP). A CPP's board is required to ensure its LOIP focuses on achieving priority outcomes for residents. The act also required each CPP to produce individual Locality Plans for specific communities within the CPP's wider geographical area. These are to reflect the views of local communities; focus on addressing local needs; reduce inequalities; and improve outcomes for a locality's residents. An important function of the CPP's board is to share ownership of the LOIP and Locality Plan(s) and manage their implementation.

57. In making tough choices about spending their budgets, councils and their CPP partners should liaise with communities about the sustained impact of decreasing council spending on public services and any opportunities for improving services.[29] Slow progress or insufficient scrutiny of progress by councillors could risk CPP partners, including the council, falling short of their strategic ambitions and adversely affect the public.

58. Having sound controls within the council for community planning matters will reinforce transparent decision-making and support scrutiny of councils by the public. For its part, the council needs suitable internal controls for managing the risks that it may be exposed to. There are particular risk and control issues associated with community asset transfers, in which communities choose to take responsibility for specific land and buildings from the council. Well-intended residents may lack the council's expertise in financial management, property management and service delivery. The council therefore has a responsibility to conduct due diligence work on the community organisation that would assume responsibility for any transferred asset.

Health and social care integration

59. The Public Bodies (Joint Working) (Scotland) Act 2014 aims to ensure that health and social care services are well integrated, so that people receive the care they need at the right time and in the right setting. The reforms affect everyone who receives, delivers and plans health and care services in Scotland. The Act was intended to help shift resources away from the acute hospital system towards preventative and community-based services. However, there is still a lack of agreement about whether this is achievable in practice.

60. The act requires councils and NHS boards to collaborate in new partnerships, known as Integration Authorities (IAs). The size of IAs varies depending on council boundaries. NHS boards have between one and six IAs within their boundary.[30] Of the 31 IAs in Scotland, 30 are Integration Joint Boards (IJBs) and in Highland the NHS board and council each lead integrated services. Clackmannanshire and Stirling councils have created a single IA with NHS Forth Valley. A report produced by Audit Scotland in November 2018 found that:

- numerous IAs have had leadership changes in the past few years
- there is significant variation in the role and remuneration of IAs' chief officers (COs) and chief financial officers (CFOs)
- there is evidence of a lack of support services for IAs, in relation to HR, finance, legal advice, improvement, and strategic commissioning. This will limit the progress that they are able to make
- cultural differences between partner organisations are proving to be a barrier to achieving collaborative working.[31]

61. An IJB is a separate legal entity that is responsible for strategic planning and commissioning of health and social care services across a partnership's area. Membership of the IJB comprises a mix of voting and non-voting members. It includes elected members from the council; non-executive directors from the NHS; and representatives from service users, carers and the voluntary sector. The IJB must appoint a chief officer and finance officer (who may also be chief officer).

Integration authority (IA)

A partnership between a council and the NHS to ensure health and social care services are well integrated, so that people receive the care they need at the right time and in the right setting.

Integration Joint Board (IJB)

A separate legal entity, responsible for strategic planning and commissioning of the wide range of health and social care services across the partnership's geographical area.

A short guide to the integration of health and social care services in Scotland April 2018

Health and social care integration – update on progress November 2018

62. A council and NHS board delegate budgets to the IJB, which decides how to use this funding to achieve its objectives. The IJB directs the NHS board and council to deliver public services. In 2017/18, IAs directed £8.9 billion of health and social care resources. IJBs directed £8.3 billion of this, money previously managed separately by councils and NHS boards. In total, 29 per cent (£2.4 billion) of IJB funding was allocated from councils and £5.9 billion (71 per cent) from the NHS.[32]

63. The scale and complexity of ongoing organisational change; significant financial and demographic pressures; and the level of resources involved make it imperative that councils, NHS boards and IAs have rigorous systems of risk management and internal control. It is important that risk management and assurance arrangements apply across IAs and their health and social care partners so that risks from delegated services are regularly monitored.

64. With partnership working increasing in scope and complexity, the corresponding nature of evolving controls may itself pose a risk to effective oversight and scrutiny by councillors and a council's senior officers. A councillor who sits on an IJB needs to be clear about the expectations of their role and alert to scope for conflicts of interest between their council and its partners.

Arm's-length external organisations

65. These organisations (ALEOs) have been established by many councils to deliver services traditionally provided by a council itself, such as leisure centres and parks. Councillors have a leadership role in the options appraisal process that makes the case for establishing an ALEO at the outset. For example:

- Have officers provided councillors with all the information they need to make informed decisions about risks and benefits?
- Is the risk of failure so high that risks are better managed in-house?
- Are the likely benefits of options other than ALEOs outweighed by their implementation costs?
- Are there opportunities to share risks and benefits with partner bodies?[33]

Arm's-length external organisation (ALEO)

A separate organisation that is established by a council to provide services on its behalf.

Councils' use of arm's-length organisations May 2018

66. ALEOs can bring financial and operational benefits, with more potential for innovation but also considerable risks. Once an ALEO is operating, councillors need to oversee its financial and service performance; financial sustainability; associated risks; and seek assurance from council officers that suitable controls are in place for managing these risks. Risks include a potential conflict of interest where a councillor sits on an ALEO's board, especially should it encounter financial difficulties.

67. Oversight, accountability and good management are essential. In managing their links with ALEOs, councils should continue to apply the statutory code of practice on Following the Public Pound and annually review the governance arrangements for its links with major ALEOs.[34] It is also councillors' responsibility to decide whether an ALEO remains the optimum way of providing a service or whether there are other valid options, such as bringing a service back in-house.

