Public Document Pack

To: Members of the Risk, Audit and Performance Committee

Town House,
ABERDEEN 16 June 2022

RISK, AUDIT AND PERFORMANCE COMMITTEE

The Members of the **RISK, AUDIT AND PERFORMANCE COMMITTEE** are requested to meet in **Virtual - Remote Meeting on THURSDAY, 23 JUNE 2022 at 10.00 am.**

FRASER BELL
CHIEF OFFICER - GOVERNANCE

BUSINESS

DECLARATION OF INTERESTS

1.1 Members are requested to intimate any declarations of interest

DETERMINATION OF EXEMPT BUSINESS

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

STANDING ITEMS

3.1 Minute of Previous Meeting of 26 April 2022 (Pages 3 - 10)

3.2 Business Planner (Pages 11 - 16)

3.3 Directions Process Report - HSCP.22.043 (Pages 17 - 22)

GOVERNANCE

4.1 Audit Scotland - Drug and Alcohol Service Briefing - HSCP.22.048 (Pages 23 - 28)

4.2 Review of Audit Scotland Reports - HSCP.22.050 (Pages 29 - 78)

AUDIT

5.1 Internal Audit Annual Report - HSCP.22.045 (Pages 79 - 94)

5.2 Internal Audit Report - IJB Performance Management Reporting HSCP.22.046 (Pages 95 - 98)

PERFORMANCE

6.1 Primary Care Improvement Plan Update - HSCP.22.044 (Pages 99 - 114)

6.2 Signposting Protocol to External Services - HSCP.22.049 (Pages 115 - 120)

6.3 CAMHS - Mental Welfare Commission - Young People - Monitoring Report 2020-21 - HSCP.22.047 (Pages 121 - 184)

6.4 Justice Social Work - Annual Performance Report - HSCP.22.042 (Pages 185 - 216)

EXEMPT / CONFIDENTIAL BUSINESS

7.1 None at the time of issuing the agenda

CONFIRMATION OF ASSURANCE

8.1 Confirmation of Assurance

COMMITTEE DATES

9.1 Date of Next Meeting - Tuesday 9 August 2022 at 10am

Future meetings:
Tuesday 1 November 2022, at 10.00 a.m.
Tuesday 28 February 2023, at 10.00 a.m.

Should you require any further information about this agenda, please contact Emma Robertson, emmrobertson@aberdeencity.gov.uk

Aberdeen City Health & Social Care Partnership
A caring partnership

RISK, AUDIT AND PERFORMANCE COMMITTEE

ABERDEEN, 26 April 2022. Minute of Meeting of the RISK, AUDIT AND PERFORMANCE COMMITTEE. Present:- John Tomlinson Chairperson; and Luan Grugeon (NHS Grampian), Councillors Philip Bell and John Cooke; Martin Allan, Jamie Dale, Alison MacLeod and Alex Stephen.

Also in attendance: Alex Bertram (for Item 15), Kay Diack, Stella Evans, John Forsyth, Michelle Grant, Stuart Lamberton, Grace Milne, Amy Richert and Michael Wilkie.

Apologies: Jonathan Belford.

The agenda and reports associated with this minute can be found here.

Please note that if any changes are made to this minute at the point of approval, these will be outlined in the subsequent minute and this document will not be retrospectively altered.

WELCOME AND INTRODUCTIONS

1. The Chair welcomed everyone, and members also welcomed back Michael Wilkie from External Auditors KPMG and Stuart Lamberton, Transformation Programme Manager – AHSCP, to his first meeting of the Committee.

DECLARATIONS OF INTEREST

2. Members were requested to intimate any declarations of interest in respect of the items on the agenda.

There were no declarations of interest intimated.

EXEMPT BUSINESS

3. There was no exempt business.

MINUTE OF PREVIOUS MEETING OF 1 MARCH 2022

4. The Committee had before it the minute of its previous meeting of 1 March 2022, for approval.

The Committee resolved:-

(i) with regard to Article 11 of the Minute (Leadership Team Objectives - Update - HSCP.22.012), to note that Quarter 3 Carers' Support figures were still awaited and that the Strategy and Transformation Lead would circulate them along with Quarter 4 figures once they were available; and
(ii) to otherwise approve the minute as a correct record.

BUSINESS PLANNER

5. The Committee had before it the Committee Business Planner.

Members heard from the Chief Finance Officer who provided context around future reporting. He apologised for the late circulation of reports at Items 5.1 and 6.1 of the agenda.

Michael Wilkie explained that the timetable for presenting the unaudited accounts had been altered during 2022 to take account of local government elections but would now revert to the traditional audit timing and therefore the Audited Accounts would be presented to the RAPC on 9 August 2022 and not June 2022 as stated in the Planner.

The Committee resolved:-
(i) to agree that Item 19 (Annual / Biennial Report on Adult Social Care) had been presented to the IJB and CCG and could therefore be removed for the RAPC Planner;
(ii) to agree that Items 31 (Primary Care and Social Care Vacancies) and 32 (Workforce Plan) could be combined into one item on the Planner;
(iii) to note that the timescale for the Audited Accounts would be August 2022 and the Planner would be updated accordingly;
(iv) to note the at the Directions Tracker would include a traffic light system; and
(v) to otherwise note the content of the Planner.

WHISTLEBLOWING UPDATES - VERBAL UPDATE

6. The Committee heard from the Business Manager who stated that there had been no whistleblowing incidents raised during the last quarter either through the IJB Policy or by NHS standards.

The Committee resolved:-
(i) to agree that a report on Whistleblowing policy and reporting would be added to the Planner and submitted to a future Committee; and
(ii) to note that there had been no Whistleblowing incidents raised during the last quarter.

RISK, AUDIT AND PERFORMANCE COMMITTEE
26 April 2022

REVIEW OF LOCAL CODE OF GOVERNANCE - HSCP22.022

7. The Committee had before it a report on the Local Code of Corporate Governance which was a review of the governance for the Integration Joint Board (IJB) previously agreed by Audit & Performance Systems Committee (APS). The purpose of the report was to allow the Risk, Audit and Performance Committee (RAPC) to comment on the sources of assurances used to measure the effectiveness of the governance principles contained in the CIPFA/SOLACE 'Delivering Good Governance in Local Government: Framework' document.

The Chief Finance Officer spoke to the report and responded to questions from Members.

The report recommended:-
that the Committee approve the sources of assurance, as highlighted in Appendix A of the report.

The Committee resolved:-
(i) to agree that reference to the IJB's development work on Culture would be added to the final version of the document;
(ii) to instruct the Chief Finance Officer to review climate change duties and take recommendations on the implications back to Committee; and
(iii) to otherwise approve the recommendation.

REVIEW OF FINANCIAL GOVERNANCE - HSCP22.023

8. The Committee had before it the Review of Financial Governance Arrangements, the purpose of which was to provide the results of the review undertaken by the Aberdeen City Health and Social Care Partnership (ACHSCP) Leadership Team against financial governance requirements contained in the Chartered Institute of Public Finance and Accountancy (CIPFA)'s statement on the 'Role of the Chief Financial Officer in Local Government' (2016).

The Chief Finance Officer spoke in furtherance of the report and explained that this review was an annual requirement.

The report recommended:-
that the Committee note the content of the report and the accompanying results of the Executive team review contained at Appendix A.

The Committee resolved:-
(i) to agree that the Chief Finance Officer would add further narrative in respect of effective tendering with regard to the Procurement Regulations; and
(ii) to otherwise note the content of the report.

ANNUAL GOVERNANCE STATEMENT - HSCP22.025

9. The Committee had before it the Annual Governance Statement.

The Chief Finance Officer spoke to the report and responded to questions from members.

The report recommended:-
that the Committee -
(a) comment on and approve in principle the annual governance statement; and
(b) agree that assurances on the governance framework can be provided to Aberdeen City Council and NHS Grampian.

The Committee resolved:-
(i) to agree that reference to the IJB development work on Culture would be added to Principle 1 – Behaving with integrity, demonstrating strong commitment to ethical values and representing the rule of law;
(ii) to agree that the assurance statement would be expanded to include more explanation on procurement;
(iii) to agree to add a seminar topic on Ethical Approach to Commissioning to the Planner; and
(iv) to otherwise approve the recommendations.

ANNUAL REVIEW OF RAPC - HSCP22.021

10. The Committee had before it the Review of Duties & Year End Report, the purpose of which was to review the reporting for 2021/22 and the intended schedule of reporting for 2022/23 to ensure that the Committee was fulfilling all the duties as set out in its terms of reference.

The report recommended:-
that the Committee note the contents of the report and Appendix A – Duties and Annual Plan.

The Committee resolved:-
(i) to thank the Chief Finance Officer and all his Team for their work; and
(ii) to otherwise note the content of the report.

APPROVAL OF UNAUDITED ACCOUNTS - HSCP22.024

11. The Committee had before it the Unaudited Final Accounts for 2021/22.

The Chief Finance Officer spoke to the report and began by thanking the Strategy and Transformation Lead, Business Manager and accountants who had been involved in the preparation work. He then responded to questions from Members.

The report recommended:-
that the Committee consider and comment on the Unaudited Final Accounts for 2021/22 at Appendix A (Additional Circulation) of the report.

The Committee resolved:-
(i) to thank all those involved in the preparation of the accounts; and
(ii) to otherwise note the information provided.

QUARTER 4 MONITORING REPORT - HSCP22.032

12. The Committee had before it the Quarter 4 Monitoring Report, which (1) summarised the 2021/2022 revenue budget performance for the services within the remit of the Integration Joint Board (IJB) as at Period 9 (end of March 2022); (2) highlighted the current forecast in relation to the additional costs of COVID-19 reclaimed from the Scottish Government (SG); (3) advised on any areas of risk and management action relating to the revenue budget performance of the IJB services; and (4) sought to approve the budget virements so that budgets were more closely aligned to anticipated income and expenditure.

The Chief Finance Officer spoke to the report and responded to questions from Members.

The report recommended:-
that the Committee-
(a) note the report in relation to the IJB budget and the information on areas of risk and management action that were contained therein; and
(b) approve the budget virements indicated in Appendix F of the report.

The Committee resolved:-
(i) to note that the Chief Finance Officer would circulate further detail regarding Directorate overspend;
(ii) to instruct the Chief Officer to ask the Moray IJB for an update regarding G-Med and to subsequently report back to Committee in this regard; and
(iii) to otherwise approve the recommendations.

EXTERNAL AUDIT PLAN 2022/23 - HSCP22.031

13. The Committee had before it the External Audit Plan for 2021-22.

Michael Wilkie, External Auditor (KPMG) spoke to the report. Mr Wilkie advised that there would be a new auditor appointed from 2023 and that indications were that the Committee should expect a significant rise in the audit fee.

The report recommended:-
that the Committee note the contents of the report.

The Committee resolved:-
to approve the recommendation.

SIGN POSTING TO EXTERNAL SERVICES - HSCP22.030

14. The Committee had before it a report which sought to create a protocol to be adopted by Aberdeen City Health and Social Care Partnership (ACHSCP) specifically and deliberately signposting patients, clients, carers and service users to organisations that had not gone through the commissioning or grant funding process.

The Strategy and Transformation Lead introduced the report and responded to questions from Members.

The report recommended:-
that the Committee -
(a) consider the draft Signposting Protocol attached at Appendix A of the report and provide comment; and
(b) if agreed, present a final version to the RAPC on 23 June 2022.

The Committee resolved:-
(i) to instruct the Strategy and Transformation Lead to seek further legal advice regarding endorsement and to incorporate this into the final version of the report;
(ii) to instruct the Strategy and Transformation Lead to share the final draft of the report with Committee members in advance of the agenda papers for RAPC on 23 June 2022 being issued; and
(iii) to otherwise agree in principle the recommendations.

LEADERSHIP TEAM OBJECTIVES - PERFORMANCE FRAMEWORK - HSCP22.029

15. The Committee had before it a report relating to the Leadership Team Objectives - Reporting Framework.

Alison MacLeod - Strategy and Transformation Lead, explained that, following the approval of the Leadership Team Objectives for 2022/23 at the Integrated Joint Board on 10 March 2022, the report was seeking to inform the Risk, Audit and Performance Committee of the reporting framework surrounding this. Ms MacLeod introduced

colleagues Michelle Grant and Alex Bertram who presented the Health Care Intelligence Dashboard and responded to questions from members.

The report recommended:-
that the Committee note the Leadership Team Objectives Reporting Framework as appended to the report, noting in particular the reporting timetable.

The Committee resolved:-
(i) to note that the Performance Framework would be circulated to members;
(ii) to agree that the Health Care Intelligence Dashboard and covering report would be added to the Planner as an action for the August 2022 meeting and thereafter on a quarterly basis;
(iii) to agree that a seminar topic of Strategic Intent be added to the Planner; and
(iv) to otherwise agree the recommendations.

CONFIRMATION OF ASSURANCE

16. The Chair enquired of Members if they were satisfied on matters presented before the Committee or if further examination was required.

The Committee resolved:-
to note they had received Confirmation of Assurance from the reports and associated discussions presented and that further assurance had been evidenced by the activity of all staff in not only producing the necessary information but also by the delivery and modifications of processes and services in a regular and sustained manner.

DATE OF NEXT MEETING

17. The Committee had before it the dates for future meetings:
- Thursday 23 June 2022 at 10am;
- Tuesday 9 August 2022 at 10am;
- Tuesday 1 November 2022 at 10am; and
- Tuesday 28 February 2023 at 10am

The Board resolved:-
to note the future meeting dates
- **JOHN TOMLINSON, Chair**

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	A	B	C	D	E	F	G	H	I	J
1	RISK and AUDIT PERFORMANCE COMMITTEE BUSINESS PLANNER The Business Planner details the reports which have been instructed by the Committee as well as reports which the Functions expect to be submitting for the calendar year.									
2	**Date Created**	**Report Title**	**Minute Reference/Committee Decision or Purpose of Report**	**Report Number**	**Report Author**	**Lead Officer / Business Area**	**Directorate**	**Update/ Status (RAG)**	**Delayed or Recommended for removal or transfer, enter either D, R, or T**	**Explanation if delayed, removed or transferred**
3	**23 June 2022**									
4	Standing Item	Directions Tracker Process Report	On 23.09.2020, RAPC resolved: to direct the Chief Finance Officer to report on the Directions Tracker every 6 months - see 21 December 2021	HSCP.22.043	Alex Stephen / Amy Richert	Chief Finance Officer	ACHSCP			At RAPC on 26.04.22 Members requested that a Traffic Light system be incorporated into the Tracker.
5	23.09.21	Primary Care Improvement Plan Update	Further update report (last reported at 23 September 21 RAPC - HSCP.21.105)	HSCP.22.044	Emma King / Sarah Gibbon		ACHSCP			Due to system and workload pressures this report was deferred. A Workshop is also now planned to cover 2C and Primary Care Update on 13 July 2022.
6	10.03.22	Audit Scotland Drug and Alcohol service briefing	Request for paper from Alex Stephen on 10/03/22 in response to national report.	HSCP.22.048	Simon Rayner		ACHSCP			Members agreed on 26 April 2022 to defer to June RAPC to allow for further development of the report.
7	Standing Item	Review of relevant Audit Scotland reports	Good practice to see national position	HSCP.22.050	Alex Stephen	Chief Finance Officer	ACHSCP			
8	Standing Item	Internal Audit Reports - Annual Report & IJB Performance Manangement Reporting	Assurance that services are operating effectively	HSCP.22.045 & HSCP.22.046	Jamie Dale	Chief Internal Auditor	Governance			22/02/22 - Jamie Dale advised reports will be; Annual Report & Audit recommendations follow up.
9	06.12.2021	Governance Standards for signposted organisations	Sign posting to external services	HSCP.22.049	Alison Macleod	Lead Strategy and Performance Manager	ACHSCP			At RAPC on 26.04.22 Members instructed the Strategy and Transformation Lead to seek further legal advice regarding endorsement and to incorporate this into the final version; and to share the draft of the report with Members in advance of the agenda papers being issued for RAPC on 23 June 2022

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10	01.03.22	CAMHS Update report - Young People Monitoring Report 2020-21, Mental Welfare Commission		HSCP.22.047	Jane Fletcher / Amanda Farquharson					
11	22.06.2021	Justice Social Work Performance report and Justice Social Work Annual Report	On 22.06.21, from Justice Social Work Performance Management Framework - HSCP.21.053; (i)to approve the Justice Social Work Performance Management Framework as a first iteration of work in progress and agree to its implementation by the justice service; and (ii)to instruct the Chief Officer (ACHSCP) to use this framework as the basis for a report outlining the performance of the justice service and present this report to RAPC no later than the end of Q1 2022-2023 and then similarly on an annual basis thereafter.	HSCP.22.042	Kevin Toshney/ Claire Wilson / Lesley Simpson / Liz Cameron	Lead for Social Work	ACHSCP			Request to defer to June meeting - Performance data not available for April meeting but will be available for June. Amalgamated with JSW Annual Report - "On 06.07.21 at IJB 08/07/2021 (ii)to instruct the Chief Officer, ACHSCP to present an annual update to the Risk, Audit and Performance Committee on the progress being made with the implementation of this delivery plan. "
12	Standing Item	Whistleblowing Updates	At IJB on 06.07.21: (ii)to instruct the Chief Officer to report on a quarterly basis on any whistleblowing incidents raised under the Standards to the Risk, Audit and Performance Committee and NHS Grampian Board;		Martin Allan	Business Manager	ACHSCP		D	Quarterly reporting instructed. This was considered at RAPC on 26 April 2022, so will next be presented at RAPC on 9 August 2022.
13	Standing Item	External Audit Strategy 2021/22			Michael Wilkie	KPMG	KPMG		T	Considered at April 2022 RAPC
14	Standing Item	Strategic Risk Register	Bi-Annual - last report December 2021		Martin Allan	Business Manager	ACHSCP		D	Deferred to November to coincide with work on next Strategic plan and August IJB workshop.
15	Standing Item	OHF Report	Quarterly Reporting		Calum Leask	Lead Strategy and Performance Manager	ACHSCP		R	Approved within in report HSCP.21.075 at June RAPC recommendation ii) to note that learning outcomes from OHF reporting would feature within future reporting on Leadership Team Objectives and Strategic Planning.

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16	Standing Item	Review of Local Code of Governance	To provide assurance on Governance Environment	HSCP.22.022	Alex Stephen	Chief Finance Officer	ACHSCP		D	At RAPC on 26.04.22 Members agreed to include reference to the IJB's work on Culture in the final version and to instruct the CFO to review the climate change dutiesand take recommendaitons on the implications back to RAPC. These updates to be incorporated within final audited accounts.
17	Standing Item	Annual Governance Statement	To provide assurance on Governance Environment	HSCP.22.025	Alex Stephen	Chief Finance Officer	ACHSCP		D	At RAPC on 26.04.22 Members agreed (i) to include reference to the IJB's work on Culture into Principle 1;(ii) to agree that the assurance statement would be expanded to include more explanantion on procurement; and(iii) to agree to add a seminar topic on Ethical Approach to Commissioning. These updates to be incorporated within final audited accounts.
18	01.03.22	Primary Care and Social Care Vacancies / Workforce Plan	Members agreed on 01/03/22 to to instruct the Chief Finance Officer to provide further information regarding vacancies in Primary Care and Social Care / and Workforce Plan to the meeting of RAPC on 23 June 2022		Alex Stephen / Martin Allan	Chief Finance Officer / Business Manager	ACHSCP		D	Primary Care vacancies update was issued on 01/03/22. At RAPC on 26.04.22 Members agreed to combine these two topics into one report. 01/06/2022 - Workforce plan due to be completed by 31st July deferred to August Meeting.
19	01.03.22	Hosted Services SLAs	RAPC members agreed 01/02/22 that hosted services SLAs would be considered at the meeting of RAPC on 23 June 2022		Alison Macleod	Strategy and Performance Manager	ACHSCP		D	30/05/22 - Delayed to August RAPC to coincide with other partnerships who are delaying due to workload pressures.
20	01.03.22	Self Directed Support	RAPC members agreed 01/02/22 that Self Directed Support would be considered at the meeting of RAPC on 23 June 2022		Claire Wilson	Lead for Social Work	ACHSCP		D	Delayed due to prioritisation of the inspection. Email from Claire Wilson 17.05.22: showing the outcomes for all SDS options is complex and we need to do a lot of work on this to be able to have a framework in place for doing this. Request to delay for now until D365 is embedded which should allow us to use the data in a different way - defer for review in November 2022.
21	**9 August 2022**									
22	Standing Item	Internal Audit Reports	Assurance that services are operating effectively		Jamie Dale	Chief Internal Auditor	Governance			
23	Standing Item	Review of relevant Audit Scotland reports	Good practice to see national position		Alex Stephen	Chief Finance Officer	ACHSCP			
24	Standing Item	Board Assurance and Escalation Framework (BAEF)	26.08.2020; The Committee resolved :- (iv) to note that the Framework will be reviewed by the Committee on an annual basis.		Martin Allan	Business Manager	ACHSCP			
25	Standing Item	Financial Regs Review	Annual Review		Alex Stephen	Chief Finance Officer	ACHSCP			

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26	Standing Item	Whistleblowing Updates and report on Policy & Reporting	At IJB on 06.07.21: (ii)to instruct the Chief Officer to report on a quarterly basis on any whistleblowing incidents raised under the Standards to the Risk, Audit and Performance Committee and NHS Grampian Board;		Martin Allan	Business Manager	ACHSCP			Committee resolved on 26 April 2022: to agree that a report on Whistleblowing policy and reporting would be added to the Planner and submitted to a future Committee
27	15.03.22	Audited Accounts	At RAPC on 26.04.22 Milchael Wilkie (KPMG) advised members that Audited Accounts would be presented to the August meeting.		Alex Stephen	Chief Finance Officer	ACHSCP			
28	26.04.22	Report on Whistleblowing Policy and Reporting	At RAPC on 26.04.22 Members requested that this report be added to the Planner.		Martin Allan	Business Manager	ACHSCP			
29	06.07.21	Locality Plans - HSCP.21.078	At IJB on 06.07.21: (iii)to instruct the Chief Officer, ACHSCP to report to the Risk, Audit and Performance Committee in 12 months with an update on locality planning including implementation of the locality plans.		Alison Macleod	Lead Strategy and Performance Manager	ACHSCP		D	Request from Lead Strategy and Performance Manager to defer to 01/11/22 to allow the Committee to consider this with the Annual Performance Report.
30	15.03.22	Audited Accounts	Committee was advised on 26 April 2022 by Michael Wilkie that Audited Accounts would be presented in August 2022 and not June as originally planned.		Alex Stephen	Chief Finance Officer	ACHSCP			
31	01.03.22	Health Care Intelligence Dashboard	At RAPC on 26.04.22, following discussion on LT Objectives, Members agreed that the Health Care Intelligence Dashboard and covering report would be added to the Planner as an action for RAPC in August 2022 and therafter on a quarterly basis; and to agree that a seminar on Strategic Intent be added to the Planner.		Alison Macleod	Lead Strategy and Performance Manager	ACHSCP			
32	27.01.22	Audit Scotland Briefing on Social Care	Social Care Briefing Report January 2022 prepared by Audit Scotland	HSCP.22.009 As per note.	Alex Stephen/Claire Wilson/Anne McKenzie	Chief Finance Officer	ACHSCP		D	Email from Alex Stephen requesting addition to Planner, 07/02/2022 Alex Stephen requested that this was withheld from the 010322 preagenda pack following consultation feedback, listed as postponed. Awaiting further advice on timing.
33	15.06.22	ASP Inspection report	Overview of the recommendations of the recent inspection.		Claire Wilson / Val Vertigans	Lead social Worker	ACHSCP			Report is being published on 21 June 2022.
34	**1 November 2022**									
35	Standing Item	Internal Audit Reports	Assurance that services are operating effectively		Jamie Dale	Chief Internal Auditor	Governance			

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36	Standing Item	Review of relevant Audit Scotland reports	Good practice to see national position		Alex Stephen	Chief Finance Officer	ACHSCP			
37	Standing Item	Strategic Risk Register	Bi-Annual - last report December 2021		Martin Allan	Business Manager	ACHSCP			
38	Standing Item	OHF Report	Quarterly Reporting		Calum Leask	Lead Strategy and Performance Manager	ACHSCP		R	Approved within in report HSCP.21.075 at June RAPC recommendation ii) to note that learning outcomes from OHF reporting would feature within future reporting on Leadership Team Objectives and Strategic Planning.
39	Standing Item	Directions Tracker	On 23.09.2020, RAPC : (iii) to direct the Chief Finance Officer to report on the Directions Tracker every 6 months - see 21 December 2021		Alex Stephen	Chief Finance Officer	ACHSCP			
40	Standing Item	Whistleblowing Updates	At IJB on 06.07.21: (ii)to instruct the Chief Officer to report on a quarterly basis on any whistleblowing incidents raised under the Standards to the Risk, Audit and Performance Committee and NHS Grampian Board;		Martin Allan	Business Manager	ACHSCP			
41	01.03.22	IJB Annual Performance Report 2020/21	Members noted at RAPC on 01/03/22 that the IJB Annual Performance Report 2020/2021 - HSCP.21.105, would be presented to the meeting of IJB on 30 August 2022 and thereafter to RAPC on 1 November 2022		Alison Macleod	Lead Strategy and Performance Manager	ACHSCP			
42	**28 February 2023**									
43	24.08.21	Navigator project evaluation	IJB 24.08.21 - NAVIGATOR REPORT - HSCP.21.086 - to instruct the Chief Officer, ACHSCP to present an evaluation and update report to the RAPC prior to conclusion of Year 2 funding. (First two years October 21 to October 23)		Simon Rayner	ADP Strategic Lead	ACHSCP			
44	27.01.22	Annual Review of RAPC			Alex Stephen / Amy Richert	Chief Finance Officer	ACHSCP			
45		Approval of Unaudited Accounts			Alex Stephen	Chief Finance Officer	ACHSCP			
46	Standing Item	Review of Financial Governance	To provide assurance on Governance Environment - annual report. Last RAPC was 26 April 2022.		Alex Stephen	Chief Finance Officer	ACHSCP			

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RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	23rd June 2022
Report Title	Directions Update – Process for future reporting
Report Number	HSCP 22.043
Lead Officer	Alex Stephen, Chief Finance Officer
Report Author Details	Name: Amy Richert Senior Project Manager Arichert@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Appendices	Appendix A – Example of proposed new layout for Directions spreadsheet

1. Purpose of the Report

1.1. This report proposes a revised reporting process for RAPC for Directions instructed to Aberdeen City Council (ACC) and National Health Service – Grampian (NHSG). An update on the status of Directions was presented to the RAPC on 1st March 2022 where Committee member suggested improvements which would support members to better understand the position of Directions issued, specifically the development of a 'traffic light' system.

2. Recommendations

2.1. It is recommended that the Risk, Audit and Performance Committee:

a) Agree the process as outlined in section 3.5 and demonstrated in Appendix A.

3. Summary of Key Information

3.1. As per the Roles and Responsibilities Protocol of the Integration Joint Board (IJB) and its Committees, the IJB are obliged, "to issue Directions to the Partners under sections 26 and 27 of the Public Bodies (Joint Working) (Scotland) Act 2014, in line with the Integration Scheme and legislative framework sitting around the CEOs of the Partners."

RISK, AUDIT AND PERFORMANCE COMMITTEE

As agreed by the RAPC on 23 September 2020 a report will be presented every 6 months to provide Committee the opportunity to overview the ongoing directions.

3.2. The Directions Tracker indicates when they were submitted to the constituent organisation(s), the financial commitment, and the status of each direction. Most of the Directions issued by the IJB are to incur financial expenditure and are therefore centred around commissioning or our transformation programme.

3.3. The Directions Tracker is provided for review at the Chief Officers' monthly performance meeting. This ensures overview from ACC and NHSG Chief Executives and the Chair and Vice Chair of IJB. The tracker is regularly updated by the leadership team and lead officers. The existing process has two classifications of status for a direction:

1. Complete – represents a direction where the date has expired, and the direction is either no longer required or has been superseded by a new direction. It also includes directions which have been completed within a set timescale and will not be required to continue beyond that.

2. Ongoing – represents where the current direction is still valid.

3.4. Members discussed at the RAPC on 1st March 2022 that they wished reporting to more clearly represent any areas of concern and any potential upcoming decisions required on the status of Directions. A 'traffic lights' system with three levels was proposed.

3.5. The proposed revised classifications are as follows;

1. GREEN (Ongoing) represents where the current direction is still valid, in place and not due for renewal or completion.

2. AMBER (Due) Directions which are due for renewal or completion within the next 6 months including those which are at risk of not being completed within the timescale and / or within the allocated budget. Update to RAPC required.

3. RED (Concern) Directions which have either
    a. Not been implemented due to issues with implementation e.g. no service available to deliver on the direction.
    b. Directions which have expired and have not been reported as renewed or completed.

4. GREY (Complete) - represents a direction where the date has expired, and the direction is either no longer required or has been superseded by a new direction. It also includes directions which have been completed within a set timescale and will not be required to continue beyond that.

4. Implications for IJB

4.1. Equalities, Fairer Scotland and Health Inequality – there are no direct implications arising from this report.

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

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

4.4. Legal – Scottish Government guidance which provides that there should be a log kept of all Directions made - Health and Social Care Integration Statutory Guidance- Directions from Integration Authorities to Health Boards and Local Authorities (Jan 2020). RAPC monitoring and reviewing Directions issued ensures that the IJB is discharging this requirement.

4.5. Other – NA

5. Links to ACHSCP Strategic Plan

5.1. Ensuring that the RAPC has overview of the Directions process will help ensure that the IJB achieves the strategic aims and priorities as set out in the strategic plan.

RISK, AUDIT AND PERFORMANCE COMMITTEE

6. Management of Risk

6.1. Identified risk(s):

Good governance and ensuring that the IJB's committees are delivering on their roles and responsibilities are fundamental to the delivery of the Strategic Plan and therefore applicable to most of the risks within the Strategic Risk Register.

6.2. Link to risk number on strategic or operational risk register:

This report links to Risk 5 on the Strategic Risk Register, "There is a risk that the IJB, and the services that it directs and has operational of, fail to meet both performance standards/outcomes as set by regulatory bodies and those locally determined performance standards as set by the board itself. This may result in harm or risk of harm to people".

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

This report proposes a revised reporting model for Directions as part of our governance framework, and in the discharge of or requirements within the statutory guidance outline at paragraph 4.4 above.

Approvals	
[signature]	Sandra Macleod (Chief Officer)
[signature]	Alex Stephen (Chief Finance Officer)

APPENDIX A – Directions Tracker example (For example purposes only – does not reflect actual status of Directions)

Direction	Associated Budget	Lead Officer	ACC/NHSG	Effective Until	Status at Feb 2022	Narrative
Alcohol Drugs Partnership (ADP) Investment Programme	Alcohol and Drug Partnership	S. Macleod	ACC	Ongoing	Red	Drug treatment and support services; majority of funding is recurring
Alcohol Drugs Partnership (ADP) Investment Programme	Alcohol and Drug Partnership	S. Macleod	NHSG	Ongoing	Red	Drug treatment and support services; majority of funding is recurring
Transformation Report - Delayed Discharge Reporting	£25,440.07	A Macleod	ACC		Red	Ongoing (in line with Action 15)
Transformation - Decisions Required: Action 15 (Prison)	£194,786 (for 4 years)	S. Macleod	NHSG		Red	Progressing recruitment/service delivery
Musculoskeletal (MSK) Physiotherapy First Contact	£1,184,825.00	A Macleod	NHSG	28/08/2022	Amber	PCIP
Primary Care Psychologists	£2,514,445.00	A Macleod	NHSG	28/08/2022	Amber	PCIP
Technology Fund	HSCP Budget - £480,000	S. Macleod	ACC	31/10/2022	Amber	Fund available in support of Care at Home and Supported Living Services
Chaplaincy Listening Service	£178,369 (4 years)	A Macleod	NHSG	31/03/2023	Green	Ongoing (in line with Action 15)
Aberdeen Links Service	Primary Care Improvement Fund £985,575.00	S. Macleod	ACC	31/03/2023	Green	Continuity of provision of Aberdeen Links Service (ALS)
Winter Planning – additional funding from Scottish Governm	Interim - £1,507,000. Care at Home - £2,337,000. Multidisciplinary teams - £754,000. £10.02 per hour Adult Social Care - £2,091,000	S. Macleod	ACC	31/03/2023	Green	Scottish Government additional monies for Winter Plan
Winter Planning – additional funding from Scottish Governm	Interim - £1,507,000. Care at Home - £2,337,000. Multidisciplinary teams - £754,000. £10.02 per hour Adult Social Care - £2,091,000	S. Macleod	NHSG	31/03/2023	Green	Scottish Government additional monies for Winter Plan
Action 15 - Mental Wellbeing - Out of Hours	£659,814.00	K. Gunn	NHSG	30/04/2023	Green	Ongoing (in line with Action 15)
Action 15 - Mental Wellbeing - Out of Hours	£659,814.00	C.Wilson	ACC	30/04/2023	Green	Ongoing (in line with Action 15)
Grant to Independents	£394,371.00	A.McKenzie	ACC	30/07/2023	Green	Ongoing review of commissioned services, annual workplans
Living Wage	NA	A. Stephen	ACC	NA	Grey	Incoporated in annual MTFF update
Primary Medical Services - prescribing	Invest to save	A. Stephen	NHSG	NA	Grey	Incoporated in annual MTFF update
Alcohol & Drugs Services: procurement and contract extension	NA	C. Wilkie	ACC	Completion of procurement process	Grey	Commissioned Service updated
Transformation Projects	£2,256,576.00	G. Woodcock	NHSG	31/03/2017	Grey	All transformation projects now mainstreamed
Transformation Projects	£2,218,875.00	G. Woodcock	ACC	31/03/2017	Grey	All transformation projects now mainstreamed

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Aberdeen City Health & Social Care Partnership
A caring partnership

RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	23 June 2022
Report Title	Audit Scotland Drug and Alcohol Service Briefing
Report Number	HSCP22.048
Lead Officer	Alex Stephen, Chief Finance Officer
Report Author Details	Simon Rayner; simon.rayner@nhs.scot Alcohol and Drug Partnership
Consultation Checklist Completed	Yes/No
Appendices	None

1. Purpose of the Report

In March 2022 Audit Scotland published a report on national arrangements for responding to alcohol and drug challenges in Scotland. This report describes the local response and mitigations that have been put in place.

2. Recommendations

2.1. It is recommended that the Risk, Audit and Performance Committee:

a) Note the content of this report

3. Summary of Key Information

3.1. In 2009 Audit Scotland published a report on national arrangements for responding to alcohol and drug challenges in Scotland. Since that initial report there have been updates most recently in 2019 and 2022

3.2. The most recent 2022 report highlights the reduction in funding for Alcohol and Drug Partnerships prior to April 2021 and since then an increase of funding of £250m nationally *"to around the level it was six years ago in cash terms, but with no real terms increase in funding".* The report highlights the harm caused by drug and alcohol use and in particular the high levels of drug

and alcohol related deaths. The report also highlights the requirement to respond to the root causes of alcohol and drug harms; improving outcome and progress reporting citing the Christie Report, Hard Edges, and poverty as key references to the underlying drivers of harm.

3.3. The report reflects the complex nature of alcohol and drug related harms and also the complex nature of funding and subsequent service delivery. However, it's not clear from the Audit Scotland report what sources have been used to formulate views presented – for example, local ADPs or service providers weren't contacted or interviewed to provide evidence.

3.4. **Governance and Accountability:** Aberdeen City Alcohol and Drug Partnership (ADP) is an Outcome Improvement Group (OIG) of the Community Planning Partnership (CPP) and as such it establishes outcomes that contribute to the Local Outcome Improvement Plan and reports to the CPP Management Group and Board. The ADP uses the Improvement Methodology established by the CPP. The ADP has shared improvement projects with other OIGs - the Children Services Board and Community Justice Partnership and the Resilient Included and Support groups. The ADP has been involved in cross-cutting themes such as stigma and reducing poverty.

3.5. Aberdeen ADP reports to the Integration Joint Board (IJB) in relation to planned work and investment. The ADP will develop the strategic and operation plans and associated business case and seek ratification via the IJB. The IJB issues the appropriate directions. The ADP reports annually to the IJB on progress and to the RAPC.

3.6. The ADP uses commissioning and procurement processes of the Health and Social Care Partnership / Aberdeen City Council and NHS Grampian.

3.7. The ADP has been developing the process of learning from adverse events and drug related deaths. This has included the ADP starting to report learning to the Chief Officers Group as part of a Public Protection agenda to ensure system response to the complex challenge in reducing drug / alcohol related harm.

3.8. Drug and alcohol treatment services are delegated to the Health and Social Care Partnership and fall under their governance and management arrangements.

3.9. **Planning and Investment:** The increase of funding from the Scottish Government has been announced throughout the financial year of 2021/22. The funding has been supplied linked to specific initiatives or through specific routes and is specifically for drug services. Some funding has been awarded directly and some has to be "bid" for. The duration of funding streams is not always clear. Some funding for major programmes has not been confirmed yet. Aberdeen now has seventeen income streams for service delivery. Consequently, throughout 2021/22 it has been hard to redesign services and plan for delivery. It has been difficult to invest and plan for "a" when you don't know what "b" might look like. Overall, the cumulative impact of this has slowed pace of development.

3.10. People experiencing acute drug problems have multiple complex needs. On this basis Aberdeen has aspired over the past 10 years to provide multi-disciplinary services that are as integrated as possible to ensure the best possible care and meet as many cares needs as possible through a single system.

3.11. To mitigate the planning risks associated with complex multiple needs and complex multiple funding streams the ADP has worked to ensure a systems approach to improvement and to reduce the risk of lots of discreet service developments the ADP has sought to 1) build on existing systems, 2) remodel existing services, 3) undertake co-production of proposals and developments, 4) as far as possible undertake primary, secondary and tertiary harm reduction and prevention work. The intended outcome of this approach is to have a unified service based on need.

3.12. **Outcomes and Progress:** The demand for help from people experiencing harm from drugs and alcohol has not reduced and continues to be a system wide challenge. The ADP has sought to balance improvements in relation to prevention, early intervention and continue to meet the demand from expressed need, particularly in relation to acute harm reduction with considerable efforts going to immediate efforts to reduce drug deaths. Aberdeen ADP has seen progress in key outcomes, however there is room

for improvement. Aberdeen initiated a collaboration between Aberdeen, Dundee, Edinburgh and Glasgow as the areas with highest levels of drug and alcohol harm has been established to share learning and approaches and is meeting fortnightly.

3.13. Aberdeen had been making some progress in reducing drug deaths but initial figures for 2021 suspected drug deaths show a potential increase in drug deaths. In particular a cluster in March 2021 and the ongoing challenge of illicit, toxic benzodiazepines have had a significant impact. Confirmed figures for 2021 will be published by National Records Scotland in July 2022. The ADP is progressing a number of Government funded improvements and our services are moving to a new Target Operating Model in response

3.14. **Prevention and Tackling Inequalities:** The ADP Delivery Framework has a balance of primary, secondary and tertiary prevention outcomes and associated programmes of work. These are detailed as part of the Community Planning Partnership Local Outcome Improvement Plan and can be seen in more detail here. As an Outcome Improvement Group of Community Planning the ADP works in conjunction with other groups and cross cutting themes. In particular cross-cutting themes of poverty and stigma.

3.15. **Conclusion:** People with drug and alcohol related issues still face considerable stigma in accessing help. The benefit of having and ADP is that there is a discreet forum to ensure that the needs of vulnerable are appropriately planned and accounted for.

3.16. People with drug and alcohol related issues often have multiple other complex needs. Complex service arrangements and complex funding arrangements make ensuring progress is delivered at pace more difficult.

3.17. The underlying drivers of alcohol and drug related harm in our society are far wider and deeper than the scope of the ADP. Therefore, the fact that in Aberdeen the ADP is part of the CPP, which has an overall aspiration to improve the underlying causes of trauma, poverty and stigma, gives assurance that, as a collective system, we are working to a collective aim of harm prevention.

RISK, AUDIT AND PERFORMANCE COMMITTEE

4. Implications for IJB

4.1. Equalities, Fairer Scotland and Health Inequality: There are no direct equalities, Fairer Scotland or Health Inequalities implications arising from the recommendations of this report.

4.2. Financial: There are no direct financial implications arising from the recommendations of this report.

4.3. Workforce: There are no direct financial implications arising from the recommendations of this report

4.4. Legal: There are no direct legal implications arising from the recommendations of this report

5. Links to ACHSCP Strategic Plan

5.1. The Scottish Government expect to see alcohol and drugs as an identifiable section within the ACHSCP Strategic Plan and outcomes relating to this are contained with the extant plan and the revised Strategic Plan. This plan, the ADP Delivery Plan and priorities within the Community Planning Partnership should all be corporate, and work is being undertaken to ensure this.

6. Management of Risk

6.1. Identified risks(s)

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

6.2 Link to risks on strategic or operational risk register:

Risk 5. “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.”

RISK, AUDIT AND PERFORMANCE COMMITTEE

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

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

This report sets out the relationship between the ADP, the IJB and the Community Planning Partnership. These arrangements aim to give assurance that financial governance and outcome performance are each accounted for by bodies external to the ADP.

Approvals	
[signature]	Sandra Macleod (Chief Officer)
[signature]	Alex Stephen (Chief Finance Officer)

Aberdeen City Health & Social Care Partnership
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RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	23rd June 2022
Report Title	Review of Audit Scotland Reports
Report Number	HSCP22.050
Lead Officer	Alex Stephen, Chief Finance Officer
Report Author Details	Name: Amy Richert Senior Project Manager Arichert@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Appendices	Appendix A – NHS in Scotland 2021

1. Purpose of the Report

1.1. The purpose of this report is to draw the attention of Committee members to relevant reports published by Audit Scotland which have relevance for the ongoing work of the Risk, Audit and Performance Committee, Integration Joint and the Health and Social Care Partnership.

1.2. Audit Scotland produce a range of local and national reports on the performance and financial management of Scotland's public bodies. The following report has been reviewed and identified as specifically relevant for committee members.

- NHS in Scotland 2021

2. Recommendations

2.1. It is recommended that the Risk, Audit and Performance Committee:

a) Note the recommendations made by Audit Scotland in the 'NHS in Scotland 2021' report.
b) Note the other reports listed in Section X which have recently been published and may be of interest to members.

RISK, AUDIT AND PERFORMANCE COMMITTEE

3. Summary of Key Information

3.1. The Auditor General's report, [‘NHS in Scotland 2021’]() (Appendix A) published by Audit Scotland examines the NHS response to the COVID-19 pandemic during 2021 and the subsequent recovery plans for the NHS in Scotland. This is relevant to the RAPC due to both NHS Grampian being a parent organisation for the Health and Social Care Partnership and a key partner. Many NHS services are also devolved to the Aberdeen City health and Social Care Partnership (ACHSCP) or hosted by the ACHSCP.

3.2. There is one recommendation for the Scottish Government within the report and nine recommendations for NHS Boards. These nine recommendations are.

- Work with partners in the social care sector to develop a long-term, sustainable solution for reducing delayed discharges from hospital.
- publish data on performance against the clinical prioritisation categories, to enable transparency about how NHS boards are managing their waiting lists.
- work with patients on an ongoing basis to inform the priorities for service delivery and be clear on how services are developed around patients' needs.
- take a cohesive approach to tackling health inequalities by working collaboratively with partners across the public sector and third sector and be transparent on how it will do this.
- Improve the availability, quality and use of workforce data to ensure workforce planning is based on accurate projections of need.
- Monitor and manage risks around the impact of additional work outlined in the NHS recovery plan on the NHS workforce, to make sure recovery does not negatively affect staff wellbeing.
- communicate widely with the public on changes to how services are delivered so that people are aware of how best to access services and monitor the effectiveness of that communication.
- prioritise the prevention and early intervention agenda as part of the recovery and redesign of NHS services, to enable the NHS to be sustainable into the future.
- improve the availability, quality and use of data on primary, community and social care so that service planning is based on accurate measures of existing provision and demand

3.3. The above recommendations represent a fair reflection of the actions needed to support the NHS to continue to deliver services and recover from COVID-

19 in 2022. There are no areas where consideration is not already being made within local planning either at an NHS Grampian level through the NHS Grampian Plan for Our Future or at an Aberdeen City level through the ACHSCP's Strategic Plan 2022-2025 and the accompanying workforce plan currently in development.

4. Implications for IJB

4.1. Equalities, Fairer Scotland and Health Inequality

This report does not indicate any change in policy or service which would have any impact on those with protected characteristics and is not strategic as defined within the Fairer Scotland duty.

4.2. Financial

There are no specific financial impacts as a result of this report.

4.3. Workforce

There are no specific workforce impacts as a result of this report.

4.4. Legal

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

4.5. Other

5. Links to ACHSCP Strategic Plan

5.1. The recommendations made by the Auditor General in their report, 'NHS in Scotland' are in line with our strategic aims as determined by the ACHSCP Strategic plan 2022-2025.

6. Management of Risk

6.1. Identified risks(s)

There is a risk that the RAPC is not aware of Reports published by Audit Scotland where content would be relevant to the remit of the Committee. This report addresses this risk.

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

This is linked to following risks on the Strategic Risk Register;

RISK, AUDIT AND PERFORMANCE COMMITTEE

- Risk 1
  Cause: The strategic commissioning of services from third and independent sector providers requires both providers and ACHSCP to work collaboratively (provider with provider and provider and ACHSCP) in order to strategically commission and deliver services to meet the needs of local people. This is a new dynamic, based on mutual trust.
  Event: Limitations to the extent with which strategic commissioning of services progresses between ACHSCP and third and independent providers of health and social care.
  Consequence: There is a gap between what is required to meet the needs of local people, and services that are available; consequences to the individual include not having the right level of care delivered locally, by suitably trained staff; consequences to the sector include investments made in services that will not be fully utilised and thereby risks to sustainability; and consequences to the partnership includes an inability to meet peoples needs for health and care and the additional financial burden of seeking that care in an alternative setting
- Risk 5
  Cause: Performance standards/outcomes are set by national and regulatory bodies and those locally-determined performance standards are set by the board itself.
  Event: There is a risk that the IJB, and the services that it directs and has operational oversight of, fails to meet the national, regulatory and local standards.
  Consequence: This may result in harm or risk of harm to people.
- Risk 9;
  Cause: Impact of Covid19 has accelerated and accentuated long-term workforce challenges
  Event: Insufficient staff to provide patients/clients with services required.
  Consequence: Potential loss of life and unmet health and social care needs, leading to severe reputational damage.”

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

This report draws attention to recommendations made in the NHS Scotland report which are relevant to the RAPC and ensures these have been noted

and considered. These are specifically linked to wider mitigations in place around the identified risks.

Approvals	
[signature]	Sandra Macleod (Chief Officer)
[signature]	Alex Stephen (Chief Finance Officer)

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NHS in Scotland 2021

Prepared by Audit Scotland
February 2022

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Audit team

The core audit team consisted of: Leigh Johnston, Derek Hoy, Eva Thomas-Tudo, Claire Tennyson and Lucy Ross under the direction of Angela Canning.

Key messages

1. **The NHS in Scotland is operating on an emergency footing and remains under severe pressure.**
The success of the vaccinations programme has reduced deaths but the ongoing impact of responding to variants of Covid-19 has created a growing backlog of patients waiting much longer for treatment. The backlog poses a significant risk to the Scottish Government's recovery plans, which aim to transform how care is delivered. Reform is key to the sustainability of the NHS, and it must remain a focus, building on the innovation seen throughout the pandemic. Crucially, the public must be kept aware of and involved in changes to service provision. But transforming services will be very difficult to deliver against the ongoing competing demands of the pandemic and an increasing number of other policy initiatives, such as plans for a National Care Service.

2. **NHS and social care workforce planning has never been more important.**
Frontline NHS and social care staff, leaders and civil servants have shouldered a heavy burden over the last two years, and this has affected their wellbeing. The Scottish Government has introduced measures to support staff and is monitoring their effectiveness. But it must also prioritise addressing workforce availability challenges if its recovery plan is to be successful. Its plans to recruit and retrain staff are ambitious and will be challenging to achieve given the NHS's historical struggles to recruit enough people with the right skills.

3. **The NHS's ability to plan for recovery from Covid-19 remains hindered by a lack of robust and reliable data across several areas.**
This includes workforce data, as well as primary, community, social care and health inequality data. The collection and use of this data must improve to support decision-making and to ensure policy decisions are delivering the best outcomes for people.

4. **The NHS was not financially sustainable before the pandemic and responding to Covid-19 has increased those pressures.**
In 2020/21, the Scottish Government allocated £2.9 billion for pandemic-related costs. It has committed additional funding for health and social care in 2021/22 and beyond but there is uncertainty about future Covid-19 funding levels and the longer-term financial position. The Scottish Government plans to bring financial planning, service planning, workforce planning and capital investment together under a new Care and Wellbeing Portfolio. This has the potential to help the NHS become sustainable, but it is very early days. The key to financial stability remains a clear focus on the Scottish Government's long-standing commitment to transform how health and social care services are delivered.

Recommendations

The Scottish Government should:

- address the wellbeing risks affecting staff in the Scottish Government's Health and Social Care directorate as well as the NHS and social care workforce **(paragraph 18).**

The Scottish Government and NHS boards should:

- work with partners in the social care sector to develop a long-term, sustainable solution for reducing delayed discharges from hospital **(paragraph 15)**
- publish data on performance against the clinical prioritisation categories, to enable transparency about how NHS boards are managing their waiting lists **(paragraph 39)**
- work with patients on an ongoing basis to inform the priorities for service delivery, and be clear on how services are developed around patients' needs **(paragraph 57)**
- take a cohesive approach to tackling health inequalities by working collaboratively with partners across the public sector and third sector, and be transparent on how it will do this **(paragraphs 62 and 63)**
- improve the availability, quality and use of workforce data to ensure workforce planning is based on accurate projections of need **(paragraph 87)**
- monitor and manage risks around the impact of additional work outlined in the NHS recovery plan on the NHS workforce, to make sure recovery does not negatively affect staff wellbeing **(paragraph 90)**
- communicate widely with the public on changes to how services are delivered so that people are aware of how best to access services, and monitor the effectiveness of that communication **(paragraph 95)**
- prioritise the prevention and early intervention agenda as part of the recovery and redesign of NHS services, to enable the NHS to be sustainable into the future **(paragraph 98)**
- improve the availability, quality and use of data on primary, community and social care so that service planning is based on accurate measures of existing provision and demand **(paragraph 99)**.

Introduction

1. The Covid-19 pandemic continues to provide a unique and difficult challenge for the NHS in Scotland. This report builds on our coverage of the response to the pandemic in our NHS in Scotland 2020 report.[1] It also follows our Covid-19 briefings on personal protective equipment and the vaccination programme.[2] [3] The report examines the continued impact of the pandemic on services and people's health in 2021. It also considers the Scottish Government's recovery plans for the NHS and looks at how services might be delivered in the future to better meet changing demand. We also provide an overview of financial performance across the NHS in Scotland in 2020/21 and consider the financial challenges that lie ahead. Our audit approach is set out in the Appendix.

2. The Scottish Government and the NHS continue to respond to Covid-19 as the pandemic progresses, while pushing ahead with plans for recovery. Policy and guidance are being updated frequently and our findings reflect the situation at January 2022, using information available before publication. The Scottish Government and the NHS are working in a quickly changing environment, as the emergence of the Omicron variant in late 2021 has shown. A lot of the work we cover in the report is at an early stage. It is too early for us to make judgements on some of these programmes of work.

3. We would like to acknowledge the support and assistance provided by the Scottish Government and NHS boards that has enabled us to prepare this report.

The ongoing response to the pandemic

The NHS continues to operate under extremely challenging circumstances with an ongoing focus on the response to Covid-19 and providing emergency and urgent care

4. The NHS in Scotland is still operating in extremely challenging circumstances. NHS staff have continued to demonstrate their extraordinary commitment to public service, working under significant pressure for a period longer than anyone could have predicted at the outset.

5. Responding to the Covid-19 pandemic is still putting NHS boards under considerable strain and the Scottish Government has confirmed that the NHS will continue to operate on an emergency footing until at least March 2022. This means that non-urgent care and treatment may continue to be postponed, so that NHS boards can manage the immediate demands of responding to Covid-19 and continue to provide emergency and urgent care.

6. The ongoing need to implement public health measures to prevent and control infection continues to affect NHS capacity and resources. The Scottish Government and the NHS have put in place several programmes of work as part of the ongoing response:

- **The Covid-19 vaccination programme.** In September 2021, we published a briefing paper on the rollout of the Covid-19 vaccination programme. The NHS has made excellent progress in vaccinating a large proportion of people aged 18 years and over.[4] The programme has since been extended to offer vaccines to children aged five years and over, and to offer third doses for more vulnerable people and booster vaccinations for adults aged over 18 years. Uptake has been very high: at 16 February 2022, 92.2 per cent of those aged 12 years and over have received at least one dose of a Covid-19 vaccine.[5]

Covid-19: Vaccination programme
September 2021

- **Test and Protect.** Scotland's approach to testing and contact tracing has developed as the pandemic has progressed. At 16 February 2022, more than 15.3 million PCR Covid-19 tests had been carried out, and more than 1.1 million of these were positive.[6] [7] In December 2021, the Scottish Government published an evaluation of the asymptomatic testing programme.[8] This found that between 25 November 2020 and 27 June 2021, more than

7,000 positive cases were identified through this programme. These cases may not have otherwise been detected if they remained asymptomatic or may have been diagnosed later once symptomatic. The evaluation found that there were some barriers to maximising the impact of the programme, including concerns about the perceived reliability of the tests, and the consistency of people self-reporting results.

- **Distribution of personal protective equipment (PPE).** PPE has been supplied to the NHS and social care services, free of charge, throughout the pandemic. The Scottish Government has committed to continue this until at least March 2022. This is currently expected to cost £158.9 million in 2021/22. It is not yet clear what arrangements will be in place after March 2022. Our briefing paper on PPE (June 2021) noted that the Scottish Government and NHS National Services Scotland (NHS NSS) have been working with partners to develop a longer-term approach to supplying and distributing PPE.

Covid-19: Personal protective equipment
June 2021

7. NHS boards' ability to implement their remobilisation plans for 2021/22 is highly dependent on how the pandemic progresses. These outlined NHS boards' priorities for increasing activity while maintaining their capacity to treat Covid-19 patients.

8. The assumptions in these plans understandably included a lot of caveats because of the uncertain ongoing impact of the pandemic on the NHS. The Scottish Government reviewed the strength and content of the remobilisation plans and identified several themes, including:

- good coverage of priorities encompassing acute, primary, community and social care
- the importance of looking after the wellbeing of the workforce
- a clear commitment to doing things differently, building on lessons learned and on innovations such as the redesign of urgent care and Near Me
- the importance of working in partnership with the public sector and third sector, with staff and clinical colleagues, and with local communities.

9. The review also highlighted several risks that had been identified by NHS boards and that could considerably affect the scale and pace of remobilisation during 2021/22. These include:

- uncertainty about how the Covid-19 pandemic will develop and the potential impact of future surges on the NHS
- workforce issues, including the need to make sure that staff have time and support to rest and take leave and concerns about sustainability because of retirals, recruitment challenges, redeployment and having the appropriate skills mix

- concerns about the longer-term impact of Covid-19 on the population and the way in which health and social care services will be delivered. Examples include the resources needed to further develop the role of public health services; the ongoing need for enhanced infection prevention and control measures; and the impact of unidentified and unmet healthcare needs on the demand for services.

The Scottish Government and NHS boards took action to prepare for a challenging winter

10. The Scottish Government acknowledged that winter 2021/2022 was likely to be extremely challenging for the NHS and, along with NHS boards, took action to prepare. The usual winter pressures, such as respiratory illnesses and falls, need to be managed along with Covid-19. The NHS has been rolling out its most extensive flu vaccination programme yet to minimise the spread of infection and the impact on services.

11. The Scottish Government asked NHS boards to update their remobilisation plans in Autumn 2021, to help ensure they were well prepared for the winter. In addition, in October 2021, the Scottish Government published a health and social care winter overview, outlining its winter planning preparations.[9] This was based on four principles:

- maximising capacity through investment in staffing, resources and facilities
- caring for staff by ensuring timely access to wellbeing support, so that they can continue to work safely and effectively
- reducing delayed discharge from hospitals and increased access to care in a range of community settings
- improving outcomes by investing in delivering the right care in the right setting.

12. The emergence of the Omicron variant at the start of winter 2021/22 demonstrated how the uncertain path of the pandemic can impact on NHS services. Covid-19 case numbers spiked dramatically throughout December and into early January followed by a spike in hospital admissions and moderate increases in deaths and ICU stays. This added to the pressure on the NHS during an already difficult winter season. This was further exacerbated by staff absences owing to Covid-19 while case numbers grew and isolation guidelines were tightened.

13. The Covid-19 vaccine booster programme was accelerated in line with updated clinical guidance following the emergence of the Omicron variant. While this was expected to reduce the health impact of the virus it added to the pressure on vaccination teams.

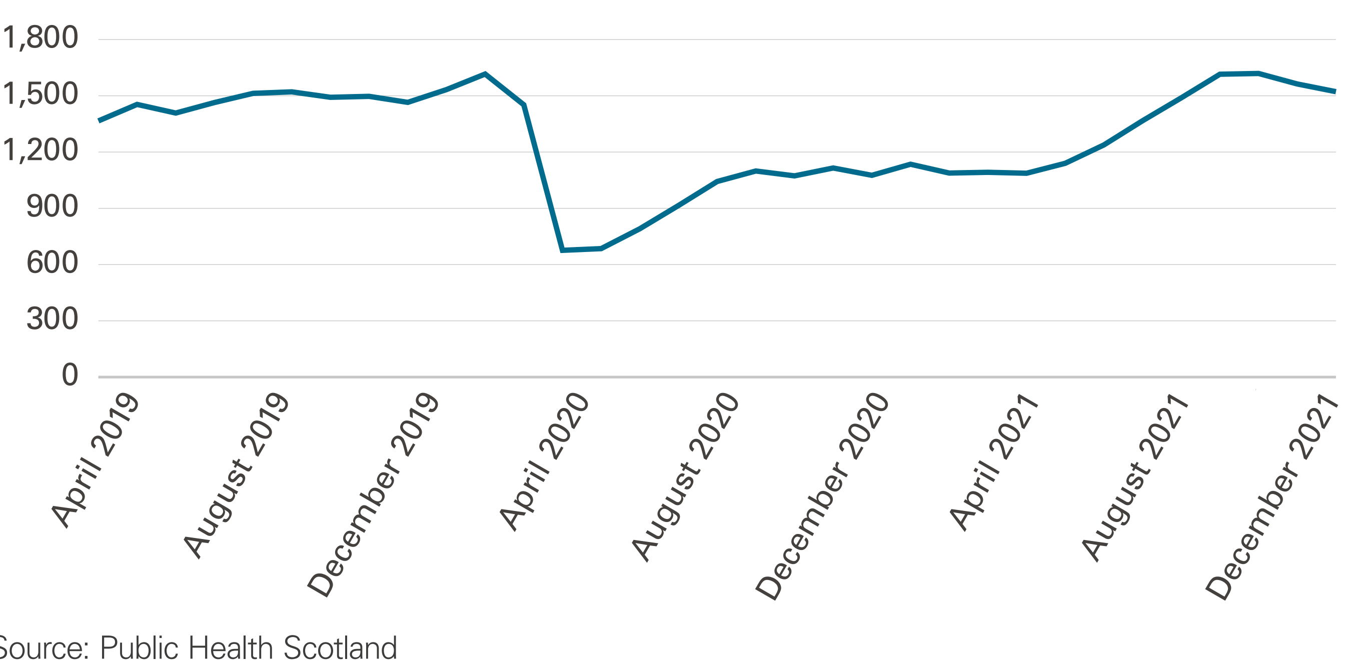
14. At the start of the Covid-19 pandemic, the Scottish Government introduced a rapid discharge strategy aiming to increase capacity in acute hospitals. This was effective, resulting in a substantial drop in delayed discharges between March and April 2020 (Exhibit 1). Delayed discharges gradually increased after April 2020 and had reached pre-pandemic levels by September 2021, putting additional pressure on NHS hospitals. The Scottish Government has said that this is because there have been increasing numbers of people admitted to hospital requiring care packages on discharge.

15. In its health and social care winter overview, the Scottish Government committed to providing £62 million, to increase the capacity for providing care at home, and funding of £40 million, to move people delayed in hospital into care homes on a short-term basis. This aimed to free up capacity in hospitals over the winter. By December 2021 there had been a small decrease in the average daily bed days occupied by delayed discharges (Exhibit 1). The measures to reduce delayed discharges, particularly during the first wave of the pandemic, were effective in the short term but a longer-term, more sustainable solution is needed.

Exhibit 1.

Average daily bed days occupied by patients whose discharge from hospital was delayed – April 2019 to December 2021

There was a substantial decrease in delayed discharges at the start of the Covid-19 pandemic, but they have since returned to pre-pandemic levels.



Source: Public Health Scotland

The unprecedented pressures of the pandemic continue to limit the capacity of the NHS workforce

16. Scottish Government and NHS staff have been working relentlessly to support the ongoing response to the pandemic and deliver services. Staff absences attributable to Covid-19 continue to limit capacity (Exhibit 2, page 11).[10] Vacancy rates for nursing and midwifery, and allied health professionals, such as physiotherapists, were higher in September 2021 than in any of the previous four years.[11]

17. The Scottish Government recognises that the risks relating to workforce capacity and wellbeing are significant. This has been reflected throughout the year in the Scottish Government's Health and Social Care Risk Register. The Scottish Government has introduced a range of controls to mitigate the risks. For example, it developed a recruitment plan to address winter pressures and winter disease. It also set up a Sustainable Vaccination Workforce Group to ensure that delivering the vaccination programme did not put further pressure on the wider healthcare system. It is too early to tell how effective these measures have been.

18. The workforce risks included in the Health and Social Care Risk Register refer only to health and social care staff. The Scottish Government should also consider risks affecting staff in the Scottish Government's Health and Social Care directorate.

19. Our NHS in Scotland 2020 report highlighted the negative impact of the pandemic on NHS staff wellbeing. This impact persists almost two years into the pandemic. Staff surveys carried out by trade unions and regulators continue to show a high number of staff saying their physical and mental wellbeing has been negatively affected. The results of the annual iMatter staff experience survey are currently being analysed and the Scottish Government intends to publish the report in early 2022.

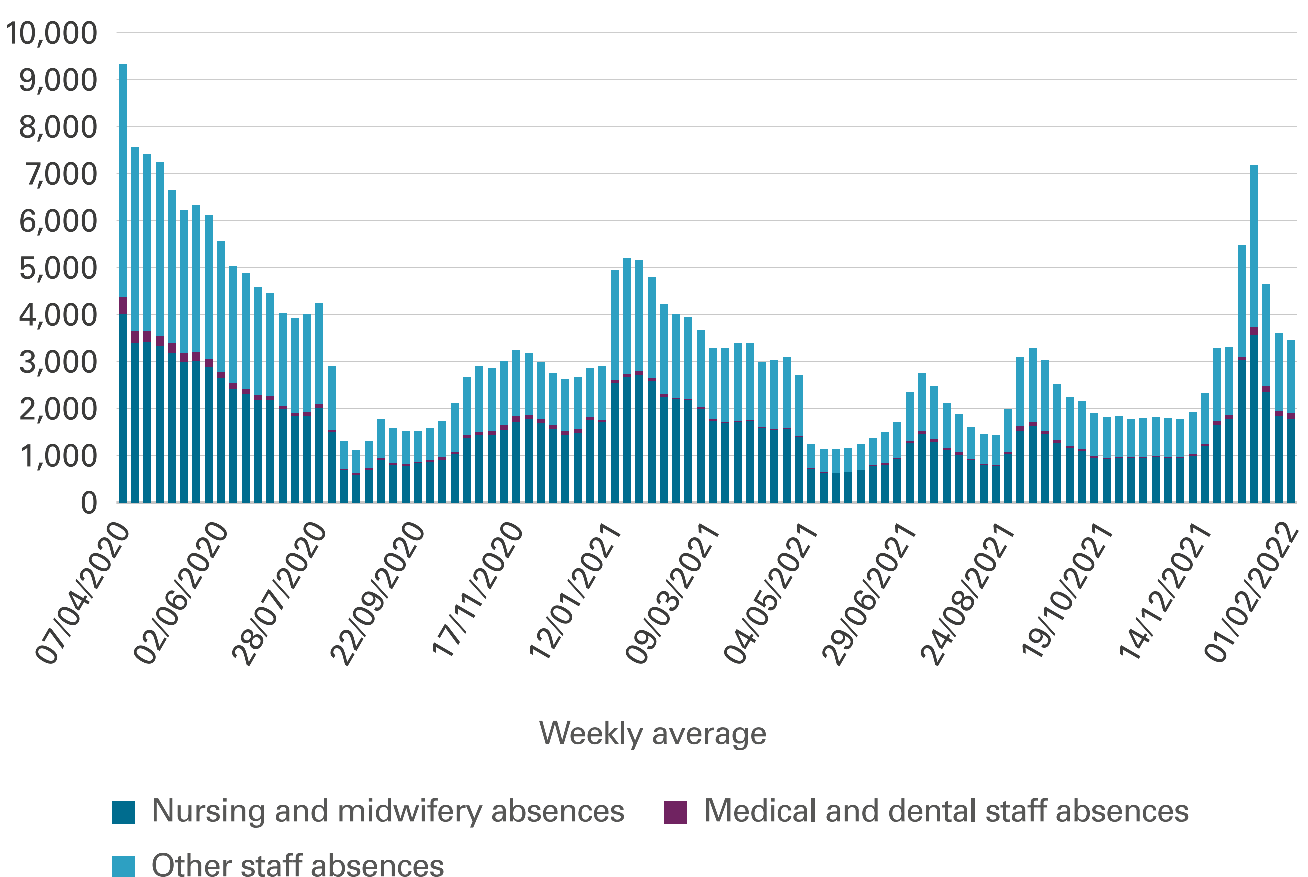
20. The 2021 Royal College of Nursing (RCN) Employment survey found that 40 per cent of nursing staff in Scotland are working beyond their contracted hours on most shifts.[12] Also, 67 per cent said they were too busy to provide the level of care they would like and 72 per cent said they were under too much pressure at work. It also found that 61 per cent are thinking about leaving their current position, with the main reasons being feeling undervalued, feeling under too much pressure, low staff levels and low pay. In comparison, 36 per cent of respondents to the RCN UK-wide Pay and Working Conditions Survey at the start of the pandemic said they were thinking of leaving their current position.[13]

21. The percentage of sickness absence attributable to stress and/or poor mental health increased for most NHS boards in 2020/21, compared with 2019/20. It is not clear whether those increases were caused by work-related stress or poor mental health owing to the pressures of the pandemic. The data also needs to be considered in the context of overall lower rates of non-Covid-19 sickness absence in 2020/21.

Exhibit 2.

The number of NHS staff absent because of Covid-19 – April 2020 to February 2022

Staff absence due to Covid-19 has varied but has been high throughout the pandemic.



Note: This graph shows the weekly average of daily absences.

Source: Scottish Government

The Scottish Government and NHS boards worked quickly to support staff wellbeing, but it is too soon to assess the effectiveness of the measures put in place

22. The Scottish Government and NHS boards worked quickly to increase the support available for the health and social care workforce. In 2020/21, the Scottish Government allocated £8 million for wellbeing support and announced a further £4 million in October 2021 to support wellbeing during the winter pressures.[14] [15] Seven measures have been introduced at a national level to support staff. These include access to support via a National Helpline, an online National Wellbeing Hub and a

Workforce Specialist Service offering specialist support in understanding the mental health needs of health and social care professionals who may be reluctant to seek help or struggle to find confidential care.

23. The measures put in place so far are appropriate, but it is too soon to fully assess their effectiveness. Governance arrangements for the programme of work are in place and include project teams, an oversight group and a programme board. The Scottish Government is monitoring the uptake of the measures and gathering feedback from service users.