City region and growth deals

68. These are agreements between the UK Government, Scottish Government, and councils' other regional partners. They are intended to help deliver long-term strategies that improve regional economies. Each deal is specific to its region and can include measures relating to issues such as housing, transport, infrastructure and culture. They provide regions with the opportunity to set their own priorities and decide where to target investment, through programmes agreed among a deal's partners. In return, the UK Government and Scottish Government contribute funding for Scotland's six City Region deals (Exhibit 6). Deals differ in their stage of development and funding arrangements.

City region deal
An agreement between the UK Government, Scottish Government and one or more councils to invest in cities and their regions.

69. Some councils participating in city region or growth deals may risk gaps between their income and spending in future years, which could threaten their financial sustainability if risks are not managed carefully. So it is important for councillors to:

- ensure their council has clear, effective governance arrangements that underpin partnership working with other organisations in the deal – whether they are in the public, private or third sectors
- ensure council officers are managing suitable internal controls that help to identify and manage risk
- scrutinise the impact of borrowing on their council's revenue expenditure commitments, such as the costs and durations of loan repayments.

Exhibit 6

City region deals and growth deals
There are deals across Scotland.

Geography	Deal type	Participating Scottish councils
Aberdeen City	City region deal	Aberdeen City, Aberdeenshire
Argyll and Bute	Growth deal	Argyll and Bute
Ayrshire	Growth deal	East Ayrshire, North Ayrshire, South Ayrshire
Borderlands	Growth deal	Dumfries and Galloway, Scottish Borders
Edinburgh and South-East Scotland	City region deal	East Lothian, City of Edinburgh, Fife, Midlothian, Scottish Borders, West Lothian
Falkirk	Growth deal	Falkirk
Glasgow City	City region deal	East Dunbartonshire, East Renfrewshire, Glasgow City, Inverclyde, North Lanarkshire, Renfrewshire, South Lanarkshire, West Dunbartonshire
Inverness and Highland	City region deal	Highland
Islands	Growth deal	Eilean Siar (Western Isles), Orkney, Shetland
Moray	Growth deal	Moray
Stirling and Clackmannanshire	City region deal	Clackmannanshire, Stirling
Tay Cities	City region deal	Angus, Dundee City, Fife, Perth and Kinross

Note: Fife Council and Scottish Borders Council are each involved in two deals. Three English councils are also involved in the Borderlands growth deal: Carlisle City Council, Cumbria County Council and Northumberland County Council.
Source: Scottish Government, City region deals, Growth deals

Councillor checklist 5

Partnership working

The following questions may help you to think about partnership working in your council.

Is the answer Yes, Maybe/Partly, or No? Is action required? If so, what action and who by?

- Do the council's governance and internal controls mitigate partnerships' risks to the council?
- Does the council have risk registers concerning its various partnerships?
- What resources (such as staff, buildings and money) does the council contribute to partnerships?
- Does each partnership have a clear purpose and explicit, outcome-based objectives?
- Are governance arrangements for each partnership clear, documented and fit for purpose?
- Does the council apply the code of practice on 'Following the Public Pound' to each arm's-length external organisation?
- Does the council have sound reasons for having a representative on a partnership's board?
- If you sit on a partnership's board, do you appreciate what is required of you and the linked risks?
- Is there good-quality, transparent and publicly accessible performance information?
- Are concerns about risks posed by partnerships escalated suitably within the council?
- Is there sufficient timely training and ongoing support for officers and councillors, including you?

Councils need to invest in councillors' personal development

70. One of the Accounts Commission's strategic audit priorities is that councillors and officers have the right knowledge, skills and support to design, develop and deliver effective services in the future.[35] The Scottish public has high expectations of councillors and officers and how well they should conduct themselves in undertaking their council duties. They should meet those expectations by ensuring that their conduct is consistently above reproach.[36] The Accounts Commission has published a number of reports that could be useful to councillors, including:

- *Roles and working relationships: are you getting it right?*, 2010; and *Follow-up messages for councils* in 2016.
- *Arm's-length external organisations (ALEOs): are you getting it right?*, 2011.
- *Social work in Scotland*, September 2016.

71. Following a local government election, a good induction process is valuable for all councillors. Some councillors may need additional, tailored support on a specific topic or skill, such as their role on an audit committee or planning committee; their position as a board member of an IJB or ALEO; the type of finance involved; or the potential impact of a decision on a group of service clients.

72. Councillors need sustained, ongoing continuing professional development (CPD) that builds on their knowledge and experience; is tailored to their roles; and relates to the expertise they need for making transparent, defensible decisions about safeguarding public money. Long-serving councillors can also benefit from investing time and effort in their ongoing CPD, not least because technology, the council's operating environment, its financial situation and the risks it faces all evolve constantly. Councillors should be involved in developing their council's CPD programme so that it best meets their future needs.

Councillor checklist 6

Councillors' continuing personal development

The following questions may help you to think about the personal development opportunities in your council.

Is the answer Yes, Maybe/Partly, or No? Is action required? If so, what action and who by?

- After the last election, was the general induction programme for councillors successful?
- Do officers give you good support on knowledge topics (such as internal controls)?
- Do officers give you good support on personal skills (such as chairing meetings)?
- Do you fully understand your roles and duties at council, cabinet, committee and ward levels?
- Have you made good use of the Improvement Service's support and publications?
- Do you have a personalised CPD programme?
- Do you actively participate in, and benefit from, the support made available to you?
- Do officers monitor and understand councillors' take-up of training and development?
- Where you do not engage fully in training and development, how could officers help more?
- Does CPD for councillors help you to be effective in your governance and scrutiny roles?