24. The Scottish Government has reviewed the first 100 service users of the Workforce Specialist Service, usage of the National Wellbeing Helpline and examined analytics of the National Wellbeing Hub. Feedback has suggested that they have had a positive impact on wellbeing, although the National Wellbeing Helpline has had low call volumes. The Scottish Government will continue to evaluate the staff support measures it has introduced.

25. The scale of need for support is not clear. It is important that the Scottish Government continues to engage with the health and social care workforce and take account of the experiences of different staff groups as this programme of work develops.

26. The Scottish Government established a short life working group, including representatives from the health and social care sector, to provide recommendations to support workforce recovery. These fed into the NHS recovery plan published in August 2021.[16] The Scottish Government is exploring opportunities for a panel of health and social care staff to share their experiences. Our social care briefing, published in January 2022, highlights the immense pressure social care staff are under and the ongoing challenges with recruitment and retention within the sector.[17]

Social care briefing
January 2022

27. The Scottish Government told us that there is not a culture of seeking help in the health and social care sector. Support needs to be improved, for example by ensuring that wellbeing is part of conversations between staff and their managers. Achieving this will take time and involve managing the tension between the competing demands of staff wellbeing, the pandemic response, and remobilisation.

The Scottish Government and NHS are implementing lessons learned during the pandemic

28. Some changes brought in during the pandemic were specific to the response required and will not be adopted permanently. But other changes can bring ongoing benefits to health services and can aid the recovery effort and improve future service delivery.

29. The Scottish Government and NHS have acted quickly to learn from changes brought in during the pandemic and have started to embed that

learning across NHS services. The Scottish Government commissioned a report, published in August 2021, on lessons identified from the health and social care response to Covid-19 in Scotland during the first six months of the pandemic.[18]

30. The report concluded that a considerable amount of work had gone into identifying what had worked well and what opportunities exist for new ways of working. It identified clear examples of good practice at individual board level and through national programmes. It also recommended clearly defining roles and responsibilities for implementing lessons learned exercises, with the Scottish Government coordinating and overseeing to avoid overlap and duplication.

31. The findings have informed other work, for example, the NHS recovery plan, the Programme for Government, and the development of a Care and Wellbeing Portfolio (paragraph 103). The Scottish Government created an action tracker outlining progress against recommendations and additional commitments. It shows where lessons could inform future pandemic preparedness and the development of policy and reform work. It also outlines how lessons identified are being addressed in the creation of its Care and Wellbeing Portfolio.

32. It is important that new ways of delivering services continue to be evaluated to assess the ongoing appropriateness and effectiveness of the changes, and to avoid exacerbating or creating health inequalities.

Scottish ministers are setting up a public inquiry to investigate the handling of the Covid-19 pandemic in Scotland

33. In December 2021, the Deputy First Minister announced terms of reference and the appointment of a chair for a public inquiry into the handling of Covid-19 in Scotland.[19] The inquiry will look at the strategic response to the pandemic and cover 12 areas of investigation, to identify lessons to be learned and recommendations. It will look across pandemic preparedness, the direct and indirect health impacts, education and financial support. The inquiry will cover the period from 1 January 2020 to 31 December 2022 but will also include pandemic planning undertaken before then. The terms of reference for the inquiry were set by the Scottish Government and informed by public engagement.

The continuing health impact of Covid-19

The pandemic continues to have an impact on the health of people in Scotland, but fewer people are dying from Covid-19

34. By the end of January 2022 Covid-19 had caused or contributed to more than 12,900 deaths in Scotland. The number of people dying from Covid-19 has been significantly lower since the rollout of the vaccination programme from late 2020, despite higher numbers of positive cases (Exhibit 3, page 15).

35. From September 2021, there has been another increase in people with Covid-19 being admitted to hospital. This is putting considerable pressure on hospitals at a time when they are already under enormous strain. There is also the risk that if new variants of the virus continue to emerge, the vaccines may become less effective.

36. On average there has been a higher number of deaths from other causes during the pandemic. From the week beginning 24 May 2021, deaths were above average levels for 32 consecutive weeks. For 2021 as a whole, excess deaths were ten per cent above the average for the five-year period 2015 to 2019.[20] The Scottish Parliament has launched an inquiry to investigate what factors have led to this increase.

The Covid-19 pandemic has led to a considerable backlog of people waiting for NHS diagnosis and treatment

37. Responding to the Covid-19 pandemic has severely affected the ability of NHS boards to continue to see and treat people with other healthcare needs. The Scottish Government directed NHS boards to pause non-urgent treatment and screening programmes during the first wave of the pandemic. The NHS has been working to resume the full range of healthcare services but capacity in hospitals continues to be limited. This has led to increasing numbers of people waiting much longer for diagnosis and treatment (Exhibit 4, page 16).

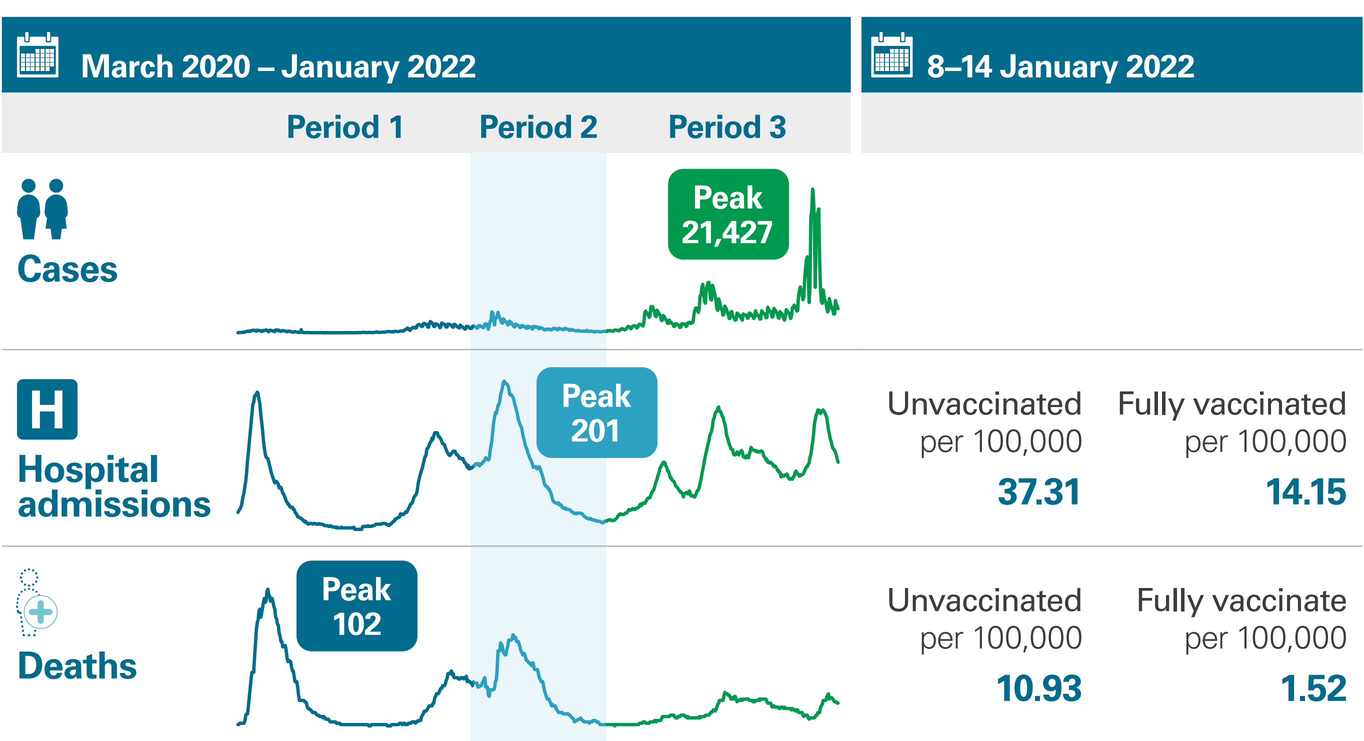
38. In November 2020, the Scottish Government published a clinical prioritisation framework outlining how NHS boards should prioritise patients for treatment during the Covid-19 pandemic.[21] This approach means that patients in most urgent need should be seen first and those of lower clinical priority will need to wait longer. Patients are categorised in priority levels as follows:

- Level 1a emergency – operation needed within 24 hours
- Level 1b urgent – operation needed within 72 hours
- Level 2 surgery – scheduled within four weeks
- Level 3 surgery – scheduled within 12 weeks
- Level 4 surgery – may be safely scheduled after 12 weeks.

Exhibit 3.

Covid-19 cases, deaths and hospital admissions – March 2020 to January 2022

The Covid-19 vaccination programme has helped to reduce the number of people needing hospital treatment or dying from Covid-19.



Period 1 – Before the vaccination programme
Period 2 – 8 December 2020: Vaccination programme began
Period 3 – 7 May 2021: 98% of priority groups 1–9 had received their first dose of a Covid-19 vaccine

Notes:
1. The data for Covid-19 deaths and hospital admissions are based on the average number of registered deaths and the average number of people admitted to hospital over the previous seven days.
2. People who are fully vaccinated are defined as having a third dose or booster shot.
3. The hospitalisation and mortality rates per 100,000 are age-standardised per 100,000 people per week, standardised to the 2013 European Standard Population.

Source: Public Health Scotland

Exhibit 4.

National trends in demand for hospital services and activity April 2019 – September/December 2021

Hospital activity is increasing but remains lower than pre-pandemic levels. Demand for services and the numbers waiting considerably longer for tests and treatment have increased.

Demand	Start	End	% change
April 2019 to September 2021			
Number waiting for diagnostic tests	92,239	125,557	↑ 36.1%
June 2019 to September 2021			
Number waiting for an inpatient or day case admission	75,608	106,496	↑ 40.9%
Number waiting for a new outpatient appointment	323,408	425,242	↑ 31.5%
Activity			**% change**
April 2019 to December 2021			
Number of scheduled elective operations in theatre system	27,204	17,836	↓ -34.4%
April 2019 to September 2021			
Number of inpatient and day case admissions	70,691	45,449	↓ -35.7%
Number of new outpatient appointments seen	361,944	286,935	↓ -20.7%
Length of waits			**% change**
April 2019 to September 2021			
Number waiting longer than 6 weeks for diagnostic tests	16,446	53,023	↑ 222.4%
June 2019 to September 2021			
Number waiting longer than 12 weeks for an inpatient or day case admission	23,930	66,602	↑ 178.3%
Number waiting longer than 12 weeks for a new outpatient appointment	86,450	220,888	↑ 155.5%

Source: Public Health Scotland

NHS in Scotland 2020
February 2021

39. We recommended in our NHS in Scotland 2020 report that data on waiting times based on the categories in the clinical prioritisation framework should be published. This will enable transparency and scrutiny of how NHS boards are managing their waiting lists. Public Health Scotland and NHS boards continue to progress this recommendation and the Scottish Government should work with them to publish this information as soon as possible.

40. Referrals are increasing but the impact of delayed or missed diagnosis is a big risk. There is evidence that some people avoided accessing health services, particularly during the first months of the pandemic. This creates the risk that health conditions will go undetected for longer, leading to potentially worse outcomes for people.

41. The first port of call for most people with medical concerns is their GP, who can refer them to specialist services where required. Data on the number of GP appointments carried out is not available, so the extent to which people avoided seeing their GPs during the Covid-19 pandemic is based on survey information and referrals to hospital services.

42. A survey by YouGov has been carried out since the start of the pandemic, to monitor public opinion in Scotland. In December 2021, it found that 25 per cent of respondents would avoid contacting a GP for immediate medical concerns unrelated to Covid-19. This has improved since April 2020 (when it was 45 per cent), but it indicates the significant unknown need that is present.[22]

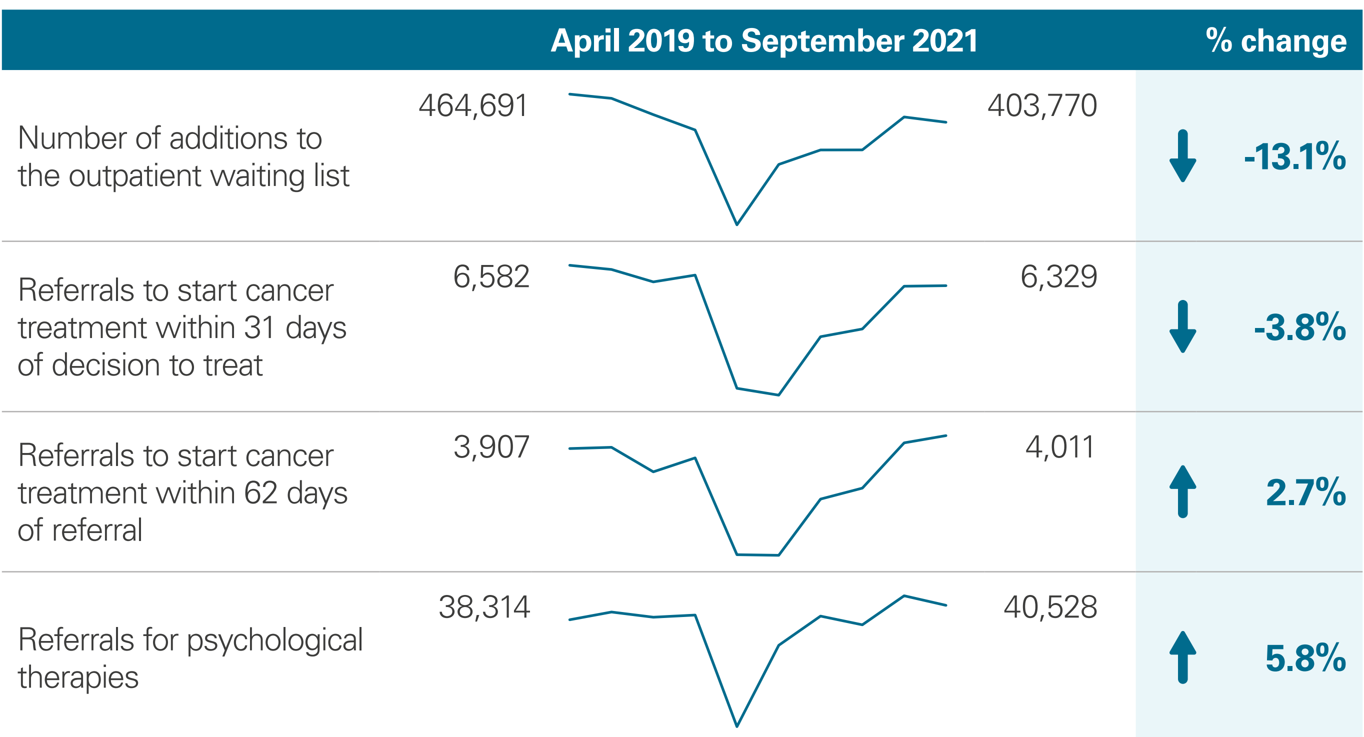
43. Referrals for outpatient appointments, cancer treatment and psychological therapies decreased significantly between April and June 2020. This is concerning, as it is unlikely to be because of a reduced occurrence of illness. There are longer-term risks associated with delayed or missed diagnosis, such as people becoming more acutely unwell and requiring more intensive treatment.

44. Referrals increased throughout 2021, indicating that more people are now seeking help for medical concerns than at the start of the pandemic (Exhibit 5, page 18). Referrals for psychological therapies have now exceeded pre-pandemic levels, and similar trends may be seen in other specialties in future.

45. Clearly the pandemic is having an impact on people's health beyond the direct effects of Covid-19. The scale of delayed diagnosis and treatment and what this means for NHS services and patients is not yet known. The Scottish Government does not yet have an overall strategy for monitoring the wider health impact of Covid-19. Public Health Scotland is monitoring some specific areas, such as the number of undiagnosed cancer cases. But a cohesive strategy is needed to better understand what the wider health impact of Covid-19 will be on NHS services and inform future service provision.

Exhibit 5.
Trend in referrals – April 2019 to September 2021

There were significantly fewer referrals for outpatient appointments, cancer and psychological therapies at the start of the pandemic, but levels have been increasing steadily since.



Source: Public Health Scotland

Demand for urgent and emergency care is putting significant pressure on hospitals

46. During the first few months of the pandemic, the number of people attending accident and emergency departments (A&E) fell significantly, and there were fewer emergency hospital admissions. These have both now increased and are similar to pre-pandemic levels.

47. Additional measures to prevent the spread of Covid-19, such as enhanced infection prevention and control measures, impact on productivity and flow in A&E.[23] This means that it is much more challenging to see and treat people within the four-hour target. For example, between 27 December 2021 and 23 January 2022, 72.9 per cent of unplanned attendances at A&E were seen within four hours, compared with 84 per cent between 30 December 2019 and 26 January 2020.[24]

48. The Scottish Ambulance Service (SAS) has also been under significant pressure. The need for additional PPE has increased the length of time that ambulance crews are spending with patients at the scene, and ambulances are also waiting outside hospitals for considerably longer. This is limiting the ability of ambulance crews to respond to other calls and leading to longer wait times for people who need an ambulance. SAS has required military support to supplement ambulance drivers and staff mobile testing centres. In September 2021, 225 military personnel were drafted in to support SAS.

49. SAS is working to improve the situation. It has accelerated plans to establish a navigation hub to direct paramedics to the most appropriate care for their patients. It is also in the process of recruiting GPs to assess the needs of patients waiting for an ambulance to prioritise their urgency more effectively.

Referrals for mental health services are now exceeding pre-pandemic levels, reflecting the impact of Covid-19 on people's mental health

50. The pandemic has had a considerable impact on mental health. It has been a difficult period for everyone, and lockdowns and physical distancing meant that some people were isolated from friends and family for months. There was, however, a considerable decrease in referrals for both adult and children's mental health services in 2020/21.[25] This is likely to reflect the impact of school closures and limited access to GPs and other services from which referrals are often made, rather than a reduction in demand.

51. In October 2020, the Scottish Government published its mental health transition and recovery plan, to respond to the mental health impacts of the pandemic.[26] The plan contains more than 100 actions, and the Scottish Government has committed £120 million in 2021/22 to take this work forward.[27] Referrals to mental health services and the number of appointments offered have now returned to pre-pandemic levels. In 2022, we plan to carry out further performance audit work on mental health services.

The Scottish Government has started to plan for Long Covid rehabilitation, but the extent of this condition is still unknown

52. Long Covid consists of prolonged symptoms, following a Covid-19 infection, that continue for more than four weeks and are not explained by an alternative diagnosis. In January 2022, an estimated 1.9 per cent of people in Scotland[28] were experiencing Long Covid symptoms.[29] The prevalence of Long Covid in Scotland is based on self-reported data, so this figure may not accurately represent the number of people with the condition. The figure only covers people living in individual

households and does not cover those in communal places of residence, such as care homes.

53. The Scottish Government has funded nine studies to develop the clinical knowledge base for Long Covid and its impact on people's health, which will also inform planning for the expected demand on NHS services.

54. In September 2021, the Scottish Government announced a £10 million Long Covid Support Fund and published its approach to supporting those affected. The approach is based on four key elements: self-management, primary care and community-based support, rehabilitation support, and secondary care services.[30] Many people are able to recover from Covid-19 at home, and the Scottish Government plans to promote self-management where possible. Self-management will also reduce any additional pressure being placed on NHS services. Several pieces of work are under way, including a self-management marketing campaign launched in October 2021.

The Scottish Government aimed to make public health measures inclusive, but some people were disproportionately affected

55. The Scottish Government and NHS Scotland took action to make attempts to control the virus as inclusive as possible. The Scottish Government carried out equality impact assessments (EQIAs) of several measures introduced to respond to the pandemic, such as the expansion of the Near Me video consulting programme. Other measures taken to support an inclusive approach included the following:

- Covid-19 vaccination programme – the Scottish Government and NHS boards worked with partners to increase vaccination uptake and reduce vaccine hesitancy through methods such as improving the accessibility of information, tailoring messages to specific communities and outreach work targeting groups that may be less likely to come forward for vaccinations.
- Test and Protect – working with partners to reach under-represented groups, for example by improving access to testing in targeted settings such as places of worship, making contact tracing scripts more accessible for non-native English speakers and people with other needs, and providing financial support for those self-isolating.

56. The Health and Social Care Alliance Scotland was invited by the Scottish Government to lead engagement work on people's experience of changes to health and social care during the pandemic.[31] The findings of this work included variation in access to services, such as GP services and specialist services. For some, such as those with chronic pain, the reduced access to support resulted in concerns about managing their health. Disability Equality Scotland also reported that disabled people

were anxious about the impact of cancelled or postponed appointments on their health.[32]

57. The Scottish Government and NHS boards should work with patients on an ongoing basis to inform the priorities for service delivery and be clear on how services are developed around patients' needs.

A collaborative approach is required to tackle long-standing health inequalities

58. Our NHS in Scotland 2020 report highlighted that some people have been more adversely affected by the pandemic than others. Those from the most deprived areas and from some ethnic minority backgrounds were more likely to die from Covid-19. Further data has shown that disabled people were more likely to have died from Covid-19.[33] Adults with learning disabilities were also at a greater risk of being hospitalised or dying from Covid-19.[34]

NHS in Scotland 2020
February 2021

59. The pandemic has exacerbated long-standing health inequalities. Life expectancy in Scotland had not changed since 2012–14, and the number of years that people live in good health has started to decrease. The trends in healthy life expectancy show that people living in more deprived areas could expect to live more than 20 fewer years in good health than those living in less deprived areas.[35]

60. Health inequalities continue to be a significant problem in Scotland since we last reported on this topic.[36] The disproportionate impact of Covid-19 on certain groups has led to the Scottish Government increasing its focus on tackling health inequalities, but there is no overarching strategy. Several programmes of work are under way targeting specific areas, for example on improving women's health and mental health, and improving race equality.

61. In September 2021, the Scottish Government published its Race Equality: Immediate Priorities Plan.[37] This aims to ensure a fair and equal recovery from Covid-19 for minority ethnic communities. It sets out the work taking place on race equality across government, as well as the actions being taken to implement the recommendations from the Expert Reference Group for Covid-19 and Ethnicity.

62. While it is positive that these programmes of work are taking place, it only targets some of the groups experiencing health inequalities. For instance, there are no separate plans for people with disabilities or those experiencing homelessness. The Scottish Government should develop an overarching strategy for tackling health inequalities and develop work programmes for all target groups.

63. Improving health and reducing health inequalities require holistic action across the Scottish Government and its partners. Public sector partners can play an important role in changing behaviours. As well as

providing health services, it is necessary to create the conditions that lead to good health, such as employment, education and good quality housing. Better health will also have wider benefits to society and the economy.

64. In December 2020, the Scottish Government established the new Health Inequalities Unit (HIU) within its Population Health Directorate. The HIU aims to embed equity and human rights in the response to the pandemic and across wider healthcare services.

65. The HIU is developing a single health equity vision. This aims to provide NHS boards with clear priorities, but this work is at a very early stage. The HIU includes a fair health team that focuses on the social and economic drivers of health inequality, such as low income, inadequate housing and poverty. The team will work with other government departments including education, social justice and housing, to bring a cross-government approach.

66. The work of the HIU will be crucial to building a sustained approach to reducing health inequalities. Such work should focus on cross-government initiatives and emphasise tackling the wider factors contributing to inequality. The fair health team will have a role in driving this work forward.

Public Health Scotland has had an important role in responding to the pandemic, and work on its wider priorities is now under way

67. Public Health Scotland (PHS) became operational in April 2020, at the start of the pandemic. PHS was established to enable and support local and national bodies to work together to improve health and wellbeing in communities. It has a key role in working with its partners to reduce health inequalities.

68. Since PHS was established, its focus has largely been on responding to the pandemic. This has included developing the Covid-19 daily dashboard, providing public health advice and supporting the Covid-19 vaccination programme. As a newly established body, PHS has also been developing its leadership and organisational structures.

69. PHS has identified priorities as part of its strategic plan 2020–23 and delivery plan 2021–23.[38] [39] These are Covid-19; mental wellbeing; communities and place; and poverty and children. These are complex challenges that will need collective action from PHS and partners across government and the public sector and third sector. Despite the pandemic being a core focus for PHS so far, several pieces of work are now under way, including:

- working with Police Scotland to produce real-time data on suicide and drug-related deaths to allow preventative action

- working with partners to support communities and local planning partners to better consider how climate change will affect their local area and on health and wellbeing
- working with children to develop mental health indicators that capture the key issues for children and young people
- providing guidance to local government on housing and homelessness.

More robust data is needed to understand and respond to long-standing health inequalities

70. Data on health inequalities is often confined to focusing on deprivation and sex, and less data is available on characteristics such as disability and ethnicity. The Scottish Government recognises this and has initiated programmes of work to improve the availability of data that can help inform decision-making. For instance, data is now being collected on Covid-19 vaccination uptake by ethnicity. This provides a better understanding of any inequity in the uptake of the Covid-19 vaccines, which will also allow appropriate action to be taken to increase uptake where it is lower in specific minority ethnic groups.

71. The Scottish Government is developing the Equality Data Improvement Programme. This aims to better understand what equality data is available and the barriers to collecting it, and to promote good practice in collecting better evidence. Some pieces of work have progressed quickly, for example the Scottish Government's chief statistician is leading a programme of work to improve data collation and analysis, by linking healthcare data with other datasets such as census and university data. This aims to improve the analysis of equality characteristics and to enable more preventative work to take place when tackling health inequalities (Case Study 1).

Drug- and alcohol-related deaths remain a serious concern

72. Despite Covid-19 being at the centre of government activity, other significant public health challenges remain. Drug and alcohol-related deaths have increased year on year, with 1,339 drug-related deaths and 1,190 alcohol-specific deaths registered in 2020. Deaths are higher among those living in deprived areas. Scotland's drug related death rates are the worst in Europe, and alcohol specific deaths rates are one of the worst in the United Kingdom.[40] [41]

73. A cross-government approach will be fundamental to providing holistic support for people at risk of drug and alcohol misuse. In the 2020/21 Programme for Government, the Scottish Government committed to investing an additional £250 million over this Parliament's term specifically to tackle the drug death emergency.[42] This will focus on community based support, quick access to treatment and expanding residential rehabilitation.

Case Study 1.
Data linkage to identify the risk factors to homelessness

Linking health data with data on homelessness has illustrated the impact that data can have on outcomes for vulnerable people.

Work led by the Scottish Government's chief statistician has connected these datasets to identify what happened to people before they became homeless. For example, people often go to see their GP about alcohol or drug use, and this information can be linked to other issues such as domestic abuse or involvement in the justice system. Using data in this systematic way helps to predict who is at risk of losing their homes, so that they can receive support to prevent them from becoming homeless in the first place. The use of data in this way supports a multi-agency and preventative approach to homelessness.

Source: Scottish Government

74. The Scottish Government has also committed to publishing quarterly data on drug-related deaths, to enable enhanced monitoring. Data from January to September 2021 shows a four per cent improvement compared to the same period in 2020.[43] But suspected drug deaths remain at a high level and there continues to be an upward trend over the period for which data is available. It is likely that results from new initiatives will take longer to show.

75. We published a drug and alcohol briefing in 2019 and plan to publish a further update in March 2022.[44] This will summarise the ongoing challenges for drug and alcohol services and the improvements needed.

Drug and alcohol services: An update
May 2019

NHS recovery and remobilisation

The Scottish Government's plans for the recovery and redesign of NHS services are ambitious but will be challenging and take a long time to realise

76. The Scottish Government and NHS Scotland are having to balance the immediate priorities of responding to Covid-19 and tackling the ever-increasing backlog of patients waiting to be seen. At the same time, they are planning for how healthcare services can be delivered more sustainably in the future. There is a long road ahead, and it will be challenging to make sufficient progress while dealing with the substantial pressures already in the system, which have been exacerbated by the pandemic.

77. The Scottish Government recognises that innovation and service redesign will be essential for the recovery of NHS services. It has published its NHS recovery plan, which aims to address the substantial backlog in planned care while continuing to meet ongoing urgent health and care needs.[45] The NHS intends to achieve this by increasing the capacity of healthcare services and redesigning patient pathways.

78. Key actions will include opening National Treatment Centres (NTCs) across Scotland to help increase inpatient and day case activity to 20 per cent above pre-Covid levels by 2025/26. Within the same timescale, redesigning care pathways is expected to contribute to an increase in outpatient activity to ten per cent above pre-pandemic levels. The Scottish Government has developed a Centre for Sustainable Delivery (CfSD), which aims to support boards to redesign how services are delivered and embed best practice across Scotland.

79. The ambitions in the plan will be stretching and difficult to deliver against the competing demands of the pandemic and an increasing number of other policy initiatives, such as plans for developing a National Care Service (NCS). The recovery plan will involve new ways of delivering services and these will take a lot of work. There is not enough detail in the plan to determine whether ambitions can be achieved in the timescales set out.

80. In our NHS in Scotland 2017 report we noted the growing complexity in how healthcare is planned, with a mix of local, regional and national planning.[46] The NTCs, CfSD and the NCS have the potential to add to this complexity. It is not yet clear how planning across these

NHS in Scotland 2017
October 2017

different levels will work in practice. It is important that roles and responsibilities, and how they link together, are well defined to ensure:

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

81. We welcome the Scottish Government's commitment to publishing annual updates on the NHS recovery plan to inform the public on the progress being made.

There are several risks associated with the successful recovery and redesign of NHS services

82. Making significant and ambitious changes in how services are delivered inevitably involves risks. The Scottish Government and the NHS must manage these risks carefully if the objectives set out in the recovery plan are to be achieved.

83. The NHS recovery plan and other key strands of recovery, such as the new Care and Wellbeing Portfolio and the new Digital Health and Care Strategy (paragraph 108), show that the Scottish Government and the NHS have plans in place to manage some of the risks. But it remains to be seen how some other risks will be managed. These are set out in the rest of this section.

New Covid-19 variants could derail recovery plans

84. The emergence of the Omicron variant towards the end of 2021 shows that the future course of the Covid-19 pandemic, and the impact on people's health and NHS services, remains uncertain. There is potential for any new variant to spread more easily, to be more resistant to vaccines, or to result in more severe symptoms. These possible outcomes could all potentially divert efforts away from recovery and back towards the immediate pandemic response.

The Scottish Government must prioritise addressing workforce availability challenges if its recovery plan is to be successful

85. The workforce commitments set out in the recovery plan are significant and build on substantial existing commitments from previous plans (Exhibit 6, page 27).

86. The additional numbers of staff needed to meet the plan's ambitions, alongside existing and potential recruitment challenges, mean that the Scottish Government will need to use innovative recruitment methods to fill positions. The recovery plan includes a commitment to invest £11 million over the next five years in new national and international

recruitment campaigns and establish a Centre for Workforce Supply. There are also plans to increase the number of undergraduate places to study medicine by 100 per year.

87. We have highlighted in previous reports that the NHS has struggled to recruit enough people with the right skills to certain positions, and that the UK's departure from the EU could further reduce the pool of workers available in future years.[47] We also highlighted a lack of robust and reliable workforce data in our NHS workforce planning – part 2 report, particularly in relation to primary care.[48] We are yet to see evidence that this has improved, and there is a risk that it inhibits effective workforce planning. It will also make it difficult to monitor progress in achieving workforce objectives.

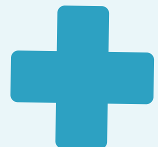
NHS workforce planning – part 2
August 2019

Exhibit 6.

New and existing workforce commitments

Existing committments from the Integrated National Workforce Plan 2018

- 800 new mental health workers by 2022
- 500 advanced nurse practitioners
- Increase the GP workforce by 800 by 2027
- 225 new advanced musculoskeletal practitioners by 2024/25
- 30 new reporting radiographer training places over the next three years
- 30 new training places in cardiac physiology



Staffing committments – NHS Recovery Plan 2021/26

- 1,500 new clinical and non-clinical staff for National Treatment Centres by 2026
- 1,000 additional staff in primary care mental health
- 100 more undergraduate medical places per annum and more widening access places
- New recruitment campaigns and establish a Centre for Workforce Supply (£11 million)
- Youth employment opportunities through the Young Person's Guarantee
- Additional training opportunities through the NHS Academy

Source: Scottish Government

88. The Scottish Government, in conjunction with the Convention of Scottish Local Authorities (COSLA), aims to publish a new national workforce strategy for health and social care in early 2022. This will include high level objectives, an action plan covering the short, medium and long term, and projections for anticipated workforce growth. It is crucial that this strategy is aligned with the NHS recovery plan and leads to a more integrated approach to workforce, service and financial planning. Recovery ambitions cannot be met if the right people with the right skills are not in place. We plan to carry out further audit work on this in due course.

Meeting ambitious targets must not come at the expense of staff wellbeing

89. There is clear commitment at Scottish Government and NHS board level to support staff wellbeing, and it features prominently in the NHS recovery plan. However, the plan also outlines significant additional demands on NHS staff that could negatively impact their wellbeing. The ambition to significantly increase activity could undermine the desire to improve staff wellbeing.

90. It will be important for the Scottish Government and health and social care bodies to work together to monitor the progress and evaluate the effectiveness of the new staff wellbeing measures (paragraph 22), and to better understand and provide for staff support needs.

Supporting and developing NHS leaders is vital

91. Leaders in the NHS and Scottish Government have been under considerable pressure throughout the pandemic. The planned NCS will see responsibility for social care transfer from local authorities to Scottish ministers. It will require significant reform which will add further pressure, along with the challenges of responding to the pandemic and the recovery and redesign of NHS services. We set out key risks and challenges in developing a NCS in our response to the Scottish Government's consultation.[49]

92. The recovery and reform of health and social care services needs stable, effective and capable leadership. We have previously highlighted issues with high turnover and short tenures in some NHS leadership positions, as well as concerns about a lack of succession planning and support for new leaders.

93. Over three years ago, the Scottish Government introduced Project Lift. This is a leadership development programme designed to create a more person-centred approach to leadership in the health and social care system. The Scottish Government is now developing a National Leadership Development Programme (NLDP), building on the progress made under Project Lift. The NLDP is at an early stage and is initially

focusing on senior and executive leaders. We will continue to monitor the impact of the NLDP in future audit work.

NHS in Scotland 2018
October 2018

94. The NLDP includes a workstream on succession planning, aimed at creating a system to identify and develop talent for senior leadership roles. In our NHS in Scotland 2018 report we found that a similar succession planning programme was under way.[50] It is not clear how the new workstream links to this previous work.

The Scottish Government needs to ensure that new ways of delivering services are clearly communicated

95. The Scottish Government and NHS boards need to continually engage with the public in a meaningful way to shape priorities for recovery and develop sustainable, person-centred ways of delivering health and social care services. The public will have to access services differently, and that will require a culture change. The Scottish Government and NHS need to clearly communicate to the public any changes to how services should be accessed.

96. The Scottish Government commissioned Health and Social Care Alliance Scotland to engage with the public to identify priorities for accessing services. The priorities it identified put people at the centre of decision-making. The Scottish Government and NHS boards should incorporate these priorities into their plans for the recovery and redesign of NHS services.

The Scottish Government and NHS need to prioritise prevention, early intervention and equity in their recovery plans

97. Early intervention and preventative care are fundamental to the long-term sustainability of NHS services and can help reduce health inequalities. The Scottish Government and NHS need to make sure that the importance of prevention is not lost as they continue to respond to the pandemic and transform how care is delivered. In his September 2021 blog, the Auditor General for Scotland discussed the slow progress in making the shift towards prevention and in improving long-term outcomes for individuals and communities set out in the Christie report.[51]

98. The NHS must prioritise this while also dealing with immediate pressures based on clinical priority and urgency. It will have to address the challenge of moving funding into early intervention and preventative care when there are existing pressures in emergency and planned healthcare.

The collection and use of health and social care data must improve to support decision-making and monitor progress in delivering outcomes

99. The lack of, or analysis of, primary, community and social care data has been a common theme in Audit Scotland reports for several years. This data is important for informed decision-making, planning and scrutiny. It is also needed to demonstrate whether, and the extent to which, government policies and initiatives are delivering improved outcomes. There should be stronger data linkages across the NHS and public sector to help deliver better outcomes for people.

100. Data is a prominent theme throughout the refreshed Digital Health and Care Strategy (paragraph 108). It commits the Scottish Government and COSLA to developing a Data Strategy for Health and Social Care. It also acknowledges the impact that poor data sharing and access to health records can have on the delivery of care and continuity between services. Information governance, assurance and cyber-security will be key elements of the data strategy.

Meeting net zero targets could make the recovery process more challenging

101. Like all public bodies in Scotland, NHS boards are required by law to reduce carbon emissions and become net zero by 2045. NHS Scotland aims to bring this forward to 2040 following consultation on its draft NHS Scotland Climate Emergency and Sustainability Strategy.[52]

102. Net zero requirements add to the challenges of the NHS recovery process and will need additional investment. It is vital that the Scottish Government and NHS make the most of the opportunities arising during the pandemic to reduce carbon emissions in the health sector.

The Scottish Government is developing a Care and Wellbeing Portfolio to improve outcomes and health and social care services

103. The Scottish Government has recognised that a new long-term strategy is needed for health and social care to direct and oversee the recovery and redesign of services. It has set up a Care and Wellbeing Portfolio to set the strategic direction for health and social care in Scotland and to oversee four programmes of work. The programmes and their aims are:

- integrated planned care – to be flexible and adaptable to respond to emerging challenges, embrace rapid change in the delivery of health and care services and be inclusive in the approach to recovery, and promote transformation and innovation to deliver a world class service

- **integrated unscheduled care** – to take a whole system approach to the redesign of services, with an overarching aim of improving outcomes for people and delivering the right care in the right place
- **preventative and proactive care** – to proactively keep people well, independent and in the most appropriate care setting for their needs
- **place and wellbeing** – communities, third sector and public sector organisations working jointly to drive improvement in health and wellbeing and reduce health inequalities of the population within local communities.

104. The Care and Wellbeing Portfolio is at an early stage of development. It has considerable potential and ambitious aims but achieving these will be challenging. The Scottish Government is committed to designing a new coherent and sustainable system, focused on reducing inequality, prioritising prevention and early intervention, and improving health and wellbeing outcomes.

105. Its objectives include developing a decision-making framework that prioritises prevention and early intervention. This is promising, but more detail is needed to determine how it will work in practice.

106. This work will require long-term, dedicated resources and commitment from leaders. It should take a whole-system approach, involving staff across government and other partners across public services and the third sector. The portfolio should embed service redesign, workforce planning, financial planning and capital investment in its approach and governance structure, to ensure that strategies are aligned and are working towards the same goals.

The NHS has implemented a range of new ways of working to improve access to healthcare services

107. Several new ways of working have been introduced throughout the pandemic to enable the NHS to improve access to healthcare services not related to Covid-19. The pandemic has also accelerated improvements that were already under way. The examples shown in Exhibit 7 (page 32) demonstrate the range of and potential for new ways of delivering services emerging from the crisis.

Maintaining patient access

The rapid rollout of NHS Near Me and other non-face-to-face consultations helped to maintain some access to healthcare services during the early stages of the pandemic (Exhibit 7).

The Scottish Government is committed to embracing digital technologies

108. The Scottish Government is committed to increasing the use of digital technologies as part of the recovery and remobilisation of NHS services. The Scottish Government and COSLA published a revised Digital Health and Social Care Strategy in October 2021.[53] It highlights the progress made during the pandemic, and identifies gaps that need to

Exhibit 7.

The NHS has introduced innovative new ways of working throughout the pandemic

There is scope to roll out new ways of delivering services beyond the pandemic with potential benefits to future healthcare provision

Theme	Case study	Benefits
Maintaining patient access	The rapid rollout of NHS Near Me and other non-face-to-face consultations helped to maintain some access to healthcare services during the early stages of the pandemic.	Reduced need for physical attendance at a hospital or GP practice, helping maintain patients at home during the pandemic while reducing the risks associated with delayed diagnosis. There are also timesaving, environmental and travel safety benefits. It helps to reduce the number of missed appointments and cuts back on PPE usage.
Technological innovation in treatment, diagnosis and monitoring	Rollout of faster, simpler alternatives to endoscopic procedures for diagnosing conditions like Barrett's Oesophagus, a known risk factor for oesophageal cancer.	Procedures can be carried out in locations other than traditional hospital environments, like community health centres and GP practices. It frees up senior staff and capacity within endoscopy units and reduces the cost and time needed to diagnose and treat patients.
Using data to improve services	PHS is collaborating with some Scottish universities on the EAVE-II study, which tracks the progress of the Covid-19 pandemic in near real-time across Scotland.	EAVE II shows the difference Covid-19 vaccines make, but it shows that by linking data we can learn about the difference a whole series of interventions can make to Scotland's health. This approach offers opportunity to study other conditions, to describe their risk and the public health benefit of treatments in the future.
Introducing new operational models	The Redesign of Urgent Care (RUC) programme is designed to address the demand issues in urgent and unscheduled care.	The Scottish Government continues to review the new model, but if successful it should reduce A&E waiting times and relieve pressure on A&E staff and ambulance services.
Multi-agency and collaborative working	Local multidisciplinary teams from NHS boards and councils enhanced the oversight of local care homes and wider social care services during the pandemic.	The relationships built up in these multi-disciplinary teams enhanced support for social care services. These relationships will hopefully lay the foundations for further collaborative working and strengthen health and social care integration.

Source: Scottish Government and Audit Scotland

be addressed, particularly digital exclusion. The Accounts Commission's September 2021 blog post on digital exclusion highlights how Covid-19 has exacerbated inequality in this area.

109. The revised strategy aims to improve the care and wellbeing of people in Scotland by making best use of digital technologies and delivery of services. It has three main aims:

- Aim 1 – Citizens have access to, and greater control over, their own health and care data, as well as access to the digital information, tools and services they need to help maintain and improve their health and wellbeing.
- Aim 2 – Health and care services are built on people-centred, safe, secure and ethical digital foundations that allow staff to record, access and share relevant information across the health and care system, and to use digital technology confidently to improve the delivery of care.
- Aim 3 – Health and care planners, researchers and innovators have secure access to the data they need to increase the efficiency of our health and care systems and develop new and improved ways of working.

110. Adopting digital technologies will be crucial to the transformation needed to make sure NHS services are sustainable in the future. But this cannot be done in isolation. It must be part of wider overall service redesign plans that are built around the needs of patients and staff.

NHS finances

The Covid-19 pandemic resulted in significant additional expenditure across the NHS in 2020/21

111. Responding to the Covid-19 pandemic resulted in significant additional costs. In 2020/21, £2.9 billion of funding was allocated across health and social care for Covid-19-related costs.[54] Of this, £1.7 billion was allocated to NHS boards and integration authorities (IAs). In 2020/21, NHS boards' total funding allocation was £16.3 billion (Exhibit 8, page 35). This is 19 per cent more in cash terms than in 2019/20 (£13.7 billion).

112. The Scottish Government provided clear direction to NHS boards about how Covid-19 expenditure should be monitored and reported throughout 2020/21. External auditors found that financial management associated with Covid-19 expenditure was appropriate across all NHS boards, with a clear distinction between reporting of Covid-19 and non-Covid-19 expenditure. Our NHS in Scotland 2020 report sets out detail of the monitoring and reporting arrangements in place during 2020/21.

NHS in Scotland 2020
February 2021

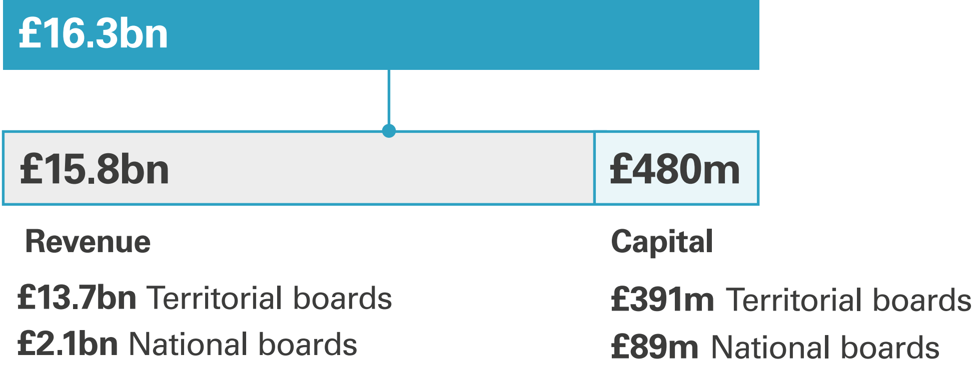
Covid-19 had a considerable impact on NHS boards' ability to achieve efficiency savings

113. Responding to the Covid-19 pandemic has had a considerable impact on NHS boards' ability to deliver efficiency savings. In recognition of this, in February 2021, the Scottish Government stated that it would fully fund NHS boards and Health and Social Care Partnerships (HSCPs) to achieve financial balance for 2020/21.[55]

114. Several NHS boards relied on this support from the Scottish Government in 2020/21. In total, the Scottish Government allocated £102 million to 14 NHS boards for this purpose. The shortfall is recurring, and boards will need to achieve the savings in future years, adding to the substantial financial pressures which existed in the NHS before the pandemic.

115. The Scottish Government is providing additional support to six NHS boards facing a particularly challenging financial position. As part of this, since autumn 2021 these NHS boards have been submitting monthly plans to the Scottish Government on how they plan to achieve savings, with the aim of improving their positions by the start of the 2022/23

Exhibit 8.
A breakdown of NHS funding in 2020/21 and key areas of spending



Examples of key areas of spend

£8.6bn
Staffing costs
£7.6bn in 2019/20

£2.7bn
Drug and medical supplies
£2.4bn in 2019/20

Notes:
1. Staffing costs include medical and dental (£2bn), nursing (£3.3bn), and other (£3.3bn).
2. Drugs and medical supplies includes prescribed drugs secondary care (£818m), prescribed drugs primary care (£1.1bn), PPE and testing kits (£286m), and medical supplies (£492m).
3. Central spending is the amount spent centrally on behalf of NHS boards – this includes initiatives such as non-discretionary payments (Family Health Services), the £500 thank you payments and the nursing bursary.

Source: Scottish Government 2020/21 Spring Budget Revision, Scottish Government 2020/21 consolidated accounts

financial year. These boards are NHS Ayrshire and Arran, NHS Borders, NHS Dumfries and Galloway, NHS Fife, NHS Highland and NHS Orkney.

116. NHS Tayside has been subject to ongoing parliamentary attention in recent years. In December 2020, we presented a sixth consecutive Section 22 report to the Scottish Parliament on NHS Tayside.[56] This found that NHS Tayside was making progress under its new executive leadership team, financial management was stronger and there were some improvements in service performance. However, there were still

The 2019/20 audit of NHS Tayside
December 2020

Case Study 2.
NHS Tayside

The board operated within its revised financial targets for 2020/21 and achieved its planned efficiency savings of £28.1 million. This was after repaying £3 million to the Scottish Government of its outstanding £7 million borrowed and returning £7 million of its allocated funding to the Scottish Government for re-allocation in 2021/22. In common with all NHS boards, the Covid-19 pandemic has had a significant impact on the focus and priorities of NHS Tayside, and the effect of this on the board's longer-term financial position and savings targets is still uncertain.

Improvements are being made in mental health services in Tayside although significant work is still required. NHS Tayside is considering its response to the recent independent inquiry into mental health services in Tayside, Trust and Respect, Progress Report 2021. The Minister for Mental Wellbeing and Social Care has recently appointed an independent group to provide oversight and assurance, and support progress in improving Tayside's mental health services. We will monitor the board's progress in this area in 2021/22.

In June 2021, the Scottish Government de-escalated NHS Tayside from stage 4 on the escalation framework to stage 2, in relation to financial position, governance and leadership, and performance; and to stage 3, in relation to mental health performance. This further reflects the improvements made by the board.

Source: Audit Scotland

matters to be addressed. The 2020/21 annual audit found that NHS Tayside is continuing to make progress (Case Study 2).

NHS boards face an uncertain and challenging financial position in 2021/22 and beyond

117. The NHS was not financially sustainable before the Covid-19 pandemic, with boards relying on additional financial support from government or non-recurring savings to break even. The scale of the financial challenge has been exacerbated by the pandemic. The cost of delivering services has risen and additional spending commitments made by the Scottish Government add to NHS boards' financial pressures.

118. The Programme for Government 2021-22 sets out the Scottish Government's intention to increase funding for frontline healthcare services by at least £2.5 billion by 2026/27.[57] It also commits to increasing primary care funding by 25 per cent, and to reviewing the NHS funding formula to ensure that the funds are distributed equitably. The Scottish Government has not yet set a date for this review to be completed.

119. The Programme for Government also sets out the commitment to invest £10 billion over the next ten years to replace and refurbish healthcare facilities across Scotland. Of this, a considerable amount, £400 million, will be spent on the NTCs. The Scottish Government has also now committed to bringing forward its target date for the NHS estate to achieve net zero emissions from 2045 to 2040. This will require substantial investment and it is not yet clear whether additional capital funding will be needed to achieve this over and above the £10 billion already announced.

120. The Scottish Government required NHS boards to produce one-year financial plans for 2021/22 because of the ongoing uncertainty about the costs and financial impact of Covid-19 and about what funding would be available. In September 2021, NHS boards and HSCPs submitted updated projections of the costs associated with Covid-19 and remobilisation for the 2021/22 financial year. These showed that they expect to spend £1.5 billion, including predicted unachievable savings of £116.6 million. The main areas of expected spending are as follows:

- Covid-19 vaccination programme – £203.7 million
- testing – £184.6 million
- additional PPE – £158.9 million
- additional staff costs – £95.1 million.

121. The Scottish Government has confirmed that all frontline health-related Barnett consequentials received from the UK Government would continue to be passed on to health and social care in Scotland.[58] At

February 2022, the Scottish Government has confirmed £2.5 billion in Covid-19 health-related consequentials in 2021/22.

122. There is uncertainty in the longer term about what Covid-19 related expenditure will be needed and about what funding will be available. NHS boards should return to medium-term financial planning in 2022/23, to help identify the known factors in NHS funding over the next three to five years and ensure a balance between policy ambitions and available resources.

123. The Scottish Government is working with NHS boards to determine which Covid-19 related costs are likely to become recurring. Uncertainty about how the pandemic will progress makes this particularly challenging. Greater certainty about costs would enable the Scottish Government to develop more accurate funding requirements for NHS boards and would enable NHS boards to develop more accurate financial plans.

124. The Scottish Government has committed to revising the health and social care medium-term financial framework. The timing of this will depend on the impact of Covid-19 across health and social care and planned reforms, including the impact of the Care and Wellbeing Portfolio and establishing an NCS.

Endnotes

1 NHS in Scotland 2020, Audit Scotland, February 2021.
2 Covid-19: Vaccination programme, Audit Scotland, September 2021.
3 NHS in Scotland 2020, Audit Scotland, February 2021.
4 Covid-19: Vaccination programme, Audit Scotland, September 2021.
5 Daily Trend of Vaccinations by Age Group and Sex, Public Health Scotland, February 2022.
6 PCR means polymerase chain reaction. These tests are a highly accurate way to diagnose certain infectious diseases, such as Covid-19.
7 Coronavirus (COVID-19): trends in daily data, Scottish Government, February 2022. COVID-19 Daily Dashboard, Public Health Scotland, February 2022.
8 Coronavirus (COVID-19) asymptomatic testing programme: evaluation – November 2020 to June 2021, Scottish Government, December 2021.
9 Health and social care: winter overview 2021 to 2022, Scottish Government, October 2021.
10 Coronavirus (COVID-19) trends in daily data, Scottish Government, February 2022. Numbers of NHS staff reporting as absent for a range of reasons related to Covid-19. Covers hospital and community health services and excludes those working in general practice. Stress-related absence due to Covid-19 is recorded as sick leave and is also excluded.
11 NHS Scotland worforce data, NHS Education for Scotland, September 2021.
12 RCN Employment Survey 2021, Royal College of Nursing, December 2021.
13 Ibid.
14 £8 million package for health and social care workforce wellbeing, Scottish Government, June 2021.
15 Health and social care: winter overview 2021 to 2022, Scottish Government, October 2021.
16 NHS recovery plan 2021–2026, Scottish Government, August 2021.
17 Social care briefing, Audit Scotland, January 2022.
18 Coronavirus (COVID-19) initial health and social care response: lessons identified, Scottish Government, August 2021.
19 COVID-19 Inquiry, Scottish Government, August 2021.
20 Deaths involving Coronavirus (Covid-19) in Scotland, weekly data tables (week 1, 2022), National Records of Scotland, January 2022.
21 Coronavirus (COVID-19): supporting elective care – clinical prioritisation framework, Scottish Government, November 2020.
22 Public attitudes to coronavirus: tracker – data tables, Scottish Government, December 2021.
23 Productivity in UK healthcare during and after the Covid-19 pandemic, The Productivity Institute, February 2021.
24 NHS Performs – weekly update of emergency department activity and waiting time statistics, weekly NHS Scotland data, Public Health Scotland, week ending 9 January 2022.
25 Child and Adolescent Mental Health Services, Audit Scotland, August 2021.

26 Coronavirus (COVID-19): mental health – transition and recovery plan, Scottish Government, October 2020.

27 NHS recovery plan 2021–2026, Scottish Government, August 2021.

28 Long Covid estimates are based on participant responses to the Coronavirus Infection Survey, collected over the four-week period ending 2 January 2022 and are weighted to represent the UK population.

29 Coronavirus (COVID-19) latest insights: infections, Office for National Statistics, January 2022.

30 Coronavirus (COVID-19): Scotland's Long Covid service, Scottish Government, September 2021.

31 Health, Wellbeing and the COVID-19 Pandemic: Scottish Experiences and Priorities for the Future, Health and Social Care Alliance Scotland, September–December 2020.

32 Impact of COVID-19 on Disabled People, Disability Equality Scotland briefing paper, Disability Equality Scotland, March 2020.

33 Deaths involving coronavirus (COVID-19) in Scotland, National Records of Scotland, March 2021.

34 COVID-19 infection and outcomes in a population-based cohort of 17,173 adults with intellectual disabilities compared with the general population, Scottish Learning Disabilities Observatory, February 2021.

35 Scotland's Population 2020: The Registrar General's Annual Review of Demographic Trends, August 2021.

36 Health inequalities in Scotland, Audit Scotland, December 2012.

37 Race equality: immediate priorities plan, Scottish Government, September 2021.

38 Public Health Scotland Strategic Plan 2020–23, Public Health Scotland, September 2020.

39 Public Health Scotland Delivery Plan 2021–24, Public Health Scotland, June 2021.

40 Drug-related Deaths in Scotland in 2020, National Records of Scotland, July 2021.

41 Alcohol-specific deaths, National Records of Scotland, August 2021.

42 A Fairer, Greener Scotland: Programme for Government 2021-22, Scottish Government, September 2021.

43 Suspected drug deaths in Scotland: July to September 2021, Scottish Government, December 2021.

44 Drug and alcohol services: An update, Audit Scotland, May 2019.

45 NHS recovery plan 2021–2026, Scottish Government, August 2021.

46 NHS in Scotland 2017, Audit Scotland, October 2017.

47 NHS in Scotland 2020, Audit Scotland, February 2021. NHS Workforce Planning – Part 2, Audit Scotland, August 2019. NHS Workforce Planning, Audit Scotland, July 2017. Scotland's NHS Workforce, Audit Scotland, February 2017.

48 NHS Workforce Planning – Part 2, Audit Scotland, August 2019.

49 Response to consultation on a National Care Service for Scotland, Audit Scotland, November 2021.

50 NHS in Scotland 2018, Audit Scotland, October 2018.

51 Christie 10-years on, Audit Scotland, September 2021.

52 Consultation draft: NHS Scotland Climate Emergency and Sustainability Strategy 2022-26, NHS Scotland, November 2021.

53 Digital health and care strategy, Scottish Government, October 2021.

54 Covid-19: Tracking the impact of Covid-19 on Scotland's public finances, Audit Scotland, September 2021.

55 Health and Social Care Partnerships were formed to integrate services provided by NHS boards and councils in Scotland.

56 The 2019/20 audit of NHS Tayside, Audit Scotland, December 2020.

57 A Fairer, Greener Scotland: Programme for Government 2021-22, Scottish Government, September 2021.

58 The UK Government uses the Barnett formula to allocate funds to Scotland, Wales and Northern Ireland when additional money is spent in areas that are devolved to the relevant administrations, such as health.

Appendix

Audit methodology

This is our annual report on the NHS in Scotland. Given the continuing challenges of the Covid-19 pandemic in 2021, the report focuses on:

- the ongoing response to the Covid-19 pandemic
- the health impact of the pandemic on the population of Scotland
- the impact of the pandemic on the NHS workforce
- the progress being made towards the recovery and remobilisation of NHS services
- the financial impact of the Covid-19 pandemic on the NHS in Scotland in 2020/21, and challenges for 2021/22 and beyond.

Because of the Covid-19 pandemic, the audit was carried out remotely. Our findings are based on evidence from sources that include:

- strategies, frameworks and plans for responding to Covid-19
- the audited annual accounts and auditors' reports on the 2020/21 audits of NHS boards
- activity and performance data published by Public Health Scotland
- publicly available data and information including results from surveys
- Audit Scotland's national performance audits
- interviews with senior officials in the Scottish Government and some NHS boards.

We reviewed activity and demand information at a national level to present the national picture. We focused on a sample of indicators that cover some of the main activities in the NHS.

NHS in Scotland 2021

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Audit Scotland, 4th Floor, 102 West Port, Edinburgh EH3 9DN
Phone: 0131 625 1500 Email: **info@audit-scotland.gov.uk**
www.audit-scotland.gov.uk

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Risk, Audit and Performance Committee

Date of Meeting	23/06/2022
Report Title	Internal Audit Annual Report 2021-22
Report Number	HSCP22.045
Lead Officer	Jamie Dale Chief Internal Auditor
Report Author Details	Jamie Dale Chief Internal Auditor Jamie.Dale@aberdeenshire.gov.uk
Consultation Checklist Completed	Yes
Appendices	Appendix A – Internal Audit Annual Report for the year ended 31 March 2022.

1. Purpose of the Report

1.1. The purpose of this report is to provide the Committee with Internal Audit's Annual Report for 2021-22.

2. Recommendations

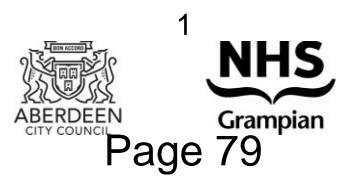
It is recommended that the Risk, Audit and Performance Committee:

2.1. Note the Internal Audit (IA) Annual Report 2021-22;

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 2021-22; and

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



Risk, Audit and Performance Committee

3. Summary of Key Information

3.1. Public Sector Internal Audit Standards require that Internal Audit produce an annual report on the adequacy and effectiveness of the Board's framework of governance, risk management and control. It is one of the functions of the Risk and Performance Committee to review the activities of the Internal Audit function, including its annual work programme.

3.2. This report is designed to meet three objectives; to present to the Risk and Performance Committee, and through them, the Council:

- A formal opinion on the adequacy and effectiveness of the Board's arrangements for:
  - Governance
  - Risk management
  - Internal control
- A narrative over the key strategic and thematic findings from the assurance work undertaken by IA during 2021-22, drawing out key lessons to be learned.
- An account of the assurance activities and resources of IA during the period 2021-22.

3.3. This report covers the period from 1 April 2021 to 31 March 2022 and any work finalised during the 2021-22 assurance period. It also takes account of work undertaken up to the date of the issue of this report, 13 June 2022. The report is grounded in the whole activity and work of IA, whether in terms of formal audit evidence and work, management assurance and consultancy activity, or evidence gathered throughout wider engagement across the Board and Council overall.

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 2021-22 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, and this output report, 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.

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Internal Audit

Annual Assurance Report and Chief Internal Auditor Opinion 2021-22

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1 Executive Summary

1.1 Introduction and background

Internal Audit's (IA) primary role is to provide independent and objective assurance on the Integrated Joint Board's (IJB) risk management, control, and governance processes. This requires a continuous rolling review and appraisal of the internal controls of the Board involving the examination and evaluation of the adequacy of systems of risk management, control, and governance, making recommendations for improvement where appropriate. Reports are produced relating to each audit assignment and presented when finalised to the Risk, Audit and Performance Committee. Along with other evidence, these reports are used in forming an annual opinion on the adequacy of risk management, control, and governance processes.

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

Public Sector Internal Audit Standards set the mission of IA as to enhance and protect organisational value by providing risk-based and objective assurance, advice, and insight.

1.2 Purpose of this report

Public Sector Internal Audit Standards require that Internal Audit produce an annual report on the adequacy and effectiveness of the Board's framework of governance, risk management and control. It is one of the functions of the Risk, Audit and Performance Committee to review the activities of the Internal Audit function, including its annual work programme.

This report is designed to meet three objectives; to present to the Risk, Audit and Performance Committee, and through them, the IJB:

- A formal opinion on the adequacy and effectiveness of the Board's arrangements for:
    - Governance
    - Risk management
    - Internal control
- A narrative over the key strategic and thematic findings from the assurance work undertaken by IA during 2021-22, drawing out key lessons to be learned.
- An account of the assurance activities and resources of IA during the period 2021-22.

This report covers the period from 1 April 2021 to 31 March 2022 and any work finalised during the 2021-22 assurance period. It also takes account of work undertaken up to the date of the issue of this report, 13 June 2022. The report is

grounded in the whole activity and work of IA, whether in terms of formal audit evidence and work, management assurance and consultancy activity, or evidence gathered throughout wider engagement across the Board and Council overall.

1.3 Conclusion

The overall Chief Internal Auditor's opinion is:

> In my opinion the Board had an adequate and effective framework for Governance, Risk Management and Control, covering the period 1 April 2021 to 31 March 2022.

For further commentary see the Annual Assurance Opinion section below.

1.4 Action requested of the Risk, Audit and Performance Committee

The Risk, Audit and Performance Committee is requested to note the contents of this report and the assurance opinion, to inform its annual report and its review of financial statements, in particular the governance statement.

2 Annual Assurance Opinion

2.1 Basis of annual assurance opinion

In accordance with the Public Sector Internal Audit Standards, our assessment and opinion over the framework of governance, risk management and control are based upon the whole activity and work of IA including:

- The results of internal audits completed (in final or draft) up to the date of this report (13 June 2022).
- Any follow-up action taken in respect of audits from previous periods.
- The effects of any significant changes in the Board's control environment.
- Matters arising from previous annual reports to the Board.
- Any limitations that may have been placed on the scope of IA – we have no restrictions to declare in this report, although we have performed all audits remotely this year and some physical verification work has not been possible.
- Reports issued by the Board's external auditors.
- Internal Audit's knowledge of the Board and the Council's governance, risk management and performance monitoring arrangements.
- The assessment of risk completed during the formation of the 2022-25 Audit Plan.
- The results of other assurance activities completed during the year.
- Consideration will be given to the contents of NHS Grampian's Internal Audit annual report when available.

The Standards also require that Internal Audit confirms to the Committee, at least annually, that it is organisationally independent. The organisational independence of Internal Audit is established through Financial Regulations (approved by the Board) and the Internal Audit Charter (approved by the Risk, Audit and Performance Committee). Other factors which help ensure Internal Audit's independence are that: the Internal Audit plan is approved by the IJB Risk, Audit and Performance 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.

2.2 Annual assurance opinion 2021-22

We are satisfied that sufficient internal audit and assurance work has been undertaken to allow us to draw a reasonable conclusion as to the adequacy and effectiveness of the Board's framework for governance, risk management and control. The Board had an adequate and effective framework for Governance, Risk Management and Control, covering the period 1 April 2021 to 31 March 2022.

2.3 Rationale for the opinion

It is the responsibility of 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 of the robustness of the internal control system.

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

- Ensure adherence to management policies and directives 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.
- 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 Board has faced its second year of unprecedented challenges and its control framework and governance arrangements have come under sustained and significant pressure; primarily as it adapted to the COVID-19 pandemic.

Consideration has been given during the year to the impact on the level of assurance available, and we are satisfied that in the short term this has not had a material impact. Our work has been and remains cognisant of the risks to internal control from changes introduced in response to the pandemic.

Throughout the year our audit work found that the Board's systems have flexed, adapted, and largely held up despite this significant strain. We consistently found that management was aware of the risks it was dealing with and taking steps to mitigate and manage them as best they could within the constraints created by the pandemic.

On balance, most of the audited areas were operating as anticipated. Areas of good practice, improvement, and procedural compliance have been identified and these have been detailed in individual assignment reports to the Committee. Most recommendations made by Internal Audit related to general improvements to procedures, and the requirement to evidence adherence to them.

Analysis of the findings of our reports issued within the year highlights positively that in many cases there were minimal findings, with all at the significant or important levels. This reflects a strong control environment and the need for us to only make recommendations around the general improvement of controls, the improvement of efficiency and the drive for Best Value. However, across the reports issued during the year, we did note the following:

- **Care Establishments Review** – Controls are in place however, issues were identified in the consistency of their application, particularly in respect of management of cash transactions. Improvements agreed with the Service will increase assurance over these areas. We also noted two breaches of Financial Regulations concerning once instance of a lack of a PO and another concerning the lack of appropriate authorisation.

- **Mental Health and Substance Abuse** – While requiring some legislation updates the Partnership has written procedures covering the assessment process and recording on the care management system. The Partnership's process of assessing client needs and subsequent referral to the appropriate support package is carried out by qualified staff at the appropriate level. Approval of these packages is governed by the Adult Services Resource Allocation Panel (RAP) which provides a good segregation of duties between those assessing and approving expenditure. During the pandemic, the panel did not meet, and the approval process was delegated to Service Managers. While this was appropriate to provide ongoing client support, the terms of reference covering the RAP did not fully support this level of delegation. Testing did not find any packages allocated during this period to be inappropriate in terms of client need.
- **Bon Accord Care Budget Monitoring** – As this is an ALEO, there is limited impact on the Council's control environment, but it has an impact on Council finances and reputation. Our conclusions were around the need to tighten up the control environment, and a focus on documenting institutional knowledge.

2.4 Areas of risk for future IA focus

In addition to the points above continuing to be areas of focus for the Board, in the year there will be significant new risk areas for us to consider. The specific risk and control areas in the upcoming year that we intend to focus on to a greater degree include:

- Collaborative working
- Care Reform
- Other emerging risks identified during the year

2.5 Follow up of audit recommendations

Public Sector Internal Audit Standards require that Internal Audit report the results of its activities to the Committee and establishes a follow-up process to monitor and ensure that management actions have been effectively implemented.

During 2021-22 eight agreed actions have been completed, including six completed since our last update to the Committee. There are currently no overdue actions.

Where this is not necessarily a concern for the IJB, recognising the implementation of audit recommendations as an area where more work could be done in general, over the coming months, Internal Audit will lead an exercise aimed at supporting management on the closure of audit recommendations. This will primarily focus on recommendations made to Aberdeen City Council but will also incorporate those in relation to the IJB. This will not move the bar but through engagement beyond the routine follow up exercise, we hope to close out as many actions as possible and leave only those actions that were rightly ongoing for management to focus on.