Officers are responsible for delivering council policy and managing services

73. Each council must have these four 'statutory officers', who all have specific duties and discharge their role as part of their wider responsibilities in the council:

- Head of paid service[37]
- Chief financial officer[38]
- Monitoring officer[39]
- Chief social work officer.[40]

74. These officers have an important, independent role in promoting and enforcing good governance; ensuring councils comply with legislation; overseeing the council's key controls; managing risk, and ensuring the delivery of council services. Statutory officers must have sufficient influence and experience to undertake their roles. Cohesive, effective corporate management depends on postholders in these roles having the necessary status and capacity within their council.

75. To ensure that councillors are clear on the purpose of these roles, a council's scheme(s) of delegation should set out what they involve and why they are important. The role of statutory officers should feature in induction schemes for all newly elected councillors. Councillors and committees should know when to seek assurance from these officers so that their council operates legally and responsibly.[41]

Head of paid service

76. This officer, usually called the chief executive, is responsible to councillors for the staffing and smooth running of the council and for ensuring the work of its various services is coordinated. S/he must ensure the other statutory officers have sufficient influence and scope to conduct their roles. For example, this could mean them being in, or attending, the corporate management team.

77. Councillors and the chief executive may need to balance the benefits of including all statutory officers as full members of the corporate management team against the potential merits of a slimmer, potentially cheaper, management structure – but one that may risk appearing to devalue the role of certain officers or complicate lines of communication among officers and councillors.

78. The chief executive has a complex, multi-faceted role that blends relatively clear accountability to councillors for the operational management of the workforce and service delivery with an important involvement in diverse partnership working over which s/he will have influence but perhaps limited direct authority. This situation provides some context to the council's need for a dynamic, evolving approach to risk management and the linked controls which are necessary.

Chief financial officer

79. The chief financial officer (CFO) has a key role to play in balancing control and compliance with value creation and performance. Better value for money releases resources that can be recycled into higher priorities without increasing taxation. Helping to secure positive social outcomes within affordable funding therefore lies at the heart of the CFO's role.[42]

80. The CFO (often called the Section 95 or s95 officer) underpins sound corporate management and ideally sits on the corporate management team. To deliver on their responsibilities, the CFO must manage a finance function that is sufficiently resourced and professionally qualified (Exhibit 7).

Exhibit 7

The role of the chief financial officer

The postholder is responsible for the proper administration of the council's finances.

In a public service organisation
the chief financial officer:

is a key member of the leadership team, helping it to develop and implement strategy and to resource and deliver the authority's strategic objectives sustainably and in the public interest.

must be actively involved in, and able to bring influence to bear on, all material business decisions to ensure immediate and longer-term implications, opportunities and risks are fully considered, and alignment with the authority's financial strategy.

must lead the promotion and delivery by the whole authority of good financial management so that public money is safeguarded always and used appropriately, economically, efficiently and effectively.

To deliver these responsibilities
the chief financial officer:

must lead and direct a finance function that is resourced to be fit for purpose.

must be professionally qualified and suitably experienced.

Source: Chartered Institute of Public Finance and Accountancy

81. The Local Authority Accounts (Scotland) Regulations 2014 impose responsibilities on the CFO about accounting records and supporting information; control systems; and annual accounts – which, in Scotland, include the financial statements and annual governance statement.[43] Also, the CFO needs to assure themself and councillors that decisions made by the council will be affordable. In practice, many of the CFO's day-to-day responsibilities are delegated or outsourced but the CFO should retain oversight and overall control, and have sufficient access to the corporate management team.

82. The CFO helps to safeguard public money by:

- Applying strong controls in all areas of financial management, risk management and asset control.
- Implementing effective systems of internal control that include standing financial instructions, operating manuals, and compliance with codes of practice to secure probity.
- Ensuring that the council has effective arrangements for internal auditing of the control environment and systems of internal control, as required by professional standards in line with CIPFA's Code of Practice on Local Authority Accounting in the United Kingdom.[44]
- Promoting arrangements to identify and manage key business risks, including safeguarding assets, risk mitigation and insurance.
- Applying discipline in financial management, including appropriate segregation of duties.
- Implementing suitable measures to prevent and detect fraud and corruption.
- Ensuring that any partnership arrangements are underpinned by clear and well-documented internal controls.[45]

Monitoring officer

83. In essence, the monitoring officer (MO) ensures that the council operates properly. Their work includes reporting on the legality of matters; on potential maladministration; and the conduct of councillors and officers. The MO should contribute to the promotion and maintenance of high standards of conduct by providing advice and support to councillors on the interpretation and application of the Councillors' Code of Conduct.[46] Councillors and senior officers should send clear signals to the workforce about how people should behave and interact.

84. The Accounts Commission has found through its Best Value work that in some cases the MO role can be undermined because of a lack of trust and respect between councillors and officers.[47] It may be difficult for the MO to challenge the behaviours of senior officers or councillors. The MO might need to judge carefully both how to act and when, since intercepting potential problems quickly can help prevent, deter or resolve unhelpful behaviour before they become more serious.[48]

Chief social work officer

85. This officer (CSWO) must be a qualified social worker; registered with the Scottish Social Services Council; and of sufficient seniority and experience in both the strategic and operational management of social work services.[49] Often, a CSWO is also responsible for the delivery of services such as adult social care, children's services or criminal justice social work. The CSWO provides officers and councillors with professional advice on social work and social care services, and discharges specific duties on the council's behalf.[50, 51, 52]

86. The CSWO's role has diversified significantly in recent years, and is becoming more difficult to fulfil within integrated partnership arrangements. A council's partnership with the NHS is typically through an Integration Joint Board which oversees the delivery of integrated health and social care services, and carries risks that include financial matters and risks to the health and wellbeing of service clients. In health and social care, an important control can be oversight of permission to access information on vulnerable people, and in which circumstances. Such risks require corresponding internal controls within the council. Councillors need to ensure that the CSWO has the status, capacity and access (to other statutory officers and councillors) to enable them to fulfil their statutory responsibilities to the council effectively.

Chief education officer

87. There is currently no legal requirement for councils to have a post named the chief education officer because the relevant legislation has not been implemented.[53] Nonetheless, many councils have an officer who is their lead officer for their education service, called the director of education or similar, either as part of the corporate management team or perhaps at a lower level where large departments span multiple services.

88. With education typically accounting for a large share of a council's expenditure, it is important for the head of the education service to not only have a strong professional knowledge of education but also a solid understanding of financial management; to liaise closely with the corporate finance function; and have oversight of the large share of the service's budget that is delegated to individual schools.

89. In addition, some Scottish Government funding streams are outwith the core local government finance settlement and are allocated to councils for specific purposes. For example, the Scottish Government's budget for 2019/20 includes £62.0 million of Attainment Scotland Fund to provide councils and schools with additional means to provide targeted literacy, numeracy, and health and wellbeing support for children and young people in greatest need.[54]

90. The chief education officer has responsibility for the education service having rigorous internal controls. These could include processes for ensuring that changes in staffing are passed quickly and accurately to the corporate payroll function, and that schools operate within the education service's scheme of devolved school management. Should controls at school or service-level go awry and result in money being defrauded or misspent, there is the potential for substantial consequences for numerous schoolchildren; shortfalls in compliance with national requirements; and reduced funds available for spending by other council services.

Officers who manage a service need to understand its inherent risks

91. Officers require a thorough understanding of how a service is provided; what its costs are; who the service users and other stakeholders are; and exercise ownership of the internal controls that regulate business management of the service and its associated risks.

92. Depending on their role and position in the council, officers may need a suitable level of understanding of finance, risks and controls. Council services need a joined-up approach both vertically – so that an individual service and overall corporate management share the same perspective on risk – and horizontally – so that different services across the council follow the same overall approach to risk.

93. However, there are indications from the independent external audit of councils that incremental budget cuts over successive years, combined with recruitment challenges, may have eroded the capacity of councils' back-office functions – including aspects such as financial management and risk management. This could make financial management riskier and underline the importance of sound controls being in place to contain and manage these risks.

Councillor checklist 7

Statutory officers and chief education officer

The following questions may help you think about the statutory officers and chief education officer.

Is the answer Yes, Maybe/Partly, or No? Is action required? If so, what action and who by?

- Are the roles of these officers clearly set out in the council's governance documents?
- Do these officers sit on the corporate management team, or have ready access to it?
- Are these officers sufficiently resourced to discharge their roles and responsibilities?
- Do these officers have the influence needed for ensuring the council operates effectively?
- Do councillors and committees understand how and when to consult these officers?
- Do these officers give helpful, timely, impartial support to councillors and other officers?
- Do these officers have a constructive relationship with the senior management team?
- Do you have confidence in your council's key officers?
- Is there sufficient timely training and ongoing support for officers and councillors, including you?

Internal auditing helps evaluate and improve how well things work

Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps a council to accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.[55]

94. Audit and scrutiny are both important, but their distinction can be unclear. Generally, scrutiny asks whether the council is doing the right thing, and it questions policy proposals and the performance and quality of services. Audit examines the regularity of governance and financial management, including how well the council has applied its resources to achieve its objectives.

95. Accounting regulations compel councils to operate a professional and objective internal auditing service.[56] The service brings a valuable, independent scrutiny activity. Its remit can extend beyond the council to scrutiny of the council's involvement in partnerships and alternative service delivery models, such as ALEOs. The CFO must secure and support internal auditing arrangements and ensure that the council's audit committee (or the committee with this role) receives the advice and information necessary for both functions to operate effectively.[57] There are four main types of internal auditing work (Exhibit 8, page 39).

96. Key features are that internal auditing:

- operates independently of the day-to-day running of the council
- provides a service to all levels of the council
- objectively assesses operations' effectiveness, efficiency and value for money
- forms an integral part of the framework of business controls.

97. It is important for the officer who leads the internal auditing function to have unrestricted, 'open door' access to the chief executive. This enables internal auditing staff to bring problems directly to the attention of the council's most senior officer, if necessary. In addition, the arrangement equips the chief executive with objective, independent information on the operation of the council and an early warning system regarding potentially serious issues. However, it is not necessary for the chief executive to be the line manager of the head of internal auditing.

98. Internal and external audit have different but complementary roles. A council's external auditor is appointed by the Accounts Commission and is wholly independent of the council. By contrast, a council appoints its own internal auditing function, which may be provided by:

- An in-house function serving one council – which is still the norm.
- An in-house function serving two or more councils – Aberdeen City and Aberdeenshire; Clackmannanshire and Falkirk; Midlothian and Scottish Borders.
- Co-sourcing – where an in-house team is supplemented by a private firm.

- A private firm appointed by the council – no Scottish councils at present.
- In addition to these arrangements, Glasgow City Council provides services to several organisations.

Exhibit 8

Types of internal auditing work

The work helps to safeguard public money, as illustrated by this sample of scenarios.