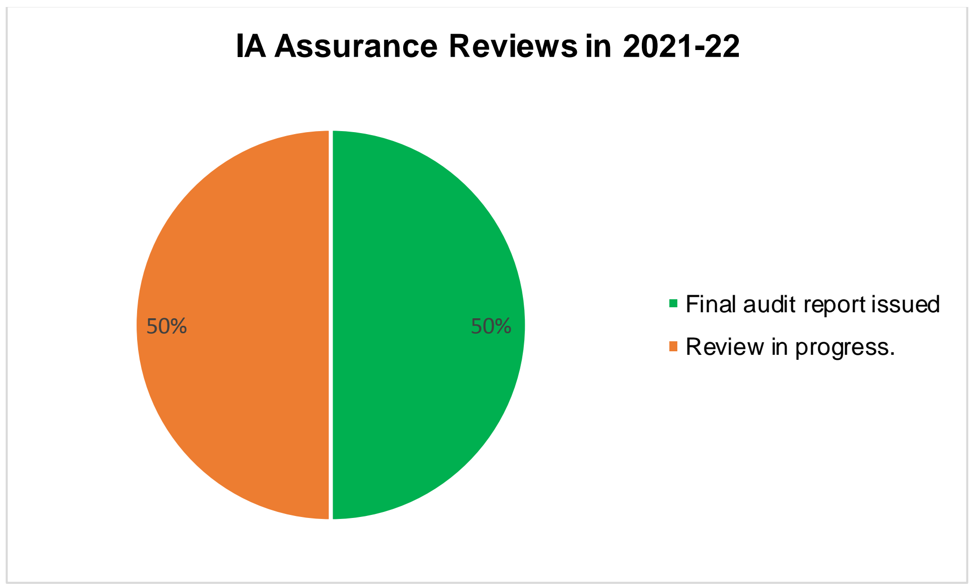
Updates on audit recommendations implementation will be provided to the Committee as part of our standard reporting, with a detailed update on the outcomes of our follow

up exercised presented to the next session of the Committee. Given the ongoing nature of the follow up, and the upcoming comprehensive update, we have not presented details of individual outstanding recommendations as part of this report.

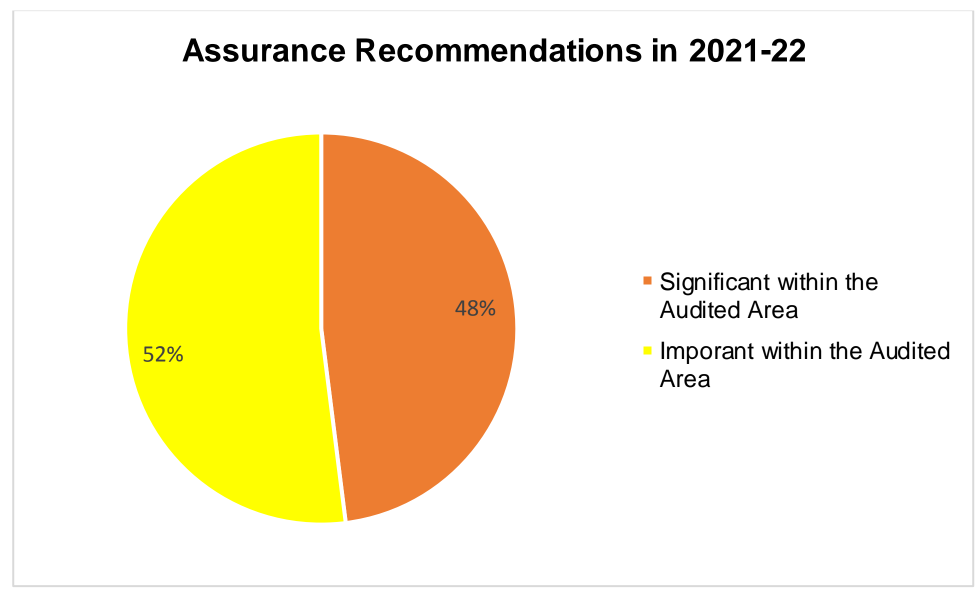
3 Audit Results

3.1 In year audit results

Across the year, irrespective of the period initially planned for the review, we issued three audit reports, with a further three currently work in progress. These reviews span the entire breadth of operations, touching on not just the IJB but the Health and Social Care Partnership overall. For those reviews currently work in progress, we have set an internal deadline to ensure that these are all completed by the end of Q2. Given the current progress of the reviews we believe this to be manageable and will also limit the impact of legacy work on our assurance plan for 2022-23.



Across the three audit reports issued, we made 25 recommendations: 12 considered Significant within the Audited area, and 13 considered Important within the audited area. 100% of recommendations made during the year were accepted by management.



This section highlights the results of our work in 2021-22, including finalisation of legacy 2020-21 reviews. It should however be noted that:

- Previous years' work, issued in the current year, is considered for and factors into our annual assurance opinion.
- Work in progress, where the report is at a draft stage, is also considered for and factors into our annual opinion.
- The deferral of audits was taken in consultation with management and also at their request.
- For all assurance reviews, we ensured that they were at the work in progress stage by year end. The majority are beyond this stage and draft reports are being finalised with the process owners for the areas under review.

Summaries are also included of fraud assurance, consultancy and other work performed by IA.

3.2 2020-21 Audits

Council Area	Audit Area	Position
HSCP	Mental Health and Substance Abuse	Final audit report issued
HSCP	Bon Accord Care Budget Monitoring	Final audit report issued
IJB	IJB Performance Management	Review in progress

3.3 2021-22 Audits

Council Area	Audit Area	Position
HSCP	Care Establishments	Final audit report issued
HSCP	Care Management	Review in progress
IJB	Transformational Programme	Review in progress

3.4 Counter Fraud

We do not have a dedicated responsibility across the Board to lead on Counter Fraud activities, this instead within the remit of a separate inhouse team of Aberdeen City Council, with NHS Grampian utilising NHS counter fraud services. The potential for fraud is however considered as part of all reviews carried out by Internal Audit from a control framework perspective.

3.5 Post year end assurance

The information presented in the above tables and charts, concerning audit work and recommendations covers the period 1 April 2021 to 31 March 2022. However, since year end we have progressed our 2021-22 work and issued a further report (IJB Performance Management). The assurance gained from this has been factored into the wider report and opinion overall for 2021-22. Our priority over the coming months will be to finalise the 2021-22 audit work and deliver on our already commenced 2022-23 Audit Plan.

4 IA Performance

4.1 Quality assurance and improvement plan

The Public Sector Internal Audit Standards (PSIAS) require that the annual report must also include a statement on conformance with the Public Sector Internal Audit Standards and the results of the quality assurance and improvement programme (QAIP).

In previous reports we updated the Committee on our work to address previously noted issues; the main driver for these being our internal quality assessment.

We are pleased to confirm that an internal review of our control framework has concluded that we fully conform with PSIAS. An External Quality Assessment, which will test our fully compliant assessment, is currently underway and will be presented to the Aberdeen City Council Audit, Risk and Scrutiny Committee when finalised.

Complete details of the QAIP (including KPIs) have been presented to the Audit, Risk and Scrutiny Committee as part of the Council's overall Annual Audit Report and Opinion.

4.2 Staffing

Throughout the year we have had several changes to staffing and resources, including the recruitment of a new Chief Internal Auditor.

At present we are operating with a 12.6 FTE, 0.4 FTE under budget.

4.3 Methodology

This report and the annual opinion contained within is based on assurance work completed under the historical IA methodology.

However, over the past few months, Internal Audit has carried out a methodology refresh exercise. This refresh mostly focused on the scoping and the report stages (encompassing new assurance terms and rating scales); we are not suggesting any fundamental changes in how we carry out our audits. The refresh is instead focused on ensuring we scope audits to set us up for the best reviews, and how we report to ensure our messages land with the most impact and support auditees to take our recommendations forward.

These changes went live in April 2022 but only for audits as part of the 2022-25 plan. For any audits underway currently, or from previous years, we will continue to use the historic methodology.

The methodology refresh is however considered a work in progress. It is expected that there will be further changes to the methodology going forward, which the Committee will be kept updated on.

5 Appendix 1 – Grading of Recommendations

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

RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	23/06/2022
Report Title	Internal Audit Report AC2109: IJB Performance Management Reporting
Report Number	HSCP22.046
Lead Officer	Jamie Dale, Chief Internal Auditor
Report Author Details	Name: Jamie Dale Job Title: Chief Internal Auditor Email Address: jamie.dale@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 IJB Performance Management Reporting that was included in the 2020/21 Internal Audit Plan for Aberdeen City Council.

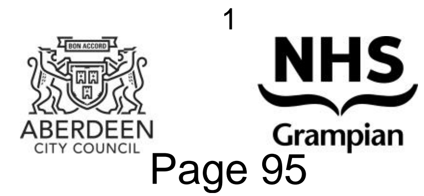
2. Recommendations

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

3. Summary of Key Information

Background

3.1. The Aberdeen City Health and Social Care Partnership (the Partnership) went live on 1 April 2016 under the governance of the Aberdeen City Integration Joint Board (IJB). In accordance with the Public Bodies (Joint Working) (Scotland) Act 2014 the IJB prepared and published its initial



three-year Strategic Plan which identified the objectives and aims which direct its operational plans.

3.2. The 2019-2022 Strategic Plan that followed, sets out the IJB's ambitions for transforming health and social care in Aberdeen, particularly in terms of services in the community, self-management and prevention. The IJB's vision for Aberdeen City Health & Social Care Partnership is of being "…a caring partnership working in and with our communities to enable people to achieve fulfilling, healthier lives".

3.3. At the time audit fieldwork was concluded, the Partnership's next Strategic Plan was in draft for consultation and due to be presented to the IJB in March 2022. The most recent draft of the 2022 – 2025 Plan expressed the same IJB vision as its predecessor, but the operational plans involved in delivering this vision and the Performance Framework intended to measure progress have moved on. Throughout the duration of the outgoing Strategic Plan, the COVID-19 pandemic necessitated a shift in Partnership strategy towards managing demands that were not envisaged when the commitments and priorities in the Strategic Plan were approved by the IJB in March 2019.

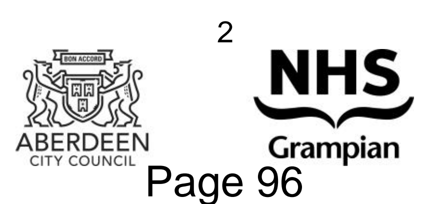
3.4. Successful delivery of the Strategic Plan ensures that the Partnership fulfils its statutory and regulatory duties. Regular assurance is therefore required in respect of service performance and delivery of the Strategic Plan.

<u>Objective</u>

3.5. The objective of this audit was to provide assurance that robust data is reported accurately and timeously to the IJB in order to provide an appropriate level of assurance regarding service performance and delivery of the IJB Strategic Plan.

<u>Assurance</u>

3.6. Whilst data is generally accurate, available and being consolidated into reports and dashboards, which have been used to inform the IJB at regular intervals regarding the Partnership's response to the COVID-19 pandemic, this primary operational focus has meant there has been less oversight over other aspects of Strategic Plan delivery than plan.



RISK, AUDIT AND PERFORMANCE COMMITTEE

Findings and Recommendations

3.7. The availability of performance information has been reviewed by the Partnership, as data for key indicators was not always available or up to date. A more high-level approach to performance management is planned for alignment with the 2022-2025 Strategic Plan.

3.8. The focus of data and reporting has shifted over the last two years towards managing COVID-19 related risks and pressures. This has meant that except for statutory annual reporting, there has been less detailed information provided to the IJB on performance against the Partnership's other strategic objectives. A recommendation graded Significant within audited area was made to ensure the IJB has sufficiently detailed and regular information to inform its oversight of Strategic Plan delivery. Data is collected by various systems for the purpose of supporting operational service delivery. Those responsible for the veracity of data span multiple organisations and where data comes from, the checks and other processes it goes through, and how it is used thereafter, is not currently mapped out. Recommendations graded Significant within audited area have been made to map the flow of data, clarify roles and responsibilities, and ensure feedback loops are in place, to clarify and promote ownership of the various data streams and reports.

Management Response

3.9. The Partnership plans to return to regular reporting from 2022/23 onwards. Our Performance Framework is being developed during 2022/23 to sit alongside the Strategic Plan, and as part of that development each of the audit findings and recommendations will be taken into account.

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 to mitigate these risks.

RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	23rd June 2022
Report Title	Primary Care Improvement Plan (Update)
Report Number	HSCP22.044
Lead Officer	Alex Stephen, Chief Finance Officer / Depute Chief Officer
Report Author Details	Sarah Gibbon, Programme Manager
Consultation Checklist Completed	Yes
Appendices	Appendix A - Scottish Government PCIP 5 Tracker Report

1. Purpose of the Report

1.1. This report presents the Risk, Audit & Performance Committee (RAPC) with an update regarding progress implementing the Primary Care Improvement Plan (PCIP).

1.2. The report presents a copy of the latest Scottish Government Tracker submission, submitted in May 2021 which provides a good overview of the work to date implementing the PCIP. The format of the report is set by Scottish Government however a summary is provided in the body of the covering report.

2. Recommendations

2.1. It is recommended that the Risk, Audit and Performance Committee:

a) Note the update presented on the PCIP, as outlined in this report and its appendices.

b) Note that a workshop is planned for a Primary Care Improvement Plan session for wider IJB members.

c) Requests that a further PCIP performance update is presented to the committee in Spring 2023 (unless required by exception).

RISK, AUDIT AND PERFORMANCE COMMITTEE

3. Summary of Key Information

3.1. Background

The PCIP sets out how the Partnership intends to transform general practice services, utilising the Primary Care Improvement Fund (PCIF) to release capacity of General Practitioners to allow them to undertake their role as Expert Medical Generalists as set out in the new General Medical Services Contract. The initial PCIP was approved by IJB on 28 August 2018, with a revised version approved in 2019. Whilst work delivering the PCIP was progressed over the following years, the PCIP plan has not been refreshed due to the pressures of the COVID-19 pandemic.

A new memorandum of understanding (MOU 2021-2023) for the GMS contract implementation for Primary Care Improvement was published, taking into account the learning and experience to inform next iteration. The MoU2 is accessible via. this link.

All six MoU areas remain areas of focus, however, the focus should be on the following three priority services:

a) Vaccination Transformation Programme
b) Community Treatment & Care (CTAC) Services
c) Pharmacotherapy Service

The GMS contract also saw Scottish Government undertake a reform for the funding of General Practice in Scotland. Phase 1 introduced a new funding formula accompanied by an additional £23m million investment in GMS to improve services for patients.

Phase 2 of the contract seeks to implement a GP income scale comparable to consultants and to directly reimburse agreed expenses; factoring in the 800 additional GPs required to help establish a baseline number of GPs. Discussions of Phase 2 have recommenced between the BMA and Scottish Governments and PCIPs leads have been invited to consultation events in early June.

3.2. PCIP Implementation Update

The report at appendix A is the PCIP 5 Tracker report which was submitted to Scottish Government in early May, following consultation with the Local Medical Committee (LMC) / GP sub-Committees.

RISK, AUDIT AND PERFORMANCE COMMITTEE

3.2.1. Vaccination Transformation Programme

The Vaccination Transformation Programme saw responsibility for delivering the following vaccination services transfer from General Practices:

- Pre school
- School age
- Out of schedule
- Adult routine immunisations
- Adult flu
- Pregnancy and travel

All services have been successfully transferred from practices, with the remaining services (adult routine immunisations and travel) transferring from practice in Jan-Mar 2022.

The PCIP vaccination programme works closely with the COVID-19 vaccination programme, though it is important to recognise the different funding streams for these areas.

3.2.2. Pharmacotherapy

The pharmacotherapy service is now providing partial access to all of the services required by the GP contract. All practices have access to pharmacists and pharmacy technicians who work within the practice. This will be supported by a hub to provide remote cover for unplanned absences (once IG issues have been resolved).

The funding model agreed in ACHSCP is 1 WTE pharmacy team member per 10,000 patients (+25% additional to cover for leave etc). The service has recruited to approximately 93% of the pharmacist workforce and 49% of the pharmacist technician workforce required to deliver the agreed model. The model required to deliver the full pharmacotherapy services outlined in the contract is likely to be closer to 2WTE per 5,000 patients. Currently this is unachievable both in terms of financial resource and availability of workforce.

There have been difficulties nationally recruiting to the pharmacy technician roles, though there is recent positive progress with the provision of funding from Scottish Government, for the recruitment of pre-registration trainee technicians. ACHSCP was allocated 2 posts

in cohort one, who are in post at the time of writing. Posts are for a fixed term of 2 years, which is the duration of the training program.

Nationally there have also been difficulties relating to the clarity on the levels of services, in particular what the definition of some of the core elements of the pharmacotherapy service actually mean. These are being interpreted differently across different health board areas. This has been raised nationally through the PCIP tracker reporting.

3.2.3. Community Treatment & Care (CTAC) Services

CTAC services include, but are not limited to, phlebotomy, management of minor injuries and dressings; ear syringing; suture removal; chronic disease monitoring; diabetic foot screening and other locally agreed services. Aberdeen's CTAC service has agreement from LMC to also undertake catheter care; PICC lines; warfarin monitoring and spirometry.

The CTAC service will be delivered through both centralised hubs and through practice-based staff:

- **Practice-based model:** The Community Treatment and Care service has successfully TUPE transferred approximately 24 WTE staff members from general practice to NHS Grampian employment in April and May 2021, providing some access to a CTAC service directly in the practices. Approximately 2/3 of the service will be provided this way. These staff will continue to be based in the practices, following the results of practice and patient engagement activities in 2020.

- **Hub-model:** The CTAC service is also recruiting to an additional capacity of six health care support workers and nine registered nurses[1] to support delivery in centralised hubs for CTAC services. Once these are operational, the CTAC service will be fully delivering based on the assumptions of the 'Week of Care' audit undertaken in 2019 to estimate the demand for these services across the city. The hubs will provide patients with a greater choice of times and locations for their appointments, as well as the opportunity to centralise certain specialist procedures such as ear irrigation. The hubs will be based in each locality, and the roll out will commence in Summer 2022 with the North

[1] Six Band 5 nurses and three Band 6 nurses

locality, followed shortly by Central and South. The main challenge to overcome for the implementation of the hubs is to find a suitable IT solution to allow proportionate and appropriate access to GP IT systems for patient information. Colleagues from NHS Grampian are working on this on a pan-Grampian basis.

3.2.4. Urgent Care

Through PCIP, Aberdeen provides a 'City Visits' service for general practice. All GP practices now have access to the service, which provides clinical assessment, diagnosis, and initial management in patients' own homes by a team of qualified and trainee Advanced Clinical Practitioners. Healthcare Support Workers provide support to GPs and the City Visits Practitioners with phlebotomy, clinical observations, ECG monitoring and bladder scanning that will contribute to diagnosis for on-the-day urgent consultations. There is an ongoing recruitment drive as vacancies arise for both Health Care Support Workers and Advanced Clinical Practitioners.

3.2.5. Community Link Workers

The Aberdeen City Community Link Workers service has been in place since 2018 and is delivered by the Scottish Association for Mental Health (SAMH) on behalf of ACHSCP.

GPs and Primary Care staff can refer patients when they assess a social issue is having a bearing on a patient's medical condition. The most common referrals are for the following categories: Money and Finance; Benefits; Housing and Homelessness; Mental Health; and Managing Conditions.

There have been 1747 referrals in 2021-22 which is an increase of 16.2% from previous year.

The initial contract was awarded in 2017 and was extended by direct award for 1 year and 3 months by the IJB on 24 August 2021. Work has commenced to retender the contract, undertaking a collaborative commissioning approach. A summary of key steps in the project are included below:

RISK, AUDIT AND PERFORMANCE COMMITTEE

Project Timeline

Aberdeen City Health & Social Care Partnership
A caring partnership

March-April 2022: Stakeholder Engagement

May – June 2022: Collaborative Commissioning

30 August 2022: Report to IJB for tender approval

1-30 September 2022: Invitation to Tender

11-13 October 2022 Clarification Presentations and Evaluation

14-24 October 2022: Standstill period

25 October: 2022 Contract Award

1 November 2022- 31 March 2023: Transition period

1 April 2023: New Contract begins

3.2.6. Additional Professional Roles – Physiotherapy / MSK

The Musculoskeletal First Contact Physiotherapy service provides experienced physiotherapists who have the advanced skills necessary to assess, diagnose and recommend appropriate treatment or referral for MSK problems on a patient's first contact with the healthcare service. The team are undertaking training to allow the physiotherapists to attain their advanced clinical qualification.

The service is currently being delivered in 10 of 27 practices in Aberdeen City.

Recruitment to the services is ongoing on a rolling basis, though there have been some difficulties recruiting suitable candidates, despite national advertising. As a result, the MSK FCP Delivery Group has been asked by the PCIP Group to consider how the future capacity can be more equally distributed across practices whilst recruitment is ongoing. The service will allocate their future workforce from ongoing recruitment to provide closer to 50% of a

practice's allocation to allow more practices to benefit from the service. There will be no change to existing levels with practices.

4. Implications for IJB

4.1. Equalities, Fairer Scotland and Health Inequality: The National Health Service (General Medical Services Contracts)(Scotland) Regulations 2018 (GMS) has had a comprehensive, nationally led Equalities Impact Assessment completed and can be accessed here: https://www.legislation.gov.uk/ssi/2018/66/pdfs/ssieqia_20180066_en.pdf This is applicable to the PCIP Programme.

4.2. Financial: There is specific ringfenced funding available in respect to the implementation of the Primary Care Improvement Plan. Whilst the funding is currently non-recurring, HSCPs have been advised by Scottish Government to plan delivery as if the funding was recurrent. A high-level summary of the available funding allocated to deliver the PCIP is as set out in the table below. It is expected that additional, recurring funding will be announced shortly.

PCIP ALLOCATION 21/22			
Fund available			
c/forward reserve	19/20		72764
c/forward reserve	20/21		2468070
Total b/forward to 21/22			2540834
21/22 Tranche 1	recd June 21		2656364
Recurring pharmacy allocation			298317
21/22 Tranche 2	recd Jan 22		2954681
Total PCIP allocation held by IJB			8450196
Actual spend			
Actual expenditure as at end March 21			4615942
Aberdeenshire contribution			-424931
			4191011
Reserve to be carried forward to 22.23			**4259185**

RISK, AUDIT AND PERFORMANCE COMMITTEE

4.3. **Workforce:** There is ongoing recruitment to acquire the appropriate workforce to support implementation of the PCIP. Recruitment remains a challenge, particularly for Pharmacy Technicians and First Contact Physiotherapists.

4.4. **Legal:** The PCIP seeks to provide the capacity within General Practice to support the implementation of the new GMS Contract. Any commissioning and procurement of services is required to implement the plan has and will continue to be progressed in a compliant manner.

4.5. **Other:** NA

5. Links to ACHSCP Strategic Plan

5.1. The PCIP is identified as a key delivery plan within both the current and revised ACHSCP Strategic Plan. It is also identified as a key priority within the strategic plan, demonstrating the importance of delivery of the PCIP to achieving ACHSCP's strategic aims and objectives, particularly to "*reshape our community and primary care sectors".*

6. Management of Risk

6.1. **Identified risks(s)**

6.2. **Link to risks on strategic or operational risk register:** There is a risk that there is insufficient capacity in the market (or appropriate infrastructure in-house) to fulfil the IJB's duties as outlined in the integration scheme. This includes commissioned services and general medical services.

RISK, AUDIT AND PERFORMANCE COMMITTEE

6.3. **How might the content of this report impact or mitigate these risks:** As recorded in the strategic risk register, delivery of the PCIP (and subsequently the implementation of the GMS contract) is a mitigating action against the risk identified above.

Approvals	
[signature]	Sandra Macleod (Chief Officer)
[signature]	Alex Stephen (Chief Finance Officer)

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Covid PCIP 5

Health Board Area: NHS Grampian
Health & Social Care Partnership: Aberdeen City
Total number of practices: 27

MOU PRIORITIES

2.1 Pharmacotherapy	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices with NO Pharmacotherapy service in place	1		
Practices with Pharmacotherapy level 1 service in place	0	26	0
Practices with Pharmacotherapy level 2 service in place	0	26	0
Practices with Pharmacotherapy level 3 service in place	0	26	0

The Pharmacotherapy service is progressing with a hub-model to provide remote cover for unplanned absence. Routine input to practices will continue to be provided in person within the practice (subject to availability of space) There have been some information governance issued raised in relation to this. This is currently being worked on.

The local GP-sub committee also raised concerns about the clarity on levels of service. This is echoed by the project team who feel that there is a lack of clarity in definition of what some of the core elements of

2.2 Community Treatment and Care Services	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices with access to phlebotomy service	0	27	0
Practices with access to management of minor injuries and dressings service	24	3	0
Practices with access to ear syringing service	27	0	0
Practices with access to suture removal service	24	3	0
Practices with access to chronic disease monitoring and related data collection	0	27	0
Practices with access to other services	0	0	27

All practices have access to a phlebotomy service, however this is listed as 'partial' as there is further capacity to be delivered through the hub-based services. We have listed most practices as having 'no' access to minor injuries/dressings and suture removal, as while some of the TUPE'd HCSWs provide these services, it is not universal. 3 practices did TUPE a nurse role which reflects those with partial access.

Practice-based service in place and TUPE process completed April / May 2021

2.3 Vaccine Transformation Program	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Pre School - Practices covered by service	0	0	27
School age - Practices covered by service	0	0	27
Out of Schedule - Practices covered by service	0	0	27
Adult imms - Practices covered by service	0	0	27
Adult flu - Practices covered by service	0	0	27
Pregnancy - Practices covered by service	0	0	27
Travel - Practices covered by service	0	0	27

Please outline any assumptions or caveats in the data and any significant changes since your October 2021 return.
Remaining services (adult imms and travel) were transferred from practice in the 1st Quarter of 2022.

2.4 Urgent Care Services	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices supported with Urgent Care Service	0	0	27

Please outline any assumptions or caveats in the data and any significant changes since your October 2021 return.
1.0wte ANP vacancy since 14th March 2022 and 1.0wte HCSW vacancy since 7th Feb 2022 , impacting on daily capacity to receive referrals from across all GP Practices

Additional professional services

2.5 Physiotherapy / MSK	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices accessing APP	17	5	5

Ongoing recruitment issues making it difficult to do a full roll out as planned giving practices their full allocation. Recent interviews have been successful recruiting our last Band 8a and another Band 7 FCP. Recruitment is undertaken on a rolling basis. The service will review allocation of the existing workforce to support more practices having a partial service (50% of the allocation). FCP service is looking into other ways of working including Hub model etc to see if this would be appropriate and effective.

2.6 Mental health workers (ref to Action 15 where appropriate)	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices accessing MH workers / support through PCIF/Action 15	1	0	27
Practices accessing MH workers / support through other funding streams	0	0	0

NB this refers to our Primary Care Psychological Therapies Service, which is funded through Action 15. The practice without access declined the service.

2.7 Community Links Workers	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices accessing Link workers	0	0	27

NA - service is fully implemented. Re-tender process has commenced ahead of current contract ending March 2023.

2.8 Other locally agreed services (insert details)	Practices with no access by 31/3/22	Practices with partial access by 31/3/22	Practices with full access by 31/3/22
Practices accessing service	0	0	0

Please outline any assumptions or caveats in the data and any significant changes since your October 2021 return.

2.9 Reflection

What have been the key successes, achievements or innovations in implementing the MOU?
Progress on developing and implementing the MoU ahead of PCIP role out (City Visits ; Link Practitioners) were a real example of local innovation that paved the way for wider roll out.
CTAC: TUPE process went very smoothly, with close working with local practices - the decision to undertake TUPE was beneficial as other HSCPs are now experiencing issues. Education opportunities for HCSWs have greatly increased under NHSG. MSK FCP: collaborative approach with GP reps to ensure robust governance is in place. Vaccinations: quick delivery in line with deadlines, resulting in keeping vaccinations away from GP workload during times of high pressure. Receiving positive feedback across the services; huge achievements and change in service delivery have been achieved by teams working under such unprecendented circumstances and pressures.

What lessons can be learned and applied moving forwards into the next phase of the MOU?
Increased communication with GP practices, patients and service users; funding allocation for education and training for a developing workforce; examine opportunities to link up individual workstrands to see what further innovation might be possible; guidance on evaluation for quantifying the impact of these additional roles in terms of creating capacity within the GP roles to enable the expert medical generalist roles; increase leadership skills and change leaders in practies; increased investment in practice representation; review of current service delivery across projects;

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Funding and Workforce profile

Health Board Area: NHS Grampian
Health & Social Care Partnership: Aberdeen City

Table 1: Spending profile 2018 - 2022 (£s)
Please include how much you spent in-year from both PCIF and any unutilised funding held in reserve

Financial Year	Service 1: Vaccinations Transfer Programme (£s)		Service 2: Pharmacotherapy (£s)		Service 3: Community Treatment and Care Services (£s)		Service 4: Urgent care (£s)		Service 5: Additional Professional roles (£s)		Service 6: Community link workers (£s)	
	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)	Staff cost	Other costs (staff training, equipment, infrastructure etc.)
2018-19 actual spend	61755	966	137521	484238	0	0	55833	-2213	227671	13679	492517	1591
2019-20 actual spend	271317	17754	316887	157744	0	0	111214	346	264676	-16811	690908	3175
2020-21 actual spend	416592	78988	608701	115103	35950	32421	237073	4503	253835	-160257	777349	9525
2021-22 actual spend	973777	19328	939933	102680	765966	80056	514662	48860	401723	-415462	759638	0
Total actual spend to March 2022	1723441	117036	2003042	859764	801916	112477	918782	51496	1147906	-578851	2720412	14291
2022-23 planned spend i.e. projected annual recurring cost	1200000	20000	1587000	120000	1577000	100000	735000	28000	505000	-425000	800000	

Table 2: Workforce profile 2018 - 2022 (headcount)

Financial Year	Service 6: Community link
TOTAL headcount staff in post as at 31 March 2018	0
INCREASE in staff headcount (1 April 2018 - 31 March 2019)	19
INCREASE in staff headcount (1 April 2019 - 31 March 2020)	3
INCREASE in staff headcount (1 April 2020 - 31 March 2021)	1
INCREASE staff headcount (1 April 2021 - 31 March 2022) [b]	0
TOTAL headcount staff in post by 31 March 2022	23

Service is at full roll-out - recruitment will be ongoing as vacancies occur. 1 WTE funded by ADP for custody suite link practioner and may not be continued

[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a

Table 3: Workforce profile 2018 - 2022 (WTE)

Financial Year	Service 2: Pharmacotherapy		Services 1 and 3: Vaccinations / Community Treatment and			Service 4: Urgent Care (advanced practitioners)			Service 5: Additional professional roles			Service 6: Community link workers
	Pharmacist	Pharmacy Technician	Nursing	Healthcare Assistants	Other [a]	ANPs	Advanced Paramedics	Other [a]	Mental Health workers (PPTs)	MSK Physios	Other [a]	
TOTAL staff WTE in post as at 31 March 2018	3.9	0.0	0.0	0.00	0.0	0.0	0.0	0.0	0.0	0	0.0	0.0
INCREASE in staff WTE (1 April 2018 - 31 March 2019)	2.0	0.0	2.0	0.00	0.0	0.5	0.0	0.0	0.0	1	1.0	19.0
INCREASE in staff WTE (1 April 2019 - 31 March 2020)	6.4	2.0	3.7	0.00	1.1	2.0	0.0	1.0	0.0	3	0.0	3.0
INCREASE in staff WTE (1 April 2020 - 31 March 2021)	-0.7	0.0	5.3	0.0	3.9	0.5	1.0	1.0	0.0	2	0.0	1.0
INCREASE staff WTE (1 April 2021 - 31 March 2022) [b]	4.8	4.8	13.3	29.8	1.4	3.0	2.0	0.0	0.0	3.0	0.0	0.0
TOTAL staff WTE in post by 31 March 2022	16.4	6.8	24.3	29.8	6.4	6.0	3.0	2.0	0.0	5.8	1.0	23.0
PLANNED INCREASE staff WTE (1 April 2022 - 31 March 2023) [b]	4.0	4.0	3.7	1.7	9.1	1.0	0.0	0.0	0.0	9.2	0.0	0.0
TOTAL future recurring staff WTE [c]	20.4	10.8	28.0	31.5	15.5	7.0	3.0	2.0	0.0	15.0	1.0	23.0

[a] please specify workforce types in the comment field
[b] If planned increase is zero, add 0. If planned increase cannot be estimated, add n/a
[c] automatically calculated as staff as at 31 March 2022 plus additional staff to be recruited by March 2023

Pharmacotherapy planned increase for 22-23: 3WTE pharmacist posts include 1WTE x Band 6 Foundation post funded using PCIP underspend. 2WTE x B7 posts increase capacity in the team while unable to fully recruit to technician posts.
Pharmacy technicanposts include 2WTE x Band (Annex 21) Trainee Pharmacy technician posts funded by SG (2 year fixed term posts), plus re-advertising for trained technician staff (still have c.5WTE unfilled tech posts for our proposed model). Our full model is more than that displayed in Line 40, but this is best estimate of what is likely to be recruited given workforce constraints
Please note that the majority of costs under the 'Other costs' heading do relate to provision of staffing under SLA with a small number of practices (which predate PCIP)

The Primary Care Psychological Therapists service has 9.4 WTE funded through the Action 15 funding.

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Local Implementation Tracker Guidance

The following tracker should be used by Integration Authorities in collaboration with Health Boards and GP sub-committees to monitor progress of primary care reform across their localities, and in line with service transfer as set out within the Memorandum of Understanding.

The **MoU Progress tab** should be used through local discussions between Integration Authorities and GP sub-committee to agree on progress against the six MoU priority services as well as that the barriers that areas are facing to full delivery. Integration Authorities should provide information on the number of practices in their area which have no/partial/full access to each service. The sum of these should equal the total number of practices in each area. Please only include numbers (or a zero) in these cells; comments boxes have been provided to supply further information.

If you are funding staff through different funding streams, for example, mental health workers through Action 15 funding, please include this information in the relevant section so we are aware that you are taking steps to recruit staff in this area.

The **Workforce and Funding Profile tab** should allow Integration Authorities to consider financial and workforce planning required to deliver primary care improvement, and reassure GP sub-committee of progress.

For the workforce numbers and projections, we are limiting our questions to WTE numbers, but are also asking you to provide headcounts for community links workers so that we can monitor progress towards the commitment to 250 additional CLWs. Please fit staff into categories provided as best as possible rather than adding extra columns. Additonal explanation of staffing roles can be provided in the comments box.

If you are funding staff through different funding streams, for example, recruiting mental health workers in Action 15, do not record these in Table 1. However, they should be included in Tables 2 and 3 to inform workforce planning.

As in PCIP 4.5 tracker we have included rows at the foot of Tables 1 and 3 (shaded in red) to try and capture future recurring workforce and costs. In Table 1, please include here your estimate of planned spend in 2022-23, which will represent recurring annual spend on the MOU for future years. In a change to last template, use cash costs expected in 2022-23 (rather than stripping out inflationary impacts). In Table 3, please include the extra staff you intend to employ in 2022-23, this will then automatically total, in the line below, to provide recurring staff numbers for 2022-23 onwards.