Type	Explanation	Scenario
Systems 	This is the review and evaluation of the manual and computer systems by which an organisation regulates and controls its activities. The internal audit section would evaluate the design of controls to conclude on their effectiveness and efficiency; and test their application to ensure users have been following procedures as intended.	Internal audit reported to the audit committee before, during and after a major new computer system was introduced to integrate previously disjointed systems. This approach gave assurance on the new computer system's controls from an early stage.
Contracts 	This can involve a review of any area of activity regarding a high-value and potentially high-risk contract, such as for care-at-home services or the construction of a new building.	Internal audit reported to the audit committee on the council's compliance with legislation; national guidance; council policy and internal controls regarding the procedure of a new nursery school.
Investigations 	Internal audit can be called on to investigate internal or external fraud, operational losses, breaches of security, or where customers have raised serious concerns with senior management. Other investigation work includes due diligence assessments.	Internal audit supplemented its annual summary report on fraud to the audit committee with a report that focused on a serious case of corruption. Internal audit recommended the upgrading of preventative controls in future.
Regularity or compliance 	Inspection is the continuous, periodic examination of procedures and transactions to ensure they comply with an established set of instructions. This type of internal auditing does not necessarily consider the appropriateness of procedures, simply that they are followed.	Internal audit reported to the audit committee on the system for paying grants to local community bodies, including the extent to which claimants and officers followed proper procedures and claimants submitted valid or falsified evidence. Internal audit identified scope for strengthening controls in future.

Source: Audit Scotland, Financial Reporting Council

99. Internal auditing is an important link in a council's system of internal control. The purpose, authority and responsibility of internal auditing may be defined in its Audit Charter.[58] It must provide an annual opinion on the state of the council's arrangements in relation to governance, risk management and internal control. It may also carry out advisory and consulting work, where the aim is to support management in improving systems and controls.

100. Internal auditors in the public sector follow the Public Sector Internal Audit Standards (PSIAS), which have been mandatory since 2013. The scope and volume of internal auditing activity in a council is a matter for its management and those responsible for its governance.[59] However, the PSIAS require that the head of internal auditing communicates its plans and resource requirements, including significant interim changes, to senior management for review and approval. A council must assess the efficiency and effectiveness of its internal auditing service, and the findings should be considered by the audit committee as part of its annual review of internal controls.

101. The head of internal auditing must communicate the impact of resource limitations. Where s/he believes that the level of agreed resources will impact adversely on the provision of the annual internal audit opinion, the consequences must be brought to the attention of 'the board' – which, in a council, is normally the audit committee or its equivalent (Exhibit 9).

Exhibit 9

Recommended audit committee practice for effective internal audit oversight.

The audit committee has a range of responsibilities
Take responsibility for the provision of internal audit, including how it is provided.
Assess and approve the internal audit charter (terms of reference) and review it regularly.
Ensure a close working relationship with the head of internal audit.
Assess the resourcing of the internal audit function.
Monitor the quality of internal audit work, whether in-house or externally sourced.
Evaluate, approve and regularly review the risk-based annual internal audit plan.
Oversee the relationship between internal audit and centralised, corporate risk monitoring.
Ensure the collective assurance roles of internal audit, other internal assurance providers and external audit, are coordinated and optimised.
Assess internal audit findings and the breadth and depth of internal audit reports.
Monitor management's implementation of internal audit's recommendations.

Source: CIPFA and others

102. The internal auditing function can find itself operating in a challenging organisational environment. It is vital for it to be independent of activities it examines, so that it can give impartial, unbiased judgements to councillors. However, there are benefits from internal auditing advising on building in suitable systems and controls at a project's outset. There are risks that internal auditing:

- lacks the staffing capacity it needs – in the context of councils becoming more complex and especially in small or remote councils, where staff recruitment and retention may be more challenging
- lacks a credible voice in the council – perhaps through the head of internal auditing not being able to express concerns directly to the chief executive or audit committee, or in an organisational culture reluctant to hear bad news
- lacks impact when it escalates its concerns – such as when high priority recommendations are not being implemented wholly and promptly.

103. External and internal auditors liaise on their respective audit roles. The external auditor considers the extent to which s/he can rely on the work of internal audit. This cooperation aims to promote good working relationships, and to minimise unnecessary duplication of effort.

Councillor checklist 8

Internal auditing function

The following questions may help you to think about internal auditing in your council.

Is the answer Yes, Maybe/Partly, or No? Is action required? If so, what action and who by?

- Does internal auditing (IA) follow Public Sector Internal Audit Standards and other reputable guidance?
- Is IA objective; free from undue influence; and independent in its thinking, work and reports?
- Is IA suitably located in the council's structure?
- Is IA sufficiently resourced to recruit, retain and develop the staff it requires?
- Is IA free of operational responsibilities that could risk compromising its independence?
- Is IA's work aligned with the council's strategies, objectives and risks?
- Does IA give senior officers and councillors clear, timely, objective, risk-based assurance?
- Does the head of IA have unrestricted access to the chief executive?
- Does the head of IA give committees the information they need to make informed decisions?
- Is there sufficient timely training and ongoing support for officers and councillors, including you?

Endnotes

1 *Local government in Scotland: Financial overview 2017/18*, Accounts Commission, November 2018.

2 Councillors' roles, conduct and pay, Scottish Government website.

3 *How councils work: Roles and working relationships in councils: are you still getting it right?*, Accounts Commission, November 2016.

4 *Public sector internal audit standards*, CIPFA, Scottish Government and other bodies, March 2017.

5 *International Standard on Auditing (UK and Ireland) 315* Financial Reporting Council, June 2016.

6 Local Authority Accounts (Scotland) Regulations 2014, October 2014.

7 *Delivering good governance in local government*, CIPFA, April 2016.

8 *Risk and resilience: Tools for officers and members with governance and scrutiny responsibilities to help them tackle major change*, Centre for Public Scrutiny, September 2016.

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10 *Risk and resilience: Tools for officers and members with governance and scrutiny responsibilities to help them tackle major change*, Centre for Public Scrutiny, September 2016.

11 *Local government in Scotland: Financial overview 2017/18*, Accounts Commission, November 2018.

12 *International Standard on Auditing (UK) 265*, Financial Reporting Council, June 2016.

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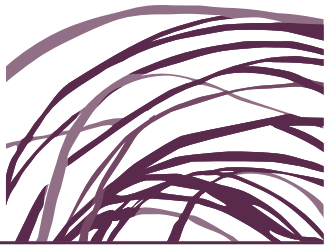
Appendix

Summary of checklists for councillors



The following questions may help you to think about internal controls and risk management in your council.

Is the answer Yes, Maybe/Partly, or No? Is action required? If so, what action and who by?

Checklist 1. Internal controls and risk management

- Do internal controls link with key corporate and service-level risks?
- Do internal controls apply to both financial and non-financial risks?
- Has the council identified the weakest internal controls?
- Are officers improving weak internal controls and minimising the risks they pose?
- Does internal auditing evaluate controls' effectiveness, and report to the audit committee?
- Does the audit committee take appropriate action?
- Does the council publicly review its system of internal controls annually?
- Is risk management actively led, supported and promoted by councillors and senior officers?
- Does the council have an up-to-date, corporate-level, risk management strategy?
- Does the corporate risk management strategy address the council's risk appetite?
- Does the council have up-to-date corporate-level and service-related risk registers?
- Is risk management embedded in business practices at both corporate and service levels?
- Does systematic evaluation and prioritisation of risks and opportunities lead to timely action?
- Are key risks and action to mitigate them monitored and reported on throughout the year?
- Do officers' reports to committees cover both financial and non-financial risks?
- Is there sufficient, timely training and ongoing support for you and relevant officers?

Checklist 2. Fraud and corruption

- Does the council have a fraud and corruption strategy for all its business, including its partnerships?
- Have cases of fraud and corruption been identified in each recent year?
- Have there been successful prosecutions for fraud or other criminal behaviour?
- Of the money lost to fraud/corruption, what percentage has been successfully recovered?
- Is the whistleblowing policy monitored for take-up; and are concerns acted upon?
- Are staff and other resources for fraud investigation proportionate to risks that the council faces?
- Are all allegations of fraud or corruption risk-assessed, and investigated accordingly?
- Are fraud alerts and good practice shared among council services in a timely way?
- Are there cost-effective measures for recovering money lost to fraud and corruption?
- Does the council actively take part in the National Fraud Initiative and act on its findings?
- Is comprehensive information on fraud and corruption reported to a relevant committee?
- Is there sufficient timely training and ongoing support for officers and councillors, including you?

Checklist 3. Consequences of weak controls

- Which services have been most affected by weak controls, and why?
- Has internal auditing tracked, assessed and reported to a committee on weak controls' impacts?
- Have consequences of weak controls for ongoing service delivery been assessed?
- Could the council do more to anticipate longer-term risk trends, such as cyber-crime?
- Is there sufficient timely training and ongoing support for officers and councillors, including you?

Checklist 4. Audit committee

- Do audit committee councillors have a clear remit that addresses the latest guidance by the Chartered Institute of Public Finance and Accountancy (CIPFA)?
- Does the chair of the committee manage committee meetings effectively?
- Does the chair routinely liaise with the head of internal audit before committee meetings?
- Do the committee's councillors attend routinely, prepare well and challenge officers appropriately?
- Does the committee approve internal audit's annual workplan and reports?
- Can internal audit report to senior officers and the audit committee without fear or favour?
- Do officers provide committee members with timely, well-written and useful reports?
- Do internal audit reports set out comprehensively and clearly what needs to improve, and how?
- Does the committee endorse and track improvements proposed by internal auditing?
- Has the committee identified the top five risks to the council?
- Is there sufficient timely training and ongoing support for officers and councillors, including you?

Checklist 5. Partnership working

- Do the council's governance and internal controls mitigate partnerships' risks to the council?
- Does the council have risk registers concerning its various partnerships?
- What resources (such as staff, buildings and money) does the council contribute to partnerships?
- Does each partnership have a clear purpose and explicit, outcome-based objectives?
- Are governance arrangements for each partnership clear, documented and fit for purpose?
- Does the council apply the code of practice on 'Following the Public Pound' to each arm's-length external organisation?
- Does the council have sound reasons for having a representative on a partnership's board?
- If you sit on a partnership's board, do you appreciate what is required of you and the linked risks?
- Is there good-quality, transparent and publicly accessible performance information?
- Are concerns about risks posed by partnerships escalated suitably within the council?
- Is there sufficient timely training and ongoing support for officers and councillors, including you?

Checklist 6. Councillors' continuing personal development

- After the last election, was the general induction programme for councillors successful?
- Do officers give you good support on knowledge topics (such as internal controls)?
- Do officers give you good support on personal skills (such as chairing meetings)?
- Do you fully understand your roles and duties at council, cabinet, committee and ward levels?
- Have you made good use of the Improvement Service's support and publications?
- Do you have a personalised CPD programme?
- Do you actively participate in, and benefit from, the support made available to you?
- Do officers monitor and understand councillors' take-up of training and development?
- Where you do not engage fully in training and development, how could officers help more?
- Does CPD for councillors help you to be effective in your governance and scrutiny roles?

Checklist 7. Statutory officers and chief education officer

- Are the roles of these officers clearly set out in the council's governance documents?
- Do these officers sit on the corporate management team, or have ready access to it?
- Are these officers sufficiently resourced to discharge their roles and responsibilities?
- Do these officers have the influence needed for ensuring the council operates effectively?
- Do councillors and committees understand how and when to consult these officers?
- Do these officers give helpful, timely, impartial support to councillors and other officers?
- Do these officers have a constructive relationship with the senior management team?
- Do you have confidence in your council's key officers?
- Is there sufficient timely training and ongoing support for officers and councillors, including you?