If there are changes to spend/WTE for the years prior to FY 2021-22, compared to previously submitted trackers, please can you provide notes in comments to explain.

We would also ask that this local implementation tracker be updated and shared with Scottish Government by **29th April 2022.**

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Aberdeen City Health & Social Care Partnership
A caring partnership

RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	23 June 2022
Report Title	Signposting Protocol
Report Number	HSCP22.030
Lead Officer	Alison Macleod
Report Author Details	Name: Alison MacLeod Job Title: Strategy and Transformation Lead Email Address: alimacleod@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Appendices	Appendix A - Draft Signposting Protocol

1. Purpose of the Report

1.1. The purpose of this report is to provide a protocol for guidance prior to Aberdeen City Health and Social Care Partnership (ACHSCP) specifically and deliberately signposting patients, clients, carers, and service users to organisations that have not gone through the commissioning or grant funding process.

2. Recommendations

2.1. It is recommended that the Risk, Audit, and Performance Committee approve the draft Signposting Protocol attached at Appendix A.

3. Summary of Key Information

3.1. There are a significant number of third and independent sector organisations providing advice, care, and support to vulnerable individuals in need in Aberdeen City. Some of these receive funding from ACHSCP through formal commissioning or grant funding processes. When these organisations are formally commissioned their governance arrangements and legitimacy are checked as part of the tendering process prior to a formal contract being

awarded. Similarly, grant funded organisations are checked using the Operational Assessment Framework under the Following the Public Pound Code of Practice.

3.2. The selection criteria used to assess an organisations suitability to even be considered for a contract award under Public Contracts Scotland Regulations 2015 include: -

- Suitability to Pursue Professional Activity e.g., enrolled in certain professional or trade registers
- Economic and Financial Standing via Accounts or Insurance Levels
- Technical and Professional Ability via qualifications, references, examples of current or previous work
- Quality Management Procedures e.g., health and safety legislation

3.3. The Following the Public Pound Operational Assessment Framework is as follows: -

- Does the organisation have a management board to oversee the direction, service delivery and financial stability of the organisation?
- Is the organisation a registered charity, and if so, have they complied with guidance from OSCR?
- Is the organisation a registered company, and if so, have they complied with their requirements under Companies Act?
- Does the organisation have a clear statement of purpose and organisational objectives?
- Is the organisation able to provide evidence or other support to demonstrate achievement of its objectives and purpose?
- Are there any known reasons that would result in a risk to the Council's reputation through association with an external body if financial or service delivery problems emerge

3.4. Organisations providing advice, care, and support in Aberdeen range in scale and complexity. Some are small, relatively informal groups offering peer support with virtually no financial turnover, and others are more formal in nature perhaps offering and charging for professional services. Some may have charitable status or belong to an umbrella organisation such as Aberdeen Council for Voluntary Organisations (ACVO), others will not. All of these organisations have a valuable place in the health and social care landscape. ACHSCP do not wish to discriminate against organisations or stifle community enterprise. Individual service users should be free to make their own choice about which services they use.

3.5. Organisations are also able to list themselves on the following databases which provide publicly accessible information on support services available locally.

- ALISS - A Local Information System for Scotland. This programme is funded by the Scottish Government and delivered by the Health and Social Care Alliance Scotland (the ALLIANCE). It is a central point for hosting health and wellbeing information for people living with long term conditions, disabled people and unpaid carers.
- Scotland's Service Directory (SSD). This is a central point for information on health and wellbeing services in Scotland.

3.6. The purpose of this protocol is to provide clarity for service users whenever ACHSCP specifically and deliberately signpost to an organisation that is not commissioned, or grant funded by them ensuring that most benefit is derived from the experience. When specifically, and deliberately signposting, ACHSCP should, where possible, signpost to more than one organisation and encourage individuals to undertake their own research before making up their mind which to use.

3.7. It is proposed that the protocol is implemented for any new organisations ACHSCP specifically and deliberately signpost to, and that there is no retrospective action.

4. Implications for IJB

4.1. Equalities, Fairer Scotland, and Health Inequality

There are no direct equalities impact on our equalities duties as a result of the recommendations within this paper.

4.2. Financial

There are no direct financial implications arising from the recommendations of this report.

4.3. Workforce

There are no direct workforce implications arising from the recommendations of this report.

4.4. Legal

There are no legal implications arising from the recommendations in this report.

4.5. Covid 19

There are no implications in relation to Covid-19 resulting from the recommendations in this report.

4.6. Unpaid Carers

There are no specific implications for Unpaid Carers resulting from the recommendations in this report.

4.7. Other

There are no other implications resulting from the recommendations in this report.

5. Links to ACHSCP Strategic Plan

5.1. This report links to the Caring Together aim of the Strategic Plan. It will support service users and patients to access a range of organisations to meet their individual needs.

6. Management of Risk

6.1. Identified risks(s)

There is a risk that service users/ patients are signposted to organisations which do not deliver the standard of service we would expect which will have a negative outcome for the individual.

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

This is linked to Risk 5 – 'There is a risk that the IJB, and the services that it directs and has operational oversight of, fails to meet the national, regulatory, and local standards'

RISK, AUDIT AND PERFORMANCE COMMITTEE

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

The use of the Signposting Protocol will provide clarity for service users encouraging them to shop around and use their own judgement thus hopefully avoiding them experiencing negative outcomes. With this mitigation in place the likelihood of risk is low.

Approvals	
[signature]	Sandra Macleod (Chief Officer)
[signature]	Alex Stephen (Chief Finance Officer)

RISK, AUDIT AND PERFORMANCE COMMITTEE

APPENDIX A

Signposting Protocol

Officers of Aberdeen City Health and Social Care Partnership who wish to signpost patients, clients, carers, and service users to organisations that have not been directly commissioned or grant funded should follow the protocol below prior to specifically and deliberately signposting: -

- Research what organisations exist locally to meet the needs of the service user cohort making use of the ALISS and SSD databases. Ideally service users should be made aware of a range of options available to them.

- Encourage the service user to undertake their own research and evaluation of the options available to them. What specific services are offered; would these meet their specific needs; what form of support is involved – is it informal peer support or more professional advice or services; and what potential benefits could be achieved from engaging with the organisation. The most valuable information will be testimonies from people who have used the service and service users should be encouraged to seek these out using the organisations website or asking directly for these.

- Encourage service users to feedback on their experience with particular services, and provide a mechanism for that, in order build up local knowledge of the value delivered.

RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	23 June 2022
Report Title	Update report re Young People Monitoring Report 2020-21, Mental Welfare Commission
Report Number	HSCP22.047
Lead Officer	Jane Fletcher, Lead for Mental Health and Learning Disability Inpatient Services, Specialist Services and CAMHS
Report Author Details	Amanda Farquharson, Service Manager, Child & Adolescent Mental Health Services (CAMHS) Amanda.farquharson@nhs.scot
Consultation Checklist Completed	Yes
Appendices	Appendix A - Young People Monitoring Report 2020-21, Mental Welfare Commission Appendix B – National CAMHS Service Specification

1. Purpose of the Report

1.1. The purpose of this report is to provide the Risk, Audit and Performance Committee (RAPC) with an update on the Young People Monitoring Report 2020-21 and provide assurance regarding our progress in relation to the recommendations made by the Mental Welfare Commission.

1.2. It is important to note that, of the mainland Child and Adolescent Mental Health Services (CAMHS) in the North of Scotland, Grampian had an increase in admission rate for children and young people to non-specialist wards, with a total of 7 young people admitted to a non-specialist setting for the care and treatment of their mental health in 2020-21. This was an increase of 3 from the previous reporting period.

RISK, AUDIT AND PERFORMANCE COMMITTEE

2. Recommendations

2.1. It is recommended that RAPC:

a) Note the recommendations made by the Mental Welfare Commission in the Young People's Monitoring Report 2020-21 (Appendix A) and provide an update on the IJB's progress in relation to these and any previous recommendations.

b) Instruct the Chief Officer to provide a further update to the Risk, Audit and Performance Committee following the publication of the 2021-22 Mental Welfare Commission in the Young People's Monitoring Report.

3. Summary of Key Information

3.1. Since the implementation of the Mental Health (Care & Treatment) (Scotland) Act 2003 (the 'Act') health boards in Scotland have a legal duty to provide appropriate services and accommodation for young people who are under the age of 18 years and who are admitted to hospitals for treatment of their mental illness. The Mental Welfare Commission (MWC) monitors the use of this legislation in relation to young people to ensure that their rights are respected, to identify and highlight any deficiencies in care, and, more recently, to monitor and record the provision of age-appropriate services under the Act.

3.2. Under article 24 of the United Nations Convention for the Rights of the Child (UNCRC), children have a right to the highest attainable standards of health within available resources and have a right to access health services for their care and treatment. In a significant majority of instances where a young person needs inpatient care and treatment for the mental illness, this is provided in a regional or national specialist child and adolescent inpatient unit. Specialist adolescent units and wards are designed to meet the needs of young people with mental illness. These units and wards differ from adult mental health wards and adult Intensive Psychiatric Care Units (IPCU) in staff training and the ward environment and a young person's needs may not be fully met in an adult mental health ward or IPCU.

RISK, AUDIT AND PERFORMANCE COMMITTEE

3.3. The MWC publishes a report annually showing the trend of admissions of young people to non-specialist wards. Between 1 April 2020 and 31 March 2020 there were 86 admissions for children and young people to non-specialist wards. This equates to 26% of overall admissions of children and young people under the age of 18 for care and treatment of their mental health in Scotland to non-specialist wards – primarily adult mental health wards and adult IPCUs.

3.4. Reasons for young people being admitted to adult wards include a shortage of specialist beds and a lack of provision for:

- Highly specialised care for young people with learning disabilities
- Young people who have offended due to mental health difficulties and require forensic care
- Young people who require intensive psychiatric care provided in specialised beds
- Young people who are in distress and need a safe space during a crisis but are unable to return to the home environment or due to a breakdown in their care placement

3.5. In comparison to the national figure of 86 admissions (26% of overall admissions) of children and young people under the aged of 18 to non-specialist wards for care and treatment of their mental health, Grampian's figure was low, with a total of 7 admissions to non-specialist wards in 2020-21.

3.6. Of the mainland CAMHS in the North of Scotland, Grampian has one of the lowest admission rates for children and young people to non-specialist wards. There are several reasons for this:

- We continue to focus on the expansion of community CAMHS to provide intensive treatment at home and in the community as an alternative to hospital admission wherever possible. This is supported by our highly skilled and dedicated Tier 4 clinicians, there is currently a vacancy for the Tier 4 Network Liaison Nurse for Grampian, however this post is at advert.
- Grampian CAMHS provides a service for children and young people up to the age of 18 years, regardless of whether or not they are in education,

which has a positive impact on the number of admissions for 16-18 year olds to non-specialist wards. Some CAMH services in Scotland will only provide a service to young people aged 16-18 years if they are in education – other young people in this age bracket who are not in education are managed by adult services for their mental illness and are more likely to be admitted to a non-specialist ward.

3.7. Grampian CAMHS is part of the Tier 4 North of Scotland Obligate Network. The Network works on the principle of "as local as possible and as specialist as necessary" where admission of young people to a non-specialist setting only occurs where it is deemed to be necessary.

3.8. All young people admitted to non-specialist beds in Grampian receive input from a CAMHS Responsible Medical Officer and other clinical members of the CAMHS multi-disciplinary team, and we work to ensure that their admission is as short as possible.

3.9. MWC makes three recommendations in the Young People Monitoring Report 2020-21, attached at Appendix A:

Recommendation 1: The Commission recommends that work to explore the accessibility and provision of intensive psychiatric care facilities (IPCU) for the under 18s in Scotland is sufficiently prioritised, resourced and supported by Scottish Government. This work should be brought to completion within one year to enable meaningful change nationally for young people having access to IPCU facilities that are age appropriate. It is essential that any such work should not be undertaken in isolation but co-ordinated with other work-streams (such as relating to National Secure Adolescent Inpatient Service and Learning Disability unit development) to ensure that access to IPCU facilities is part of a cohesive integrated pathway between and within the various specialist adolescent inpatient services

Recommendation 2: Health board managers with a duty to fund and provide advocacy services for individuals with mental health difficulties in their area should ensure the availability of dedicated advocacy support for children and young people with mental health difficulties locally and ensure the resourcing and provision of any dedicated specialist advocacy service is sufficient to be

able to meet the needs of young people with mental health problems and to support and protect their rights.

Recommendation 3: Hospital managers should ensure that whenever a child or young person is admitted to a non-specialist ward that consideration and exploration of their educational needs and their right to education should be a standard part of care planning for the young person during their hospital admission.

3.10. The progress of Grampian CAMHS regarding these recommendations is monitored and evaluated in relation to our implementation of the National CAMHS Service Specification (attached at Appendix B). Sections 1-7 of this Service Specification detail the minimum standards to be delivered by all CAMHS in Scotland. A summary of CAMHS Grampian progress in relation to the three recommendations in the Young People Monitoring Report 2020-21 is as follows:

Recommendation 1: Links to Standards 1, 3 and 7 of the National CAMHS Service Specification – (1) High Quality Care and Support that is Right for Me; (3) High Quality Interventions and Treatment that are Right for Me; (7) I Have Confidence in the Staff who Support Me. Grampian CAMHS has actively contributed to the scoping review of intensive psychiatric inpatient care provision for young people in Scotland. The Scottish government recently published the report which can be accessed via the following link - Scoping review of intensive psychiatric inpatient care provision for young people in Scotland: report - gov.scot (www.gov.scot)

Recommendation 2: Links to Standard 4 of the National CAMHS Service Specification – My Rights Are Acknowledged, Respected and Delivered. Advocacy Services in Grampian are commissioned via the Local Authority and/or Health and Social Care Partnership. All young people who are admitted to either Royal Cornhill Hospital or Dr Gray's Hospital on adult mental health beds have access to the same advocacy service that is available for rest of Hospital patients

Grampian CAMHS will routinely audit whether young people admitted to non-specialist wards are offered advocacy going forward and will work collaboratively to ensure provision of and access to dedicated advocacy

support. Ensure that there are better links with local authorities and services to improve access to advocacy and to also improve documentation on offer and utilisation of advocacy services.

Recommendation 3: Links to Standard 3 of the National CAMHS Service Specification (see above) and in particular 3.2 – *take account of children and young people's education needs and, with informed consent, work with school and education authority staff to contribute to the child or young person's educational support*. Going forward, Grampian CAMHS will monitor whether consideration of and exploration of children and young people's educational needs and their right to education are a standard part of care planning during their hospital admission and will work collaboratively with education providers. All young people admitted to non-specialist wards to have an individualised person-centred plan where decision on access to education is based on clinical presentation and severity of symptoms.

4. Implications for IJB

4.1. Equalities, Fairer Scotland and Health Inequality - There are no direct implications in relation to Equalities, Fairer Scotland or Health Inequality arising from the recommendations in this report.

4.2. Financial - There are no direct financial implications arising from the recommendations in this report.

4.3. Workforce - There are no direct workforce implications arising from the recommendations in this report.

4.4. Legal - There are no direct legal implications arising for the recommendations of this report.

4.5. Other - There are no other direct implications arising from the recommendations in this report.

RISK, AUDIT AND PERFORMANCE COMMITTEE

5. Links to ACHSCP Strategic Plan

5.1. This report ensures that our service delivers within all the headings of the Strategic Plan – Prevention, Resilience, Personalisation, Connections and Communities.

6. Management of Risk

6.1. Identified risks(s)

Risk 3 – outcomes are not delivered and non-performance is not identified

Risk 5 – risk of harm to people

Risk 6 – risk of reputational damage to the IJB and its partner organisations

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

Risk 3 - There is a risk that the outcomes expected from hosted services are not delivered and that the IJB does not identify non-performance through its systems. This risk relates to services that Aberdeen IJB hosts on behalf of Moray and Aberdeenshire, and those hosted by those IJBs and delivered on behalf of Aberdeen City.

Risk 5 - There is a risk that the IJB, and the services that it directs and has operational oversight of, fail to meet both performance standards/outcomes as set by regulatory bodies and those locally-determined performance standards as set by the board itself. This may result in harm or risk of harm to people.

Risk 6 - There is a risk of reputational damage to the IJB and its partner organisations resulting from complexity of function, delegation and delivery of services across Health and Social Care.

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

Our review of the annual report by the Mental Welfare Commission and reporting to RAPC on our position against any findings ensures we meet

RISK, AUDIT AND PERFORMANCE COMMITTEE

our requirements within the Mental Health (Care & Treatment) (Scotland) Act 2003 and we consider the risk to be low against all three risks noted above.

Approvals	
[signature]	Sandra Macleod (Chief Officer)
[signature]	Alex Stephen (Chief Finance Officer)

Young people monitoring report 2020-21

Admissions of young people under the age of 18 to non-specialist wards in Scotland 2020-21

October 2021

Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Admissions of young people under the age of 18 to non-specialist wards in Scotland 2020-21

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Foreword – Julie Paterson, chief executive

Every year we monitor and publish information on the number of young people under the age of 18 in Scotland who are admitted to non-specialist wards – usually adult wards – for treatment of their mental health difficulties.

We do this because, while there can be some instances when it might be in the best interests of a child or young person to be treated on an adult ward, this should only happen in rare situations.

Legislation recognises this, and under the Mental Health Act, health boards are obliged to provide appropriate services and accommodation for young people admitted to hospital for treatment for their mental health. This usually means one of Scotland's specialist adolescent units, designed to treat the needs of adolescents with mental illness.

The figures published in this report for the year 2020-21 show a fall from 2019-20, which in normal circumstances we would clearly recognise as a positive sign.

The numbers are however not directly comparable, and need to be understood against the backdrop of pandemic restrictions. Hospital wards and admissions and discharges across the country were adapted in 2020-21 to help cope with the pandemic, and this had an impact on bed availability and admissions.

The data published in this report nevertheless remains vital in understanding something of how services operated during that time. It also confirms that some of the issues we raised in the past as requiring attention continue to exist.

In these circumstances it is perhaps not surprising that our three recommendations for change are almost identical to the previous report's recommendations, except that this time we are asking that progress is made on identifying intensive psychiatric care facilities in Scotland for young people within one year.

Positive findings in the report include confirmation that a facility for young people who need forensic intensive psychiatric care is underway and is due to open in Ayr in November 2022.

We also welcome confirmation that national specialist facilities for young people with learning disabilities are being developed in Lothian area. This is good news for those young people who need this care and we look forward to hearing of the next stage.

Executive Summary

1. This year's report covers the year from 1 April 2020 to 31 March 2021. It describes admissions of young people under the age of 18 to non-specialist wards in Scotland. During this time there were major alterations to daily life for people living in the UK and many alterations made to hospital service provision both in response to the pandemic, and as a consequence of the impact of the pandemic on hospital staffing and the provision of care. As such this year's report covers a period of extraordinary circumstances and cannot be taken as a reflection of trends of activity outwith recent pandemic circumstances.
2. Under article 24 of the United Nations Convention for the Rights of the Child (UNCRC), children have a right to the highest attainable standards of health within available resources and have a right to access health services for their care and treatment.
3. In its concluding observations to the fifth and latest periodic report from the UK[1] in 2016, the Committee on the Rights of the Child (CRC) expressed concerns regarding the treatment of children (in Scotland and England) in hospitals far away from home, with inadequate provision of child-specific attention, support and placement in adult facilities. The CRC recommended that the prohibition of placement of children with mental health needs in adult psychiatric wards should be expedited while ensuring age appropriate mental health services and facilities were provided to children and young people.
4. The Mental Health (Care and Treatment) (Scotland) Act 2003 places a legal obligation on health boards to provide appropriate services and accommodation for young people admitted to hospital for treatment of their mental ill health.
5. In 2020-21, the number of young people under the age of 18 admitted to non-specialist hospital wards – primarily adult wards – for treatment of their mental health difficulties in Scotland was 86 admissions involving 62 young people. This is a fall from the 2019-20 figures when there were 103 admissions involving 88 young people.
6. In a significant majority of instances where a young person needs inpatient care, this is provided within the regional or national specialist child and adolescent inpatient units. According to the latest Public Health Scotland data, between 1 April 2020 and 31 March 2021 34 % of overall admissions of children and young people under the age of 18 for care and treatment of their mental health were to non-specialist wards.[2]
7. Reasons for young people being admitted to adult wards include a shortage of specialist beds, and a lack of provision for:
   a. Highly specialised care for young people with an learning disability,
   b. Young people who have offended due to mental health difficulties and require forensic care; and

[1] Para 60c and 61c.
http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhskHOj6VpDS%2F%2FJqg2Jxb9gncnUyUgbnuttBweOlylfyYPkBbwffitW2JurgBRuMMxZqnGgerUdpjxij3uZ0bjQBOLNTNvQ9fUIEOvA5LtW0GL
[2] PHS (2021) Quality Indicator Profile for Mental Health
https://beta.isdscotland.org/find-publications-and-data/conditions-and-diseases/mental-health/mental-health-quality-indicator-profile/

c. Young people who require intensive psychiatric care provided in specialised units.

8. In some instances it may be appropriate for a child or a young person to be admitted to a non-specialist setting if available alternatives would not be in their best interests. However the United Nations Convention of the Rights of the Child indicates the necessity of ensuring special safeguards for children and young people due to their stage of development.
9. The majority of admissions of young people to non-specialist wards continue to be short in length, however 48% remain on those wards (mostly adult) for over a week.
10. A continued positive finding is the specialist medical staff either supporting or available to support these admissions remains high – 60% of the doctors in charge of care or responsible medical officers (RMO) were child specialists and in a further 23% of admissions a child and adolescent mental health services (CAMHS) consultant was available to give support, if needed.
11. Of all the young people admitted to non-specialist wards, 16% were care experienced and looked after and accommodated by a local authority.
12. Access to specialist advocacy remains limited. We were disappointed to note that while 77% of young people had access to advocacy, only 13% had access to advocacy that specialised in the particular needs and rights of young people.
13. We are aware that CAMHS clinicians continue to provide support to young people in non-specialist inpatient wards, but over recent years the proportion of young people being able to access specialist CAMHS input that is not medical whilst an in-patient on a non-specialist ward has not improved.
14. Action 20 of the Mental Health Strategy is a commitment to scoping the level of highly specialist mental health inpatient services for young people and act on the findings. The Commission notes the progress towards developing inpatient facilities for children and young people who require specialist forensic care and for those young people who have a learning disability.
15. The Commission is encouraged that, following a number of recommendations in recent years, work has begun once again to explore the needs of young people who require CAMHS specialised intensive psychiatric care unit (IPCU) support in Scotland. We continue to emphasise the importance of this work and the need for it to be prioritised and brought to a conclusion. We are aware of the complexity of this task and that previous initiatives to explore this question have been unsuccessful in changing the landscape of inpatient provision for the under 18s. We continue to emphasise the importance of addressing the need for IPCU facilities nationally for young people. It is important that any work looking at access to IPCU facilities is sufficiently supported by Scottish Government to be able to come to a conclusion that will have meaningful change for young people across Scotland in the delivery of intensive psychiatric services and accommodation. From its work the Commission is aware that the young people who may need IPCU care often may also have a learning disability, they may be care experienced and/or may have a forensic history. It is important therefore that any work to develop IPCU facilities for young people regionally is sufficiently co-ordinated nationally between regional adolescent units and also with the work underway in relation to the proposed forensic and learning disability units being developed to ensure coherence in developing service provision.

Recommendations

Recommendation 1

To Scottish Government

The Commission recommends that work to explore the accessibility and provision of intensive psychiatric care facilities (IPCU) for the under 18s in Scotland is sufficiently prioritised, resourced and supported by Scottish Government. This work should be brought to completion within one year to enable meaningful change nationally for young people having access to IPCU facilities that are age appropriate.

It is essential that any such work should not be undertaken in isolation but co-ordinated with other work-streams (such as relating to National Secure Adolescent Inpatient Service and Learning Disability unit development) to ensure that access to IPCU facilities is part of a cohesive integrated pathway between and within the various specialist adolescent inpatient services.

Recommendation 2

Health board managers with a duty to fund and provide advocacy services for individuals with mental health difficulties in their area should ensure the availability of dedicated advocacy support for children and young people with mental health difficulties locally and ensure the resourcing and provision of any dedicated specialist advocacy service is sufficient to be able to meet the needs of young people with mental health problems and to support and protect their rights.

Recommendation 3

Hospital managers should ensure that whenever a child or young person is admitted to a non-specialist ward that consideration and exploration of their educational needs and their right to education should be a standard part of care planning for the young person during their hospital admission.

Cases

The following composite cases illustrate the problems this report seeks to highlight. These are not real cases but are based on the information that the Commission is aware of through its work.

JD is a 15 year old young person who is a secondary school student, and lives with their family. JD developed an episode of psychosis and required admission to a regional CAMHS inpatient unit located over fifty miles away from his home.
Whilst there, as part of their illness, JD became paranoid about the staff and other young patients. This led to episodes of aggression, and the clinical team felt JD's care needs required more intensive psychiatric care.
There are no IPCU facilities for young people in Scotland and the adult IPCU nearest to the regional CAMHS inpatient unit suggested JD would be better placed in the IPCU provided within his home health board area.
However, JD's home IPCU said that they could not accept a 15 year old and advised them to speak to other IPCUs elsewhere. This lack of clarity was difficult for the young person, the family and JD's clinical team.
JD remained on the regional adolescent unit whilst unwell but this had significant impact on JD and the other young people in the CAMHS unit. The lack of a specialised IPCU facility for young people and the lack of a clear protocol for how to progress the request for more support was unhelpful.

SK is a 16 year old person who enjoys music and puzzles. She has diagnoses of autism and mood disorder. She developed an episode of mania and required an admission to a regional young people's inpatient unit. She was very distressed and hit at her support workers on several occasions.
This led to an admission to the local adult IPCU to ensure the level of care and support she needed. However this was on a ward with very unwell adults and adults involved in the criminal justice system and she was vulnerable. This required her to have staff placed with her constantly and she perceived this as intrusive and restrictive although she understood it was for her safety.
The clinical team informed the Mental Welfare Commission of the admission of this young person to a non-specialist ward and the Commission collected information about her stay on the ward and access to CAMHS clinicians, education and age appropriate recreation.
Despite the efforts of the CAMHS team and local adult mental health services, the admission was difficult for SK and her friends and family who were concerned about the environment in which she was placed.

Introduction

This year's report describes the admissions of children and young people under the age of 18 years to non-specialist wards in Scotland as a consequence of their mental illness between 1 April 2020 and 31 March 2021.

During this period much of Scotland was affected by lockdown as a result of the Covid-19 pandemic which saw substantial alterations made to daily life for the whole of the population in an attempt to minimise the impact of the virus on everyone[3]. Movement and travel was heavily restricted for long periods, social interaction and opportunities curtailed, people worked from home or their jobs were furloughed and schools were temporarily closed in an attempt to limit opportunities for the virus spreading. At the same time hospital inpatient wards and admission and discharge processes across the country were adapted which impacted on bed availability and admission pathways. This year's report figures should be understood with this backdrop in mind.

One of the Commission's duties is to monitor the use of the Mental Health (Care and Treatment) (Scotland) Act 2003 ('the Act') and each year the Commission produced a report that describes the number of children and young people who are admitted to non-specialist wards for treatment of their mental health difficulties. Section 23 of the Act places a legal duty on health boards to provide appropriate services and accommodation for young people who are under the age of 18 years and who are admitted to hospitals for treatment of their mental disorder (or mental illness, as the Commission refers to it in this report). The most common non-specialist wards to which young people are admitted are adult mental health wards and adult intensive psychiatric care units (IPCUs).[4]

The Code of Practice to the Act states "whenever possible it would be best practise to admit a child to a unit specialising in child and adolescent psychiatry "and that young people should be admitted to a non-specialist ward only in "exceptional circumstances"[5]. Specialist adolescent units are designed to treat the needs of adolescents with mental illness and differ in staff training and the ward environment so that a young person's needs might not be fully met on an adult ward.

The Commission believes that admitting a young person to an adult ward should only happen in rare situations. This would depend upon the individual needs and circumstances of the young person e.g. the nature of their mental health difficulties and the care they require and the distance to the regional unit and what is in their best interests. When an admission to a non-specialist ward does become unavoidable then every effort should be made to provide for the young person's needs as fully as possible.

It is important to bear in mind that the Section 23 duties on health boards reflect a number of rights outlined in the United Convention on the Rights of the Child (UNCRC) which is an international human rights treaty that outlines a comprehensive range of rights that should be available to all children. (Under the UNCRC a child is defined as an individual who is younger

[3] https://www.publichealthscotland.scot/media/2999/the-impact-of-covid-19-on-children-and-young-people-in-scotland-10-to-17-year-olds_full-report.pdf
[4] Adult IPCU facilities are specialised psychiatry wards designed to provide a care setting for adults when they are very unwell and present with high levels of risk either to themselves or others.
[5] Code of Practice Volume 1, chapter 1 paragraph 50.
https://www2.gov.scot/Publications/2005/08/29100428/04302

than 18 years old.) In 1991 the UK government ratified UNCRC and made a commitment to take steps to ensure that the rights described in UNCRC should apply to all children in the UK.

The body responsible for monitoring compliance of states with UNCRC is the Committee of the Rights of the Child (CRC) which reviews and responds to the periodic submission of a report by the UK government which details what progress has been made in implementing UNCRC within the UK. The CRC describes any areas of concerns and makes recommendations to the UK government or devolved administrations (where relevant mandates such as for example health in Scotland fall under their jurisdiction) for their attention. In its concluding observations to the fifth and latest periodic report from the UK[6] in 2016 the CRC outlined concerns regarding the treatment of children (in Scotland and England) in hospitals far away from home, with inadequate provision of child-specific attention and support and placement within adult facilities. The CRC recommended that the prohibition of placement of children with mental health needs within adult psychiatric wards should be expedited while ensuring the provision of age appropriate mental health services and facilities to children and young people.

The importance of children's mental health and access to appropriate mental health services is described in a number of UNCRC rights. These in turn reflect areas that the Commission explored in its routine monitoring process relating to an admission to a non-specialist ward:

Article 6 describes the right to life and maximum survival and development of any child and is one of the core principles of UNCRC.

Article 12 describes the rights of children who are capable of forming their view to be able to express this in all matters that affect them with due weight given to their views depending on their age and maturity. Advocacy is a right that all individuals with mental illness and related conditions have a right to under the mental health act, whether compulsorily treated or not and access to specialist children's advocacy is an important mechanism by which children's rights can be protected.

Article 19 describes the rights of children to be protected from all forms of violence including mental or physical violence and also includes measures to be taken to help protect children from suicide and self-injury.

Article 24 describes the rights for children to attain the highest standard of health including mental and emotional health within available resources and includes the children's rights to access health services for treatment and rehabilitation of health. Article 24 also requires that states "strive to ensure that no child is deprived of his or her right to access health care services".

Article 28 describes the right to equal access to education for children. Specialist child and adolescent units have access to educational facilities as a standard feature of inpatient provision.

Article 31 describes a child's right to recreational facilities, leisure and play and to take part in cultural activities.

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[6] Para 60c and 61c.
http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhskHOj6VpDS%2F%2FJqg2Jxb9gncnUyUgbnuttBweOlylfyYPkBbwffitW2JurgBRuMMxZqnGgerUdpjxij3uZ0bjQBOLNTNvQ9fUIEOvA5LtW0GL

Article 37 requires that children deprived of their liberty are treated "in a manner that takes account of the needs of the person of his or her age" and goes on to state that "every child deprived of their liberty shall be separated from adults unless it is considered in the child's best interests not to do so." This may be an important consideration when young people are admitted to adult IPCUs.

On the 1 September 2020 the UNCRC (Incorporation) (Scotland) (Bill) was introduced to the Scottish Parliament and was passed unanimously on 16 March 2021. The Bill's main purpose is to bring UNCRC into Scots law and to ensure all legislation is compatible with it. Due to the fact that some areas within the UNCRC bill are not within the powers devolved to the Scottish parliament, a judgement from the UK's Supreme Court was delivered on Wednesday 6 October in relation to those matters which will be required to be revisited in the near future.

In recent years the Commission had seen that numbers of admissions to non-specialist wards can vary across the country and year to year. We have been told about a number of approaches to try and reduce admission rates which have included investing in and increasing the capacity of the specialist adolescent inpatient estate and promoting the development of CAMHS intensive services in the community to provide alternatives to admission and help reduce length of stay within adolescent units.

In 2015-16 and 2016-17 the Commission did see the numbers of young people admitted to non-specialist wards fall substantially and thereafter admission figures have remained lower from that point onwards. We welcome this development and are keen that there is ongoing investment in services to ensure that alternatives to admission are available at the point of need and that comprehensive support is available from a range of CAMHS professionals whenever there is an admission to a non-specialist ward of any duration.

In recent months Scottish Government has made available money to support further specialist CAMHS development across the country in line with the recent publication of the CAMHS national services specification in February 2020[7]. The service specification is an ambitious document that outlines a comprehensive range of specialist CAMH services which Scottish Government expects every health board should develop and provide, either individually or through jointly in conjunction with other boards. Services described include intensive home treatment capacity to help support more young people with more complex needs be looked after within community treatment rather than requiring an inpatient stay and also CAMHS support for out of hours emergency presentations of children and young people to contribute to the care and treatment of young people in crisis. In the coming years it will be interesting to see how this further development of CAMHS services will impact on non-specialist bed use.

Implementation of the CAMHS service specification is one strand of activity amongst others that are currently ongoing with the aim of improving availability and access to specialist mental health services for those children and young people who need them. Action 20 of the current Mental Health Strategy 2017-27[8] describes plans to: "Scope the required level of highly specialised mental health inpatient services for young people and act on its findings." The services referred to in this action are those that would meet the inpatient needs of young people who have learning disability or autism or who due to the nature of their illness may

[7] https://www.gov.scot/publications/child-adolescent-mental-health-services-camhs-nhs-scotland-national-service-specification/

[8] Mental Health Strategy 2017-2027 published March 2017
http://www.gov.scot/Publications/2017/03/1750

have committed offences that require their care to be delivered in specialist child and adolescent psychiatric forensic services.

Currently Scotland does not have these inpatient facilities and the Commission has highlighted the continued lack of provision in these areas previously.

NHS Ayrshire and Arran has been chosen as the site for the building of the National Secure Adolescent Inpatient Service (NSAIS) otherwise known as Foxgrove which is being designed to help meet the needs of those young people who require specialised forensic psychiatric care. Due to involvement in the ASSURE programme[9] to support development standards the building of the unit has been delayed for 6 months with the hope that the unit will be open and able to receive its first inpatients in November 2022. The Commission has been involved in supporting appropriate contingency planning for the unit.

NHS Lothian has been chosen as the location for the development of a four-bedded unit for young people between the ages of 12 and 18 with a learning disability, and facilities for the under 12s with a learning disability are to be developed within the National Child Inpatient Unit in Glasgow.

Work on the learning disability project is continuing but overall has been at a less advanced stage than the forensic unit NSAIS. The Commission has had involvement in the planning of the Lothian unit to ensure that the Lothian unit lies within the remit of CAMHS management structures rather than being managed under adult learning disability services.

In recent years the Commission has been highlighting the lack of IPCU provision for young people in Scotland and the impact that this has on young people and their families. The need for IPCU facilities is quite different from the forensic needs that NSAIS is designed for. Last year the Commission again made recommendations about IPCU provision for young people in Scotland. Historically work has taken place by different parties and at different times to explore ways in which the needs of young people for IPCU care may be addressed in Scotland. Unfortunately these previous attempts have not been able to come to a conclusion and no solution has been found as to how best to meet the needs of young people for IPCU in an age appropriate manner in a way that is practical, sustainable and accessible for the whole of Scotland.

We recognise that work is once again underway to explore the need for IPCU provision for young people in Scotland. In the Scottish Government's most recent letter to health boards announcing further mental health recovery funding, a funding allocation has been made to all three regional specialist adolescent inpatient units towards the development of IPCU provision regionally. This progress is very welcome.

However, due to the complexity of interfaces that any IPCU facilities might be expected to establish and, given that pathways into and out of any such facilities is likely to intersect with other existing and developing pathways (into NSAIS or the Learning Disability unit for example), it is crucially important that this work in developing IPCU capacity is sufficiently integrated with existing and developing streams of inpatient provision. It is vital that all the various specialist adolescent inpatient services are integrated and cohesive and IPCU development must not occur in isolation.

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[9] https://www.sehd.scot.nhs.uk/dl/DL(2021)14.pdf

Given the nature of any IPCU provision and that the number of young people requiring such provision across the country is small at any one time, the care and accommodation planned and provided must comprehensively reflects the young people's needs, mental health or otherwise. This must support their rights to be protected from any inhumane or degrading treatment with sufficient planning to minimise the use of seclusion and restraint and support integration with other adolescent service activity whenever possible.

Recommendation 1

For Scottish government

The Commission recommends that work to explore the accessibility and provision of intensive psychiatric care facilities (IPCU) for the under 18s in Scotland is sufficiently prioritised, resourced and supported by Scottish Government. This work should be brought to completion within one year to enable meaningful change nationally for young people having access to IPCU facilities that are age appropriate.

It is essential that any such work should not be undertaken in isolation but co-ordinated with other work-streams (such as relating to National Secure Adolescent Inpatient Service and Learning Disability unit development) to ensure that access to IPCU facilities is part of a cohesive integrated pathway between and within the various specialist adolescent inpatient services.

Covid-19 pandemic and lockdown

Over the timescale of this report the country was facing the challenges of the Covid-19 pandemic. Activities of everyday life in Scotland and the rest of the UK were significantly affected. As the months have passed increasing awareness has been paid to the impact that the pandemic has had on the mental health and wellbeing of individuals, and children and young people in particular. A number of reports about the impact of the pandemic are now available[10,11].

Due to the lethality of the Covid-19 virus, high levels of anxiety were experienced within the population as a whole, including children and young people, and many experienced far reaching changes in their daily routines and activities. Hospital and health services were affected by measures designed to try and limit the impact of the virus on the health of the population, and at the same time hospitals and health services were affected by altered staffing levels as a result of the pandemic, which had then to be managed.

Some of the changes put in place following the first lockdown in March 2020 remain. It is worth noting that not all the changes have been reported as negative and the pandemic has accelerated the use of virtual appointments in a way that could not previously have been imagined and some people report this has been helpful.

At present there is no widely available overview providing information across the country about how mental health services were affected by the pandemic. However, from work the Commission undertook during the first lockdown (between spring 2020 and autumn 2020), the Commission had been able to gather some information about some of the changes that took place in hospitals as wards and services reorganised to enable Covid wards to be created (to care for those in need of inpatient mental health care who also had contracted the virus). Alterations were made to admission and discharge processes, visiting arrangements and to practice around patients leaving ward for recreational purposes.

The Commission knows from its work across the year that high levels of demand were experienced in parts of Scotland (different places experienced the upswing at different times) in relation to increased presentations of young people with eating disorders. This echoes the findings of other reports from across the UK which describe significant increases in referral rates of young people presenting with eating disorder over the course of the pandemic[12]. In the early months of the year that this report covers, Skye House, the regional adolescent unit in Glasgow, was able to develop increased bed availability such that it was able to take patients from the other two regional units in Dundee and Edinburgh where demand for a specialist bed had exceeded bed supply.

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[10] https://www.publichealthscotland.scot/media/2999/the-impact-of-covid-19-on-children-and-young-people-in-scotland-10-to-17-year-olds_full-report.pdf

[11] https://www.gov.scot/publications/coronavirus-covid-19-children-young-people-families-evidence-summary-june-2021/pages/2/

[12] COVID-19 and eating disorders in young people - The Lancet Child & Adolescent Health

Specialist Child and Adolescent Inpatient Services in Scotland

In Scotland, there are three NHS regional adolescent in-patient units for young people aged between 12-18 years. These units are:

Skye House which is a 24 bedded specialist adolescent unit based in Stobhill Hospital, Glasgow. Skye House receives admissions of young people from NHS Dumfries and Galloway, NHS Ayrshire and Arran, NHS Greater Glasgow and Clyde, NHS Lanarkshire and NHS Forth Valley (West of Scotland region).

The Melville Young People's Mental Health Unit in Edinburgh is a 12 bedded unit located within the newly built Royal Hospital for Children and Young People at Little France, Edinburgh. This unit now replaces the unit formally known as the Young People's Unit which was based at the Royal Edinburgh Hospital and which is now being repurposed. The Melville unit continues to receive admissions of young people from NHS Lothian, NHS Borders and NHS Fife (East of Scotland region).

Dudhope House in Dundee is a purpose-built 12 bedded unit that receives admissions of young people from NHS Highland, NHS Grampian, NHS Tayside, NHS Shetland and NHS Orkney (North of Scotland region).

In addition to these regional units for adolescents the National Child Inpatient Unit based in Glasgow receives admissions of children under the age of 12 years with mental health difficulties from across Scotland (six beds).

The Young Person's Monitoring Process

The Commission collects information through notifications from health boards about the admissions of young people under the age of 18 years when they are admitted to wards for mental health care that are not in any of the units mentioned above. Information from mental health act forms also feed into this routine collection process.

The Commission does not collect information on those admissions that are less than 24 hours in duration, are solely related to drug or alcohol intoxication or are solely for the medical treatment of self-harm.

Once the Commission has been notified about an admission it sends out a questionnaire to the consultant in charge of the young person's care (or RMO) to find out further information about the admission.

In order to improve accuracy of the Commission's data collection in addition to the above routine process, every three months medical records staff from each health board area are required to submit details of any young person under the age of 18 who have been admitted to non-specialist wards in their health board area and who meet the Commission's criteria. Commission staff then cross reference this information with the admissions the Commission has been notified about and chase ones that are missing from routine notification processes.

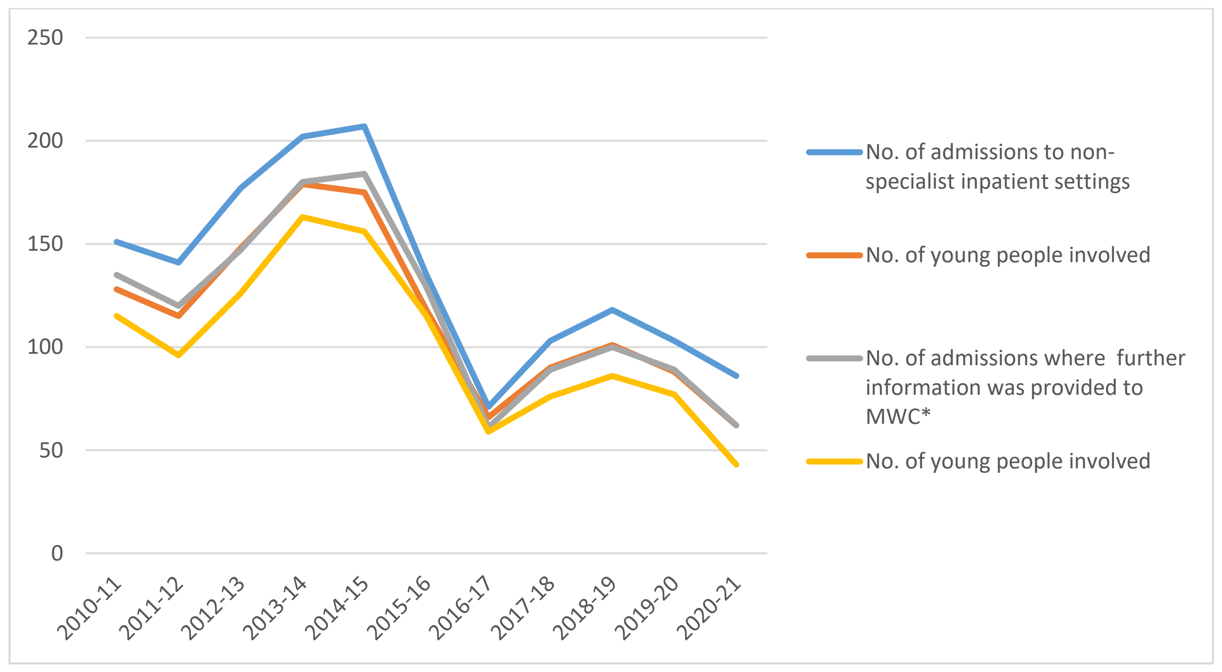
Young people (under 18) admitted to non-specialist facilities, by year 2011-21

Table 1: Young people (under 18) admitted to non-specialist facilities, by year 2010-20

	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
No. of admissions to non-specialist inpatient settings	141	177	202	207	135	71	103	118	103	86
No. of young people involved	115	148	179	175	118	66	90	101	88	62**
No. of admissions where further information was provided to the Commission*	120	147	180	184	129	61	89	100	89	62
No. of young people involved	96	126	163	156	115	59	76	86	77	43

**admissions where completed monitoring form returned to the Commission.*
*** number of young people admitted to non-specialist facilities in Scotland over the course of the year.*

Figure 1: Young people (under 18) admitted to non-specialist facilities, by year 2011-21



In 2020-21 the Commission was notified of 86 admissions to non-specialist wards which involved 62 young people across Scotland as a whole. We received further information about the care provided for 62 of these 86 admissions.

This is a decrease from last year when the Commission obtained figures of 103 admissions involving 88 young people.

The lowest numbers of admissions were collected in 2016-17 when the Commission recorded 71 admissions involving 66 young people over the course of the year.

This year saw the lowest numbers of young people involved in the non-specialist admissions. As in previous years, a small number of young people were admitted multiple times to non-specialist wards over the course of the year. However, in 2020-21 the proportion of young people who were admitted multiple times was larger overall and over the course of the year the Commission saw a small number of young people who were admitted four or five times. Taken together these multiple admissions would seem to account for the lower numbers of individuals involved in the overall admission numbers over the course of this year.

In table 2 below the breakdown of admissions per health board area is provided. The figures relate to admissions of young people to non-specialist wards in that health board area. From table 2 many health boards describe similar figures to recent years with the exception of Greater Glasgow and Clyde which is striking in the scale of the reduction of admissions over the year. We are aware, from contact with the three specialist adolescent units during the lockdown, that for several months there was a lower demand on beds at Skye House such that Skye House was able to receive patients from the other health board areas where demand on adolescent inpatient care had substantially increased over that same period.

We maintain the view that a single year's figures are difficult to interpret and several years of data collection is required in order to be able to draw conclusions about trends with any confidence. This is particularly the case for figures relating to the pandemic lockdown when admissions to specialist and non-specialist beds were impacted by the pandemic lockdown.

When looking at this data it is also important to take into consideration the different sizes of population of health board areas and the differences in configuration of CAMHS across the country with varying eligibility criteria for young people for CAMHS versus adult mental health services depending on the young person's age and educational status. Some CAMHS provide mental health services for children and young people under the age of 16 years and only for young people between the ages of 16 and 18 years who are in full time education. Others provide mental health services for children and young people up to the age of 18 years. The Commission knows from its work in previous years that this difference in service configuration can affect the numbers of young people admitted to non-specialist wards[13]. The CAMHS service specification suggests that all CAMH services in Scotland should provide services for all children and young people up to the age of 18 and the effect of this on figures in the coming years will be interesting to observe.[14]

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[13] Young Person Monitoring 2015-16. October 2016.
https://www.mwcscot.org.uk/node/904

[14] National Service Specifications for CAMHS February 2020
https://www.gov.scot/publications/child-adolescent-mental-health-services-camhs-nhs-scotland-national-service-specification/

Young people admitted to non-specialist facilities by NHS board, by year 2012-21

Table 2: Young people admitted to non-specialist facilities within an NHS board, by year 2012–21

Health board	2012-13		2013-14		2014-15		2015-16		2016-17		2017-18		2018-19		2019-20		2020-21	
	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved	Admissions	Young People Involved
Ayrshire & Arran	8	8	17	15	26	21	21	17	9	8	<5	<5	9	9	6	5	8	5
Borders	6	5	1	1	13	6	7	7	<5	<5	6	<5	5	<5	7	5	5	<5
Dumfries & Galloway	13	10	13	9	6	6	5	5	<5	<5	<5	<5	6	<5	5	5	8	<5
Fife	<5	<5	6	5	7	<5	5	5	6	6	<5	<5	8	6	8	6	<5	<5
Forth Valley	21	19	26	25	16	15	11	9	5	5	8	8	7	7	7	6	5	5
Grampian	31	22	20	17	27	23	15	12	<5	<%	17	14	6	5	<5	<5	9	7
Greater Glasgow & Clyde	30	24	37	34	36	30	17	16	7	7	16	14	28	24*	20	18	<5	<5
Highland	6	6	21	19	12	11	9	8	<5	<5	5	<5	7	7	7	<5	7	7
Lanarkshire*	48	40	*43	*38	37	34	27	24	25	22	22	19	27	21	22	18	16	12
Lothian	<5	<5	8	7	8	8	<5	<5	<5	<5	<5	<5	<5	<5	8	8	7	7
Tayside	9	9	10	9	19	17	12	11	<5	<5	14	12	12	10	11	10	18	11
Island Boards	0	0	0	0	<5	<5	<5	<5	<5	<5	0	0	0	<5	0	<5	0	0
Scotland	177	148	202	179	207	176	135	118	71	66	103	90	120	102	103	88	86	64******

* GGC total = 23, as one YP also admitted to Lanarkshire. Some of these figures (<3) relate to young people looked after by Esteem.

** We were informed that one admission to NHS Lothian was an out of area admission from NHS Greater Glasgow and Clyde (2017-18).

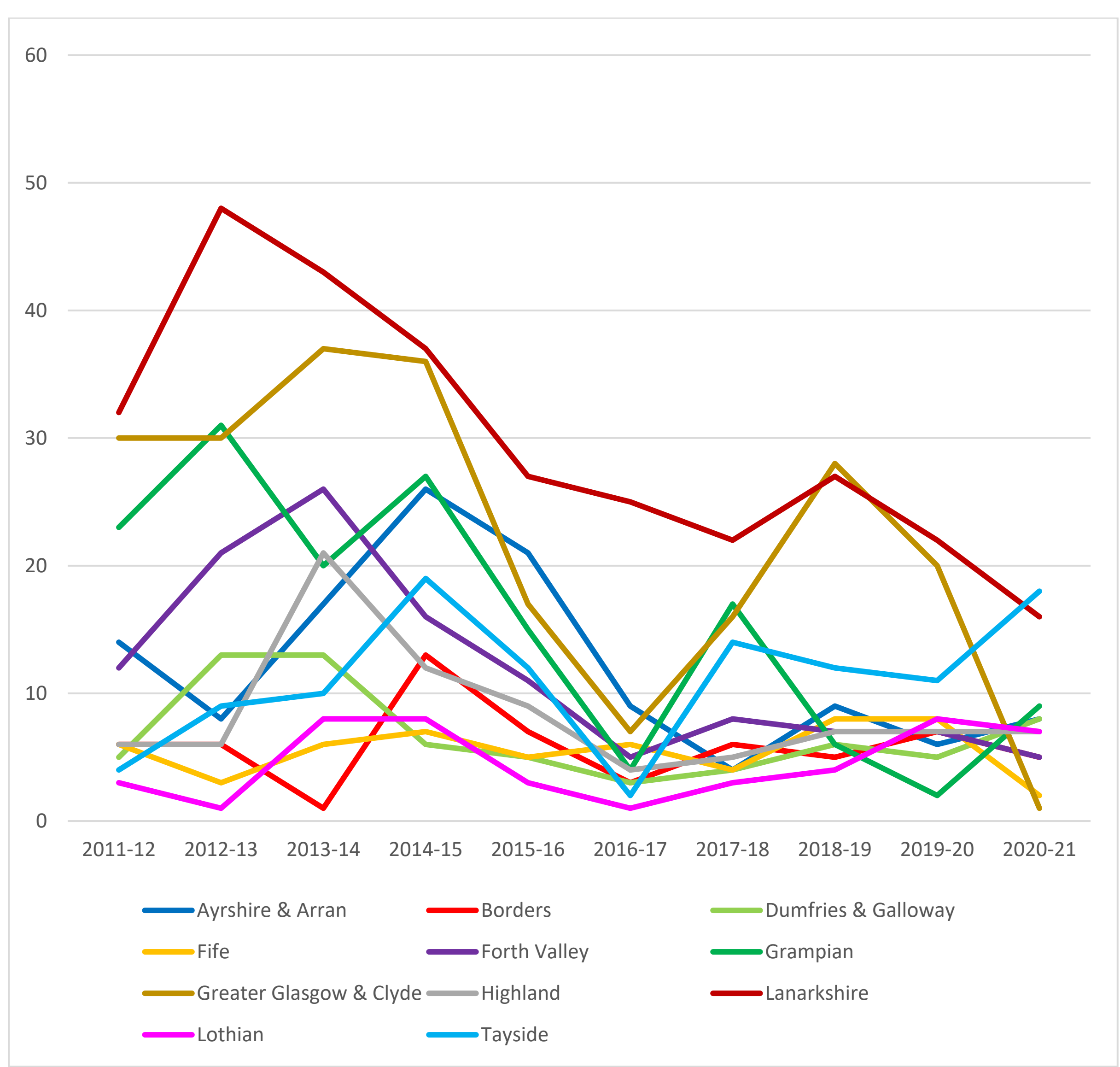
*** Ayr Clinic shown as independent rather than included in NHS Ayrshire and Arran figures. This admission followed a preceding admission to a non-specialist ward in Scotland. It is therefore not included in the individual data due to the young person being counted already elsewhere.

**** We were informed that one admission to NHS Lanarkshire was an out of area admission from NHS Greater Glasgow and Clyde (2013-14).

***** Island Boards comprise Eilean Siar (Western Isles), Shetland and Orkney. The figures have been pooled in line with good practise relating to the publication of small numbers.

****** The sum of the number of young people admitted to each HB area is greater than 62 due to the fact that a small number of young people were admitted to different HB areas.

Figure 2: Graph showing annual number of admissions within each health board area 2011-21



Length of stay in non-specialist wards, by year 2015 to 2021

In recent years the Commission had been aware, from its monitoring activity and from its visits to young people, that lengths of stay in non-specialist environments can vary considerably. A small but significant minority of young people are looked after for long periods of time on wards which are not designed for their needs.

The length of stay is the amount of time that a young person remained in a non-specialist ward during an admission.

We believe that length of stay together with standards of care provided while a young person is looked after in a non-specialist environment are important quality issues to keep in mind alongside the overall numbers of young people admitted to non-specialist wards nationally.

Table 3: Length of stay in non-specialist wards, by year 2015-21

Length of Stay*	2015-16	%	2016-17	%	2017-18	%	2018-19	**%	2019-20	%	2020-21	%
1-3 days	36	27%	25	35%	29	27%	35	30%	36	35%	34	40%
4-7 days	28	21%	17	24%	23	22%	37	31%	25	24%	19	22%
8-14 days 1-2 weeks	28	21%	8	11%	20	19%	13	11%	19	18%	10	12%
15-21 days 2-3 weeks	13	10%	<5	6%	10	9%	12	10%	9	9%	9	10%
22-28 days 3-4 weeks	11	8%	7	10%	<5	3%	6	5%	0	0%	4	5%
29-35 days 4 weeks+	7	5%	<5	4%	<5	2%	5	4%	<5	1%	3	3%
36 days or more 5 weeks +	12	9%	7	10%	19	18%	10	8%	13	13%	7	8%
Total	**135**	**100%**	**71**	**100%**	**106**	**100%**	**118**	**100%**	**103**	**100%**	**86**	**100%**
Mean (days)	15		19		23		16		21		23***	

** The Commission collects data on admissions that are 24 hours and above. Totals are based on the total number of admissions for that year.*
*** Based on 86 admissions.*
**** Median = five days.*

This year, as in previous years, the majority of admissions continue to be short in length (40% are between one and three days). However, sizable numbers of young people remain inpatients in a non-specialist environment for longer periods (38% lasted over seven days, 26% lasted over two weeks and 11% lasted over four weeks).

In previous years when the Commission looked more closely at the admissions which were over five weeks in length many involved young people for whom there was no national provision of inpatient beds for their age group and/or mental health needs including young people who have learning disability (see page 36-37). This was less evident this year with

seven admissions lasting over five weeks with many of the admissions relating to psychosis or other conditions with substantial risk presented. Only a very small number of the young people involved in these admissions were said to have a learning disability and all of the seven were either 16 or 17 years old (as in previous years).

Of these seven young people who remained in a non-specialist bed for over five weeks, almost half required IPCU admission at some point during their stay. This was similar to previous years, however, unlike previous years, none of the young people were described as care experienced young people. Approximately half of the admissions lasting over five weeks occurred in CAMHS services which do not provide care for all under 18 year olds.

In longer admissions of young people to non-specialist wards, it is very important that the young person has access to a range of CAMHS specialist care relevant to their needs and provided by differing professional groups as appropriate.

While a small majority of admissions are less than one week in length, this still represents a considerable amount of time for young people in a non-specialist environment, many of whom have never been in hospital before.

Specialist health care provision for young people in non-specialist care, 2020-21

The Commission requests information as to whether specialist child and adolescent mental health support is available to a young person admitted to a non-specialist ward, to ensure that appropriate care and treatment is being provided to the young person, and that relevant guidance and support is available for staff in non-specialist units who will have less experience of providing treatment and support to young people.

Access to specialist child and adolescent services following admission of a young person to an adult ward continues to vary across the country.

Table 4: Specialist medical provision 2020-21

	Age 0-15	Age 16-17	All	*%
RMO at admission was a child and adolescent specialist	11	26	37	60%
CAMHS consultant available to give support other than as RMO	3	11	14	23%
Nursing staff with experience of working with young people were available to work directly with the young person	10	15	25	40%
Nursing staff with experience of working with young people were available to provide advice to ward staff	11	38	49	79%
The young person had access to other age appropriate therapeutic input	8	12	20	32%
None of the above	0	8	8	13%
Total admissions*	14	48	62	100%

** Total=62, all admissions where further information was provided; percentages may sum to more than 100% as more than one type of specialist medical provision might be provided at any one admission.*

Once again in 2020-21 there has been no substantial improvement in the percentages of young people receiving specialist care input from CAMHS staff during their admission to a non-specialist unit and the figures have now remained at a similar level over several years.

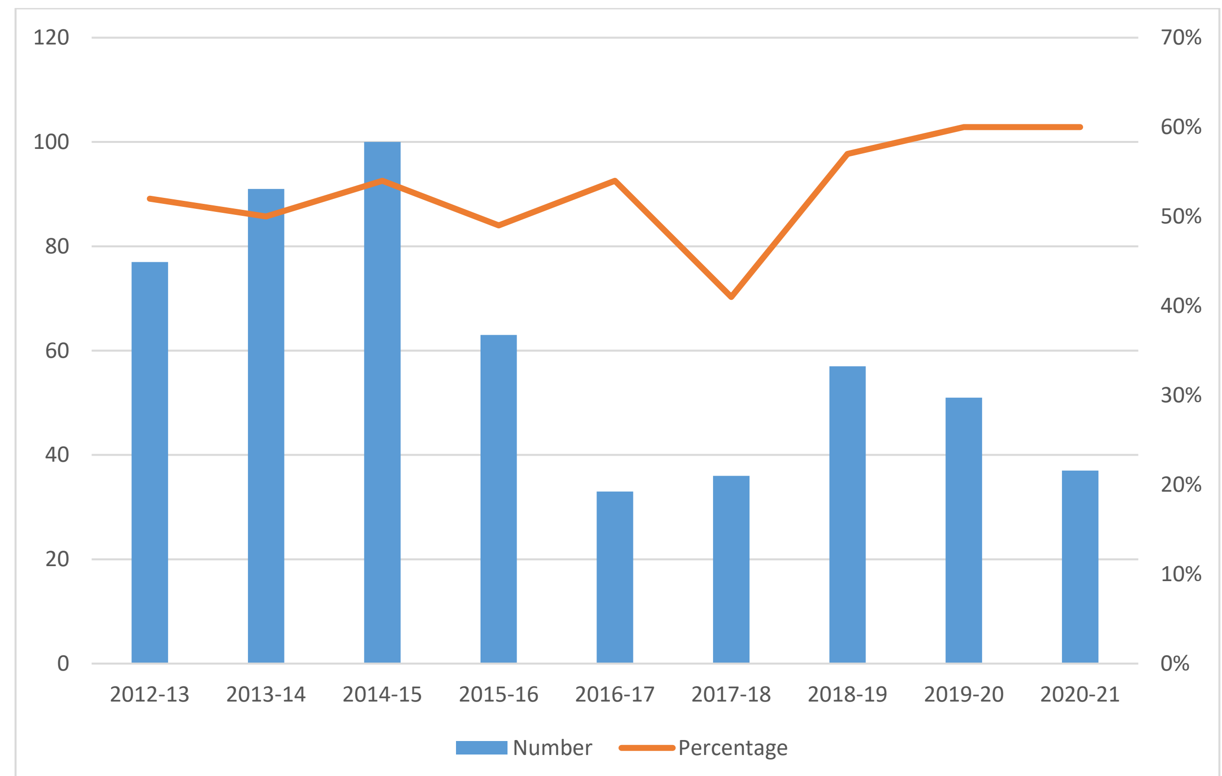
In some circumstances where an admission might be of very short duration, the provision of direct specialist clinical contact might not be as important in terms of provision of care as stays of longer duration.

However, even in short admissions the task of liaison, communication and co-ordination of care around discharge and discharge planning is crucial for young people presenting in crisis.

In 2020-21 the consultant in charge of a young person's care (or RMO) was a child and adolescent specialist in 37 out of the 62 admissions (60%). This compares with 57% in 2019-20, 57% in 2018-19, 41% in 2017-18, 54% in 2016-17, 49% in 2015-16, 54% of admissions in 2014-15, 50% in 2013-14 and 52% in 2012-13 (figure 4a).

In 2020-21 there were a further 14 admissions (23%) where a CAMHS consultant was available for advice for the admissions although was not the actual consultant in charge of care.

Figure 4a: RMO as child specialist 2020-21



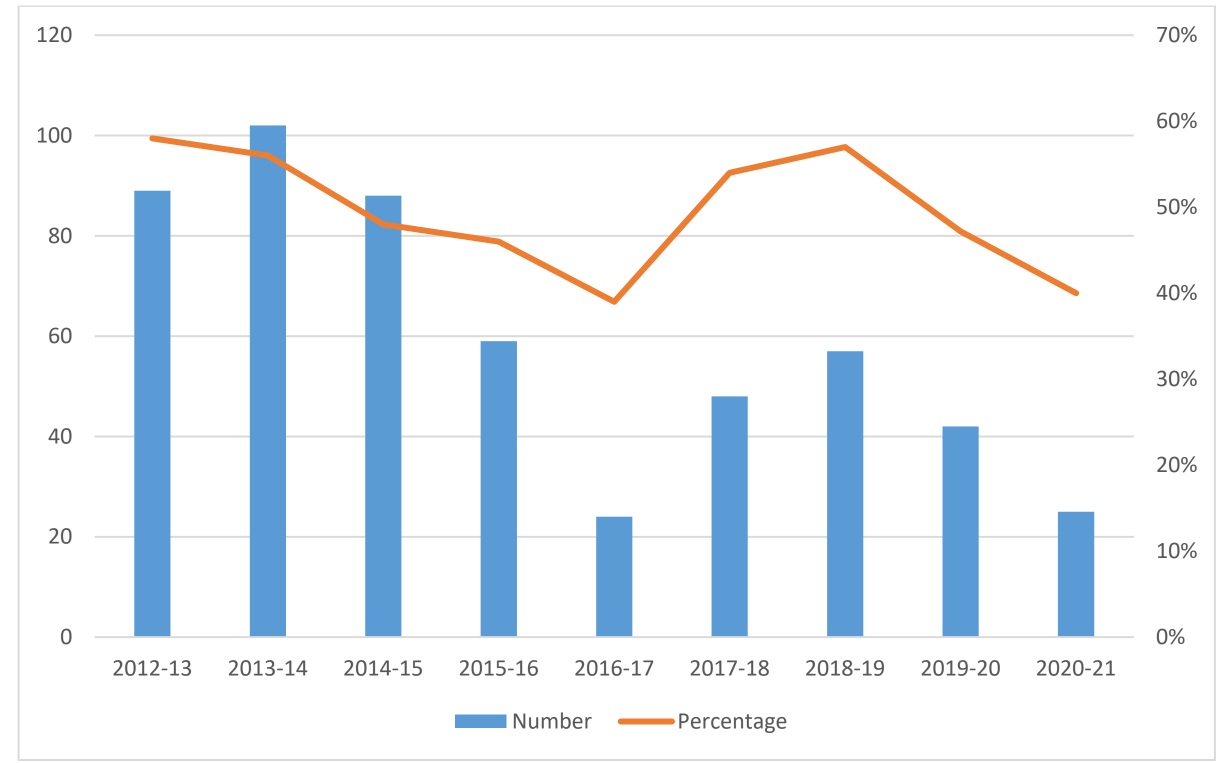
Data is based on the further information provided to the Commission (62 admissions) and reported on annually.

This year, as in previous years, in a large proportion of admissions there was no direct care provided from nurses experienced in working with children and adolescents.

In 2020-21 only 25 out of the 62 admissions (40%) experienced direct nursing care from child and adolescent experienced nurses during their stay. This compares with 47% in 2019-20, 56% in 2018-19, 54% in 2017-18, 39% in 2016-17, 46% in 2015-16, 48% in 2014-15, 56% in 2013-14 and 58% in 2012-13 (figure 4b).

The percentage of admissions where there have been nurses available with relevant CAMHS experience to provide advice to ward staff remains similar to previous years, 49 out of 62 admissions (79%).This compares with 76% in 2019-20, 80% in 2018-19 85% in 2017-18, 84% in 2016-17, 78% in 2015-16, 85% in 2014-15, 80% in 2013-14, and 76% in 2012-13. This data reports the number of admissions when nurses with CAMHS experience were available for advice if needed but not whether that advice was ever sought.

Figure 4b: Direct specialist nursing care provided 2020-21



Data is based on the further information provided to the Commission (62 admissions) and reported on annually.

In 2020-21 only 20 out of the 62 admissions (32%) were able to access additional age appropriate therapeutic input. This might be input provided by CAMHS psychologists, CAMHS allied health professionals or family therapists. This compares with 42% in 2019-20, 46% in 2018-19, 41% in 2017-18, 49% in 2016-17, 38% in 2015-16, 59% in 2014-15, 51% in 2013-14 and 88% in 2012-13.

When looking at the information provided to the Commission in relation to the admissions of young people to non-specialist wards it is often not clear what factors influence whether a young person receives input from CAMHS whilst an inpatient.

For those health boards where adult mental health services provide services for some 16-17 year olds, such young people would not necessarily be expected to receive input from CAMHS while in hospital. Of the eight admissions in which the young person received no input and where no advice was available at all from clinicians specifically trained and experienced in child and adolescent mental health all but one admission occurred in health boards whose CAMHS service does not include everyone under the age of 18 years as a CAMHS patient.

Where admissions are very short or over a weekend, for example, specialist input may not be provided.

These factors do not explain many findings, however. This year, as in previous years, the provision of specialist care remains inconsistent across non-specialist admissions.