Checklist 8. Internal auditing function

- Does internal auditing (IA) follow Public Sector Internal Audit Standards and other reputable guidance?
- Is IA objective; free from undue influence; and independent in its thinking, work and reports?
- Is IA suitably located in the council's structure?
- Is IA sufficiently resourced to recruit, retain and develop the staff it requires?
- Is IA free of operational responsibilities that could risk compromising its independence?
- Is IA's work aligned with the council's strategies, objectives and risks?
- Does IA give senior officers and councillors clear, timely, objective, risk-based assurance?
- Does the head of IA have unrestricted access to the chief executive?
- Does the head of IA give committees the information they need to make informed decisions?
- Is there sufficient timely training and ongoing support for officers and councillors, including you?

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ISBN 978 1 911494 83 6

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Aberdeen City Health & Social Care Partnership
A caring partnership

AUDIT & PERFORMANCE SYSTEMS COMMITTEE

Date of Meeting	28 May 2019
Report Title	Finance Update as at end March 2019
Report Number	HSCP.19.021
Lead Officer	Alex Stephen, Chief Finance Officer
Report Author Details	Gillian Parkin (Finance Manager) Barbara Ncube (Finance Lead – IJB)
Consultation Checklist Completed	Yes
Directions Required	No
Appendices	a) Finance Update as at end March 2019 b) Summary of risks and mitigating action c) Sources of Transformational Funding d) Progress in implementation of savings - March 2019 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 12 (end of March 2019);

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

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.

b) Notes the budget virements indicated in Appendix E.

3. Summary of Key Information

3.1 The position to the end of the financial year shows that IJB used £2,728,000 of its reserves to fund pressures on mainstream budgets and transformational spend. A detailed breakdown is reported for the financial year 2018/19 in Appendix A. This is a favourable movement of £436,000 compared to the forecast position at the end of December. Additional Scottish Government allocations received in the last quarter and reductions on spend on transformational projects are largely the reason for the movement. The IJB agreed in March 2018 to use £3.1 million of Integration and Change Fund for some of the transformation projects and cost pressures on the mainstream budget. The final outturn for the financial year shows that not all these funds were required.

3.2 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 since December.

	01/04/18 £'000	**31/12/18 £'000**	**31/03/19 £'000**
Risk fund	2,500	2,500	2,500
Primary Care Reserve	1,990	1,491	1,580
Integration and Change Funding	3,817	1,152	551
Alcohol & Drugs Funding\Action 15\PCIP			948
	8,307	**5,143**	**5,579**

The allocations received by the Scottish Government for Alcohol and Drugs, Primary Care Improvement and Action 15 have been earmarked and carried forward through the reserves if they had not been used during the year. The table above shows that this amounted to £948,000.

An analysis of variances is detailed below:

Community Health Services (Year to date variance - £1,177,000 underspend)

Major Movements:

(£521,000)	Across non-pay budgets
£163,000	Under recovery on income
(£820,000)	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 £414,000 overspend)

The main areas of overspend are as follows:

Intermediate Care: £89,000 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.

Police Forensic Service: £139,000 overspend as there has been a legacy under funding issue with this budget.

Grampian Medical Emergency Department (GMED): £315,000 relates mainly to pay costs and the move to provide a safer more reliable service which has seen 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 - £2,882,000 overspend)

Major Movements:

£2,514,000	Increase in commissioned services
£371,000	Reduced customer and client receipts

Increase in commissioned services mainly due to overspend in needs led home care £3,875,000 and reduced recovery on client contributions £384,000; partially offset by underspend on needs led residential care £694,000, underspend on direct payments £311,000, underspend on carers support £304,000 and needs led day care £155,000. Work is currently taking place with the learning disability team to investigate the movement in spend. Initial findings are that the following factors have influenced the spend:

- Transitions from childrens services costing more than initially budgeted,
- Higher client numbers and higher complexity of client needs,
- Closure of acute wards at Cornhill,
- Providers seeking above inflationary increases,
- Reduce client contributions, and
- Costs being charged to Learning Disabilities instead of older people and mental health following zero base budgeting exercise.

Mental Health & Addictions (Year to date variance - £155,000 overspend).

Major Movements:

£370,000	Increase on needs led residential care
£147,000	Increase on residential care for alcohol dependency
(£344,000)	Income from client contributions

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

Older People & Physical and Sensory Disabilities (Year to date variance - £465,000 underspend)

Major Movements:

£647,000	Under recovery of client contributions
£146,000	Overspend on staffing (turnover savings)
(£1,109,000)	Underspend on commissioned services
(£115,000)	Underspend on transfer payments

Movements in commissioned services mainly due to an underspend on older people residential care £758,000, physical disability residential care £460,000 carer support for older people £334,000 and underspend on direct payments £115,000 partially offset by; under recovery in client contributions £647,000 and overspend on older people homecare £425,000.

Directorate (£252,000 underspend)

(£374,000)	Staffing savings
(£186,000)	Over recovery of charging policy
(£425,000)	Decreased expenditure on commissioned services
£783,000	Net invoicing income reallocated to appropriate codes

The underspend on commissioned services is mainly on a provision set aside for increased funding for sleepovers, which will be moved to mental health and learning disabilities in future years where the spend is being incurred.

Primary Care Prescribing (Year to date variance – £414,000 underspend)

As actual information is received two months in arrears from the Information Services Division this position is based on actuals to January 2019 with an estimation of spend for February and March. Since April 2018 the actual volume increase has remained lower than expected with 0.14% estimated increase to March. The assumed volume increase anticipated was +0.80% in the Health & Social Care Prescribing Budget Supporting Information and data paper of January 2018.

Primary Care Services (Year to date variance - £8,000 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 main cost pressures in 2018/19 relate to established Enhanced Services which includes diabetic care, contraception services, substance misuse and extended hours. The Premises outturn includes a reduced overspend mainly relating to downward revision of estimated rental review increases still outstanding.