Of the 62 admissions that the Commission obtained additional information about, 30 (48%) neither received direct specialist nursing support nor specialist non-medical therapeutic input during their stay. Of these 30 admissions, 18 lasted under one week (48%), four lasted

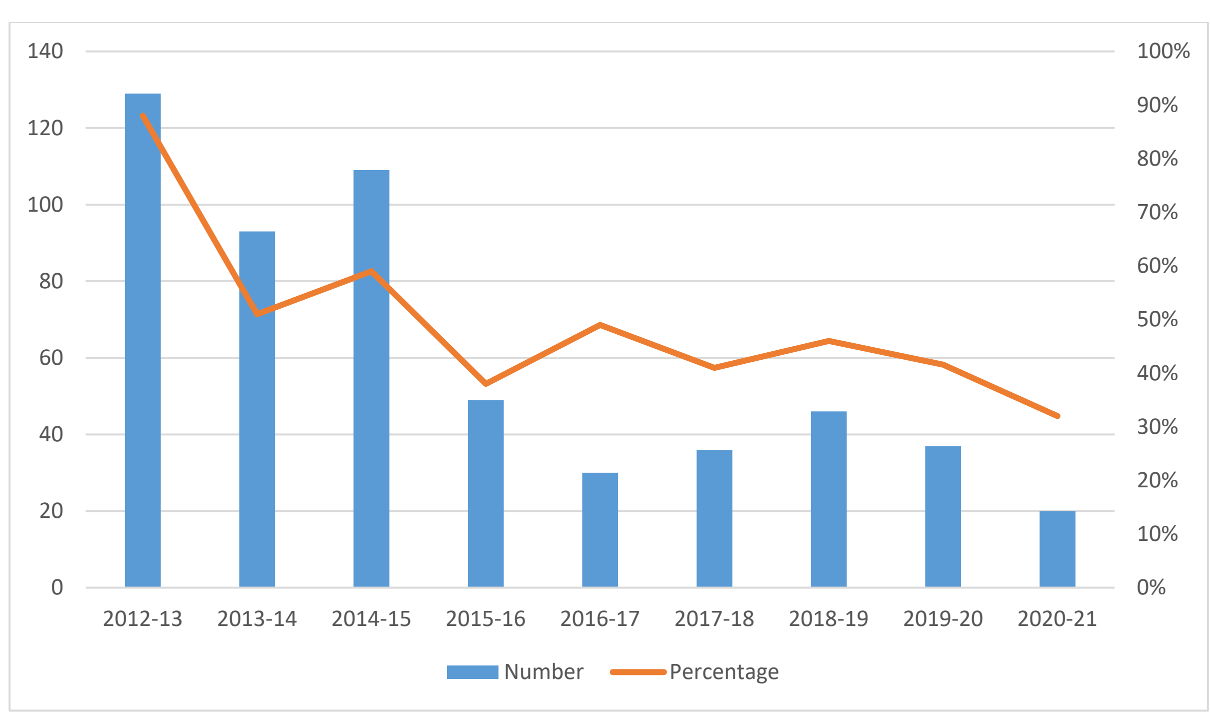
between 8-14 days (13%), and six lasted more than 21 days (20%) including three which lasted over 57 days (10%).

As in previous years, of the 19 admissions which received neither direct specialist nursing or therapeutic input from child and adolescent clinicians and whose RMO or consultant in charge was not a child and adolescent psychiatrist during their hospital stay, 42% related to admissions lasting longer than two weeks and 21% lasted longer than four weeks. 21% of these 19 admissions also required IPCU admission at some point during their hospital stay.

Of the seven admissions involving young people that lasted longer than 28 days and for whom the Commission received additional information about, 72% had either a consultant in charge of their care who was a child specialist or a CAMHS consultant available for advice if needed. Only three of these seven admissions had direct CAMHS nursing provision provided to the admission (43%) and only two (29%) had other age appropriate therapeutic intervention provided.

It is not clear if capacity issues in community CAMHS staff impacts negatively on the availability of nursing and other clinical staff to support non-specialist admissions of young people particularly during the pandemic. However given that these figures remain similar to previous years it remains a concern that direct input into inpatient care by nursing staff or other therapeutically trained staff with specialist knowledge and experience in caring for the under 18s is not provided routinely when admissions are longer than a week in duration.

Figure 4c: Other specialist therapeutic care provided 2020-21



Data is based on the further information provided to the Commission (62 admissions) and reported on annually.

Admissions of care experienced young people and social work provision for admissions of all young people to non-specialist care, 2020-21

Table 5: Social work provision for admissions of young people to non-specialist care, 2020-21

	Age 0-15	Age 16-17	All	*%
Young person was looked after and accommodated by the local authority	3	7	10	16%
No information	0	1	1	2%
Young person had access to social work	11	36	47	76%
No information	1	2	3	5%
Total	14	48	62	100%

**Total=62, based on all admissions where further information was provided to the Commission.*

The Commission is particularly concerned about vulnerable groups of individuals, and in reflection of its corporate parenting[15] duties the Commission is interested in the provision of services to care experienced or "looked after" children[16]. A young person is described as being 'looked after 'if, under the provisions of the Children (Scotland) Act 1995, they are under the care of their local authority and either subject to voluntary or statutory measures and looked after at home, or looked after away from home in foster or kinship care, a residential care home, a residential school or secure young people unit.

There is increasing evidence that care experienced children and young people experience poorer mental health than their peers and there is an established national requirement that NHS boards ensure that the health care needs of care experienced or 'looked after' children are assessed and met, including mental health needs[17]. The Guidance on Health Assessments for Looked after Children and Young People[18] emphasises that mental health problems for care experienced young people are markedly greater than for their peers in the community.

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[15] Corporate Parenting duties are defined by the Children and Young People (Scotland) Act 2014 https://www.gov.scot/policies/looked-after-children/corporate-parenting/#:~:text=The%20Children%20and%20Young%20People,young%20people%20and%20care%20leavers%22

[16] Children and young people looked after by the local authority or young people leaving care wish to be known collectively as care experienced. For this report we retain the use of the term 'looked after and accommodated' to describe a specific group of children and young people who are care experienced and are accommodated by the local authority.

[17] Action 15 Looked After Children and Young people: We can and must do better. January 2007 https://www2.gov.scot/resource/doc/162790/0044282.pdf

[18] The Scottish Government (28 April 2009) CEL16 http://www.sehd.scot.nhs.uk/mels/CEL2009_16.pdf

We have been collecting information about young person's admissions to non-specialist wards and whether the young persons are 'looked after and accommodated' since 2014. We would assume that any 'looked after' young person admitted to a non-specialist facility should have an identified social worker.

In 2020-21 ten (16%) of the 62 admissions that the Commission received further information on related to admissions of young people who were described as being 'looked after and accommodated'. This compares with 22% of the admissions in 2019-20, 21% in 2018-19, 16% in 2017-18, 13% in 2016-17, 13% in 2015-16 and 13% of young people in 2014-15 (figure 5).

Of the ten admissions of young people this year, seven were admissions of young people aged 16-17 years and three were young people either 15 years or younger. This is similar to previous years where the majority of admissions of young people who were care experienced were 16-17 years old.

The admissions lengths of young people who were care experienced were shorter this year than in previous years. Seven of the admission were seven days or less and the remaining three were over 15 days. Once again, as in previous years, a small number of young people who were care experienced also had a learning disability (this year 20% (two out of the ten)).

Once again as in previous years there was a high level of representation in young people who are care experienced who required IPCU care during their stay. In 2020-21 five out of the ten young care experienced young people who were admitted to a non-specialist environment required IPCU at some point during their admission (50% of admissions of young people who were care experienced). There were fifteen IPCU admissions of young people in 2020-21 and five of these involved young people who were looked after and accommodated (one third of IPCU admissions).

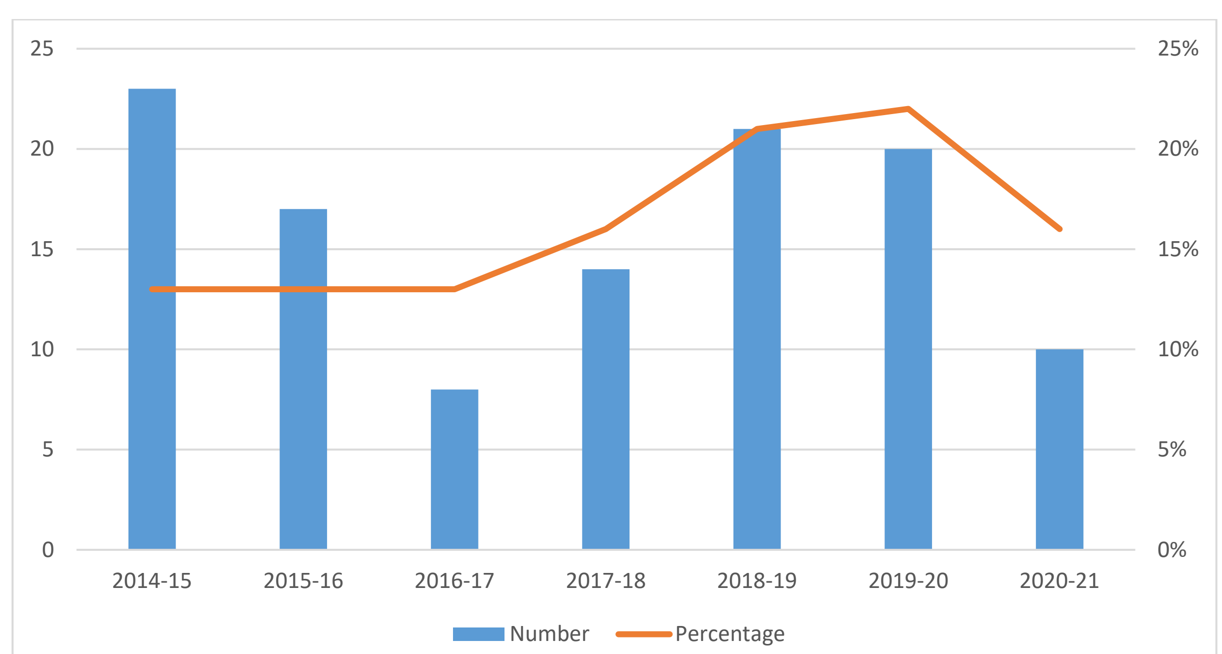
A small number of young people who are looked after by a local authority are admitted to non-specialist wards at a time of crisis and breakdown of their care placement. At times there are substantial concerns about the young person's mental health at this time and these admissions are entirely appropriate. However, the Commission had been told of other occasions when it appears that a lack of suitably available and/or suitably adapting care provision appears to be an important factor behind admission and the young person is admitted as a result of a need of a place of safety rather than for assessment or treatment of mental health difficulties.

Many of the young people admitted to a non-specialist facility will have had no prior involvement with social work services, but the Commission's expectation would be that if social work input is felt to be necessary at the time when an admission is being considered, or after admission, there should be clear local arrangements to secure that input.

In 2020-21 47 out of the 62 admissions (76%) the Commission obtained further information about confirmed there had been access to a social worker. This compares to 71% in 2019-20, 71% in 2018-19, 64% of the admissions the Commission was given additional information about in 2017-18, 77% in 2016-17, 71% in 2015-16, 74% in 2014-15, 76% in 2013-14, and 74% in 2012-13.

The Scottish Government (2014) *Guidance on Health Assessments for Looked After Children and Young People in Scotland* http://www.gov.scot/Resource/0045/00450743.pdf

Figure 5: Admissions involving care experienced young people 2014-21



Data is based on the further information provided to the Commission (62 admissions in 2020-21) and reported on annually.

Supervision of young people admitted to non-specialist care 2020-21

The Commission asked for specific information about the supervision arrangements for young people admitted to non-specialist facilities to monitor whether the need for increased observation is being carefully considered.

In previous reports the Commission has reported that young people report feeling lonely and bored due to intense supervision that might be in place on a ward on which they might be more vulnerable than they might be if on a ward with peers of a similar developmental age.

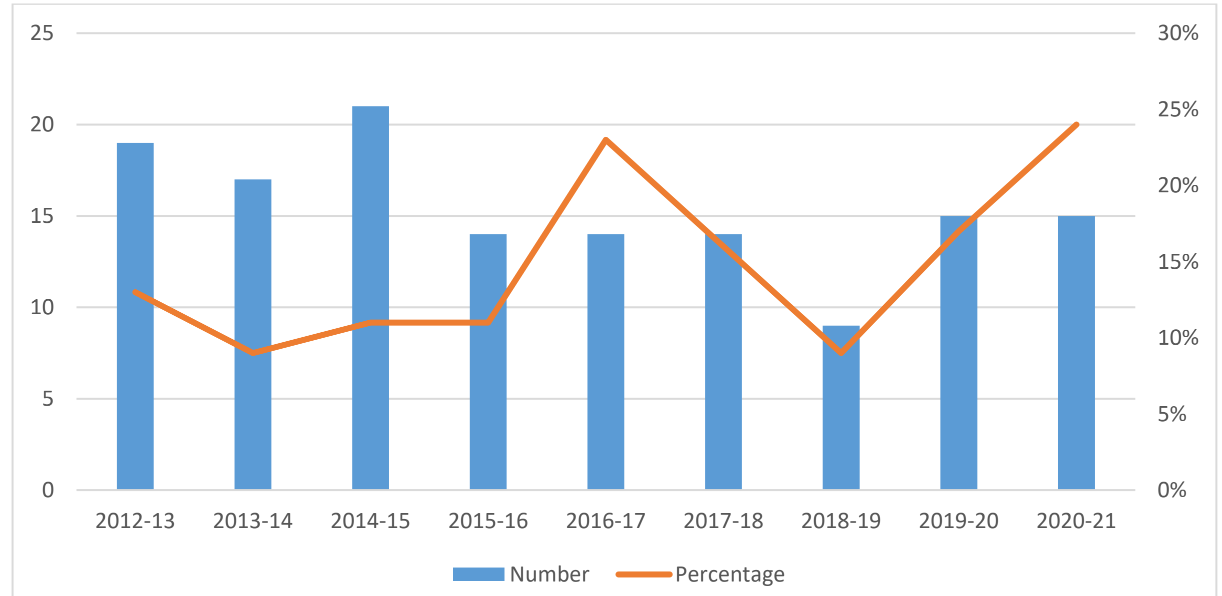
Table 6: Supervision of young people admitted to non-specialist care, 2020-21

Supervision arrangements	Age 0-15	Age 16-17	All	%**
Transferred to an IPCU or locked ward during the admission*	<5	11	15	24%
Accommodated in a single room throughout the admission	12	42	54	87%
Nursed under an enhanced level of observation	12	34	46	74%
Enhanced observation because of ward policy	12	26	38	61%
Enhanced observation following an individual assessment of the young person	10	22	32	52%
Total**	14	48	62	100%

**This is taken from information recorded on the forms.*

***Total=62, based on all admissions where further information was provided to the Commission; percentages may sum to more than 100% as more than one of the above arrangements may apply.*

Figure 6: IPCU admissions 2012-21



Data is based on the further information provided to the Commission (62 admissions in 2020-21) and reported on annually.

This year 15 of the 62 admissions (24%) where further information was supplied to the Commission were cared for in an IPCU or locked ward at some point during their hospital stay during admission.

This contrasts with 17% of admissions in 2019-20, 9% of admissions in 2018-19, 16% of admissions in 2017-18, 23% of admissions in 2016-17, 11 % in 2015-16, 11% in 2014-15, 9% of admissions in 2013-14 and 13% of admissions in 2012-13(figure 6).

In 2020-21 four young people under the age of 16 were admitted to an IPCU (26% of IPCU admissions). In previous years the proportion of the young people admitted to an IPCU or locked ward under the age of 16 had been around 25% of those admitted to an IPCU and in 2017-18 this figure rose to 36%.[19]

The lack of specialist adolescent IPCU service provision and the lack of clear pathways around access to adult IPCU facilities that are equipped to cater to the needs of younger people can add significant difficulties for the young person, their family and their clinical team when a bed for the young person within a secure hospital environment is required. Clinicians continue to inform the Commission that this is particularly difficult for young people under the age of 16 and for female young people in general requiring IPCU care.

We are also concerned that, because of the lack of any IPCU, some young people have to be cared for with significant restrictions in place in an attempt to manage risk on an open ward; a situation which may prove to be unsuitable for the young person and the other patients on the ward.

[19] Mental Welfare Commission for Scotland: Young Person's Monitoring report 2017-18 https://www.mwcscot.org.uk/node/905

The figures the Commission reports are likely to underrepresent the number of young people whose care needs indicate the need for IPCU facilities as the lack of IPCU provision means that clinicians have to try to manage these needs in other ways.

In recent years the Commission has highlighted the importance that the lack of provision of IPCU facilities has for young people under the age of 18 in Scotland and the lack of established and co-ordinated process and protocols to ensure that young people requiring IPCU facilities have access to appropriate provision when needed. We welcome the news that work has again begun to look at the issue of IPCU for young people in Scotland and funding has been allocated to each regional specialist adolescent unit to develop IPCU provision.

However, given the fact that many young people who are admitted to IPCU facilities may have a learning disability and often may be care experienced, it is important that any work to develop IPCU facilities is properly supported and co-ordinated nationally and properly integrated with the ongoing work to develop pathways and operating procedures for the NSAIS and the national inpatient learning disability provision. Also, given the challenge of providing appropriate and comprehensive facilities across the country for small numbers of young people with intense need at any one time and given the importance of ensuring there are appropriate safeguards around the use of seclusion and/or restraint due to the human rights concerns associated with their use, it is important that any IPCU provision is developed using a rights based approach to ensure that the comprehensive needs of any child or young person remain paramount in any service development.

Other care provision for young people, 2020-21

Table 7: Other care provision for young people, 2020-21

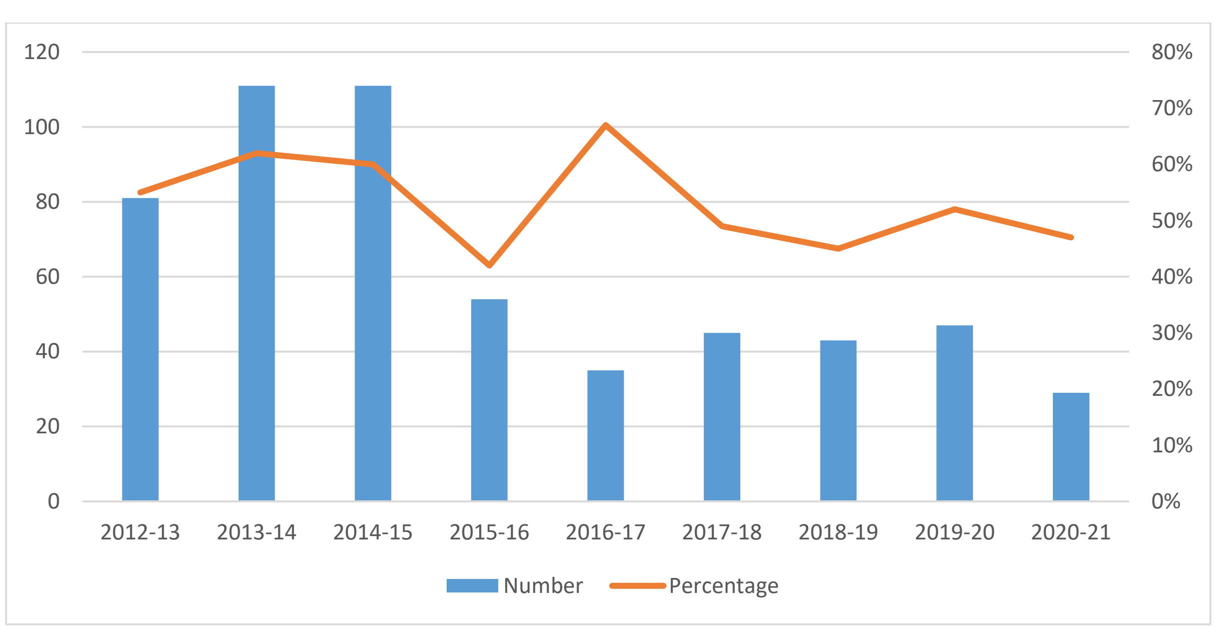
	Age 0-15	Age 16-17	All	*%
Access to age appropriate recreational activities	9	20	29	47%
Appropriate education was provided	0	6	6	10%
Access to advocacy service	10	38	48	77%
Has access to specialist advocacy service	5	3	8	13%
Total*	14	48	62	100%

**Total =62 admissions where further information provide to the Commission*

As part of its monitoring the Commission asked about access to other provisions to develop a clearer picture of how NHS boards are fulfilling their duty to provide age-appropriate services to young people. The importance of access to age-appropriate recreational activities and consideration of access to education becomes more important as the length of stay in the non-specialist environment increases.

In 2020-21 the proportion of admissions where a young person was described as having access to age-appropriate recreational activity remained at similar levels (29 out of 62 admissions) 47%. This compares to 52% of admissions in 2019-20, 47% in 2018-19, 49% in 2017-18, 67% in 2016-17, 42% in 2015-16, 60 % in 2014-15, 62% in 2013-14 and 55% in 2012-13.

Figure 7: Access to age appropriate activity 2020-21



Data is based on the further information provided to the Commission (62 admissions) and reported on annually.

Every year the Commission asks for information about the activities that young people are able to access while they were receiving care and treatment as in-patients. Normally many young people are reported to have access to electronic games, their phones and to music and DVDs. Some young people in the past have been reported to be able to access gym facilities. Due to social distancing related to lockdown restrictions some access to activities were curtailed. In previous reports the Commission had suggested that, even when admitted for a relatively short space of time, staff looking after the young person should give sufficient attention to structuring daily activity for young people with clear documentation regarding decisions made regarding appropriate activities available to a young person (involving the young person's views) and how these can be provided[20].

Article 12 of UNCRC describes the rights of all children to express their views freely in all matters that affect them and have their views "given due weight in accordance with their age and maturity." A key way in which this right can be promoted relates to the accessibility and availability of independent advocacy services for children. In its monitoring process the Commission enquired whether independent advocacy services are readily available which is a right that anyone with a mental disorder has in being able to access this service. In the 2015 amendments to the 2003 Mental Health Act, health boards were given new responsibilities to demonstrate how they are discharging their legal responsibilities in relation to the provision of advocacy.

In 2020-21 78% of young people (48 of the 62 admissions in which further information was provided to the Commission had access to advocacy. This compares with 70% of young people in 2019-20, 76% of young people in 2018-19, 67% in 2017-18, 61% in 2016-17, 65% in 2015-16, 72% in 2014-15, 65% in 2013-14 and 70% in 2012-13.

Of the young people who had access to advocacy during the admission, eight of the 62 admissions (13%) had access to advocacy which specialised in the particular needs and rights of young people. This result is lower than recent years (2019-20 data of 20% of admissions, 18% in 2017-18, 20% in 2016-17, 17% in 2015-16 and 29% in 2014-15). Our data does not provide information about whether the young people accessed advocacy during their admission, only that advocacy services might have been available should they have wished to have used them.

We expect advocacy support to be available and to be routinely offered to young people wherever they are admitted, whether informal or detained or whether from a care experienced background or not. It may be that during a very brief admission there is no time to involve advocacy to support a young person. From gathering information from hospital wards during the pandemic lockdowns the Commission learned that many advocacy services were making use of technology to undertake virtual meetings with children and young people once this was available. Due to the time required to develop this facility the findings of lower levels of advocacy support this year may reflect that the impact that social distancing measures had on visiting people in hospital. The findings from the monitoring project described in 2016, however, raised concerns about the accessibility of advocacy supports during young people's admissions to non-specialist wards. In last year's report the Commission recommended that those who have duties to fund and provide advocacy services for people with mental ill health should review the availability of specialist advocacy for children and young people. We are aware that agencies such as Who Cares Scotland are commissioned to provide advocacy for

[20] Young Person Monitoring 2015-16, October 2016.
https://www.mwcscot.org.uk/node/904

children and young people who are care experienced in many areas across the country but that, in contrast, specialist advocacy services for children and young people who have mental health difficulties is not provided comprehensively. Given the impact of the pandemic on activity and priorities the Commission repeats the recommendation again this year that the provision of specialist advocacy services for children and young people with mental ill health should be reviewed and prioritised.

Recommendation 2

Health board managers with a duty to fund and provide advocacy services for individuals with mental health difficulties in their area should ensure the availability of dedicated advocacy support for children and young people with mental health difficulties locally and ensure the resourcing and provision of any dedicated specialist advocacy service is sufficient to be able to meet the needs of young people with mental health problems and to support and protect their rights.

Article 28 of the UNCRC gives rights to children to access education and this applies whether the child is in hospital or not. In its general comments in 2007 the CRC stressed that "every child of compulsory school age has the right to education suited to his/her needs and abilities."[21] As part of its monitoring activity, the Commission asked for information about whether education has been considered for and discussed with the young person and, if not, to give reasons why. If education has been considered for a young person, the Commission asked whether education has been provided.

In 2020-21 nineteen out of the 62 admissions (31%) in which further information was provided to the Commission were reported to have had a discussion regarding access to education during their inpatient stay These figures are comparable to previous years. The remaining young people were described as being either too unwell to access education, their admission was too short or the young person either was no longer in education or had not been in education due to their mental health difficulties. Of the nineteen admissions where education was discussed, five related to young people aged 15 years and younger and therefore of statutory school age. Of the nineteen admissions in which education was discussed six young people were provided with educational materials during the course of their admission. All were 16 or 17 years old.

It may not always be appropriate or relevant to discuss access to education or learning if an admission is for a very short period of time or during a weekend or school holidays or when the young person is no longer in education. Of the five young people with whom education was discussed but none was provided four of the five admissions were under two weeks in duration but one extended beyond four weeks. In 2020-21 there were 17 admissions which related to young people 15 years and younger. In only five of these was education discussed. One of these admissions lasted longer than seven weeks and no education was provided.

[21] UN Committee of the rights of the child, general comment no 10 (2007) Children's rights in juvenile justice, para 89.

We are aware from previous reports[22] that access to education remains a fragile area of service provision when a young person has been admitted to a non-specialist facility. Education authorities have a duty to arrange for the education of young people who cannot attend school because of prolonged ill-health. We do think it is important that education needs are considered when a young person is admitted to an adult ward for a sustained period and remain concerned that staff in adult wards may not know how to access education services should that be appropriate while a young person is in hospital. Last year the Commission made a recommendation regarding education and repeats it here.

Recommendation 3

Hospital managers should ensure that whenever a child or young person is admitted to a non-specialist ward that consideration and exploration of their educational needs and their right to education should be a standard part of care planning for the young person during their hospital admission.

[22] Visits to young people who use mental health services: Report from our visits to young people using in-patient and community mental health services in Scotland 2009 (2010) https://web.archive.org/web/20180705090414/http://www.mwcscot.org.uk/media/53171/CAMHS_report_2010.pdf

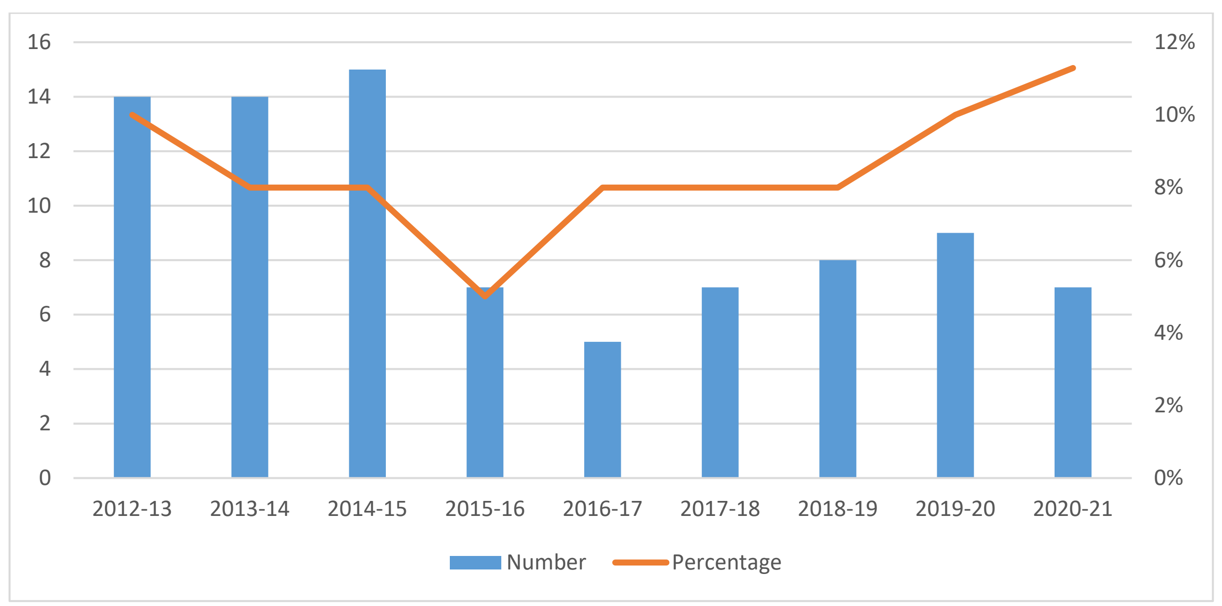
Young people with a learning disability 2020-21

Table 8: Admissions involving a young person with a learning disability 2020-21

	Age 0-15	Age 16-17	All	*%
Young person has a learning disability	<5	6	7	11%
Total *	14	48	62	100%

Total = 62 admissions where further information was provided to the Commission.

Figure 8: Admissions involving a young person with a learning disability 2012-21



Data is based on the further information provided to the Commission (62 admissions in 2020-21) and reported on annually.

The number of admissions to non-specialist settings where additional information was provided and the young people was described as having a learning disability in 2020-21 was seven out of 62 admissions (11%). This is similar to previous years in terms of percentages: 10% in 2019-20. 8% in 2018-19, 2017-18 and 2016-17, 5% in 2015-16; 8% in 2014-15 and 2013-14 and 10% in 2012-13.

In previous years children and young people who have a learning disability have made up a substantial part of the admission which are lengthy. Last year a third of admissions of individuals with a learning disability were more than five weeks in length. In 2020-21 of the seven young people with a learning disability who were admitted to non-specialist care, four were admitted for less than one week (57%) and two were admitted for over four weeks (29%).

Unlike previous years where proportions were higher, only one of the fifteen admissions (7%) to an adult IPCU in 2020-21 involved children or young people with a learning disability. In 2020-21 two of the ten admissions of children and young people who were care experienced also had a learning disability (20%) which is slightly lower than in recent years.

Age and gender 2020-21

We are interested in the age and gender of young people admitted to non-specialist settings to identify trends that develop over time that might indicate particular unmet needs.

In 2020-21 there were six children and young people aged 14 years or younger who were admitted to a non-specialist environment. Two thirds of these were admitted to a paediatric ward in the local hospital.

In 2020-21 the proportion of 16 and 17 year old young people admitted to a non-specialist environment was comparable with previous years (66 out of 86 admissions in total, 77%). In 2019-20 the proportion of 16 and 17 year old young people admitted was 76%, 75% in 2018-19, 72% in 2017-18, 82% in 2016-17 and in 2015-16, 69% in 2014-15, 65% in 2013-14 and 62% in 2012-13.

The higher rates of admissions of young people in the 16-17 year age range reflects current understanding of the prevalence and the types of mental health difficulties affecting young people in this age group in particular[23].

Table 9: Age of young person by gender 2017-21

	2017-18			2018-19			2019-20			2020-21		
Age at last birthday (years)	**F**	**M**	**Total**	**F**	**M**	**Total**	**F**	**M**	**Total**	**F**	**M**	**Total**
15	9	3	12	10	<5	13	5	6	11	8	<5	11
16	12	10	22	16	8	24	17	3	20	18	9	27
17	20	20	40	28	24	52	27	20	47	26	16	42
Total*	**49**	**36**	**85**	**62**	**39**	**101**	**56**	**32**	**88**	**57**	**29**	**86**

**Total describes all individuals admitted over the year, including where no further information was supplied to the Commission. The data for young people 14 years and under is included in this total but not provided in the table due to the low numbers. In 2020-21 there were six young people aged under 15 admitted to non-specialist wards.*
F=Female M=Male

[23] https://dera.ioe.ac.uk/32622/1/MHCYP%202017%20Summary.pdf
Mental Health of Children and Young People in England 2017:
https://digital.nhs.uk/data-and-information/pu Mental Health of Children and Young People in England 2017.blications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017

Figure 9a: Young people admitted to non-specialist wards by gender (number of individuals), by year 2008-21

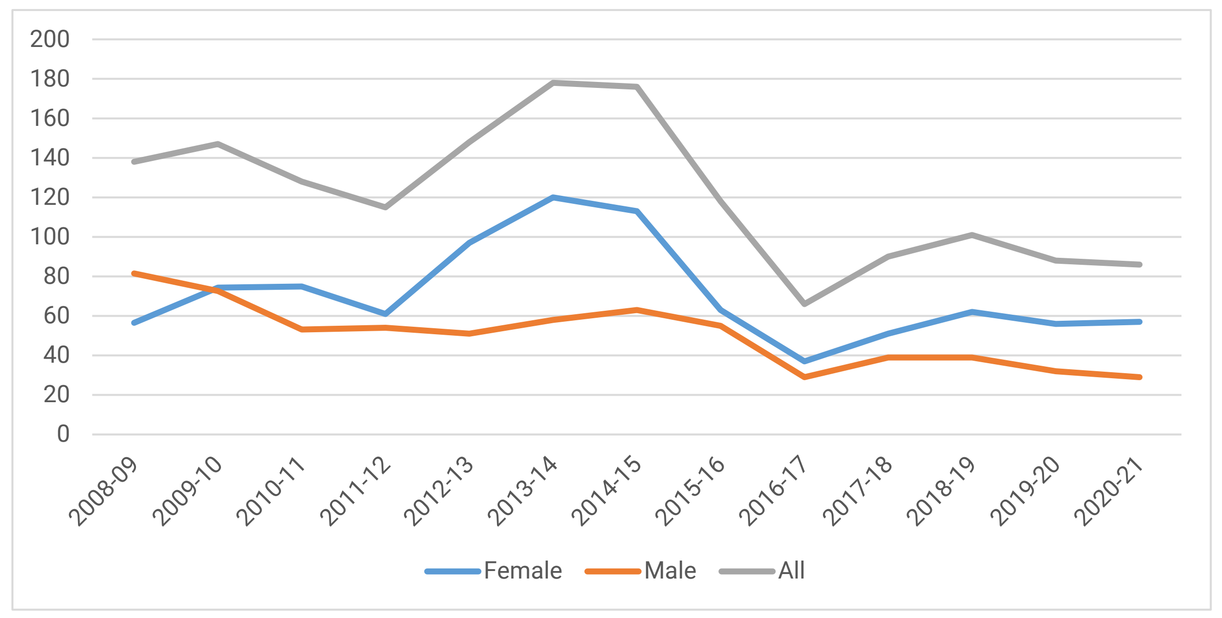