These main overspends continue to be offset in part by underspends in Board Administered Funds (BAF) which includes the impact of reduced seniority payments, professional payments and other entitlements due within BAF. A range of further minor underspends also continue to contribute positively to the overall position.

Out of Area Treatments (Year to date variance - £173,000 overspend)

Out of area placements outstripped the budget during 2018/19, even though the IJB allocated additional cost pressure funding of £512,000 on a recurring basis.

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

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 March 2019

Accounting Period 12	Full Year Revised Budget £'000	Period Budget £'000	Period Actual £'000	Period Variance £'000	Variance Percent %	Actual Year End versus Forecasted £'000
Community Health Services	32,772	32,772	31,595	(1,177)	(3.6)	(477)
Aberdeen City share of Hosted Services (health)	21,916	21,916	22,330	414	1.9	57
Learning Disabilities	31,739	31,739	34,621	2,882	9.1	1,604
Mental Health and Addictions	19,838	19,838	19,993	155	0.8	(402)
Older People & Physical and Sensory Disabilities	74,720	74,720	74,255	(465)	(0.6)	(167)
Directorate	423	423	171	(252)	(59.5)	75
Criminal Justice	93	93	98	5	6.0	28
Housing	1,861	1,861	1,861	0	0.0	0
Primary Care Prescribing	40,731	40,731	40,317	(414)	(1.0)	(105)
Primary Care	38,877	38,877	38,885	8	0.0	(113)
Out of Area Treatments	1,517	1,517	1,690	173	11.4	(10)
Set Aside Budget	46,416	46,416	46,416	0	0.0	0
Integration and Change (Transformation)	4,255	4,255	5,654	1,399	32.9	(926)
Reported position excl reserves	315,158	315,158	317,886	2,728		(436)

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). • Dilapidation in properties that may need investment to restore. (2019/20)	• 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.	• 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
	Average consultant costs £12,000 per month average locum £30,000 per month.	
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.
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	1.30		1.30
Action 15 Mental Health Strategy	0.43		0.43
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
	21.63	8.31	29.94
Adjust for social care and Health budget transfer	-17.40		-17.40
Adjust for GMED OOH Funding	-0.20		-0.20
Funding available for IJB commitment	4.25	8.31	12.56
Take off c/forward reserve			-8.31

REPORTED FULL YEAR BUDGET **4.25**

Appendix D: Progress in implementation of savings – March 2019

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 to deliver the saving.	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. **Workstream 3 – Alcohol, Detox & Chronic/Long Term Alcoholism** – *to check current information is correct, to*	A. Stephen

Area	Agreed Target	Status	Action	Responsible Officer
			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.	
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
New Monies Received Q2 & Q3		**£3,133,901**
Reported at Month 9		**£308,504,738**

Additional allocations received during quarter 4 (as per Appendix E)

Waiting Times	£1,552
Orthopaedic Project	£16,292
Hosted Services Recharge	£3,587
Shingles	£10,109
Call Down Capacity Building	£133,363
Call Down Innovation	£78,024
Non Medical Prescribing	£4,000
Child Flu	£22,272

Tec Enabled Care	£7,894	
SOAR Management Structure	(£89,837)	
HIV Lead	£3,951	
Plasma Project	£53	
SOAR Management Structure	£82,237	
Hosted Budget Adjustment period 11	£71,495	
GMED Hosted	£26,651	
Pharmacy Transfer	(£22,469)	
GP Fellowship Paediatrics	£143,000	
CMS Medical	£3,800	
MEN B	£17,064	
Rotavirus	£4,751	
ANP NES Course Fees	£3,350	
Hosted Budget Adjustment period 12	£29,052	
Set A Side Budget Adjustment	£5,907,000	
Hosted Transfer To IJB	£10,818	
Adult Social Care Directorate (Staff Costs)	£706	
Veterans Funding	£183,300	
Total		**£6,652,015**
Reported at Month 12		**£315,156,753**

Appendix E: Virements

Health 10-12	£
Waiting Times	1,552
Orthopaedic Project	16,292
Hosted Services Recharge	3,587
Shingles	10,109
Call Down Capacity Building	133,363
Call Down Innovation	78,024
Non Medical Prescribing	4,000
Child Flu	22,272
Tec Enabled Care	7,894
SOAR Management Structure	(89,837)
HIV Lead	3,951
Plasma Project	53
SOAR Management Structure	82,237
Hosted Budget Adjustment period 11	71,495
GMED Hosted	15,792
Pharmacy Transfer	(22,469)
GP Fellowship Paediatrics	143,000
CMS Medical	3,800
MEN B	17,064
Rotavirus	4,751
ANP NES Course Fees	3,350
Hosted Budget Adjustment period 12	29,052
Waiting Times	10,859
Set A Side Budget Adj	5,907,000
Hosted Transfer To IJB	10,818
Adult Social Care Directorate (Staff Costs)	706
Veterans Funding	183,300
Total Virements	6,652,015

Social Care 7-12	£
Adult Svcs Op & Physical Dis (Commissioning Services)	155,720
Adult Svcs Op & Physical Dis (Income)	(130,000)
Adult Svcs Op & Physical Dis (Premises Costs)	(6,600)
Adult Svcs Op & Physical Dis (Transfer Payments)	0
Adult Svcs Op & Physical Dis (Transport Costs)	6,600
Criminal Justice (Premises Costs)	0
Learning Disabilities (Premises Costs)	0
Transformation Fund (Commissioning Services)	362,000
Transformation Fund (Income)	22,034
Transformation Fund (Staff Costs)	(29,754)
Transformation Fund (Supplies & Services)	(380,000)
Total Virements	0

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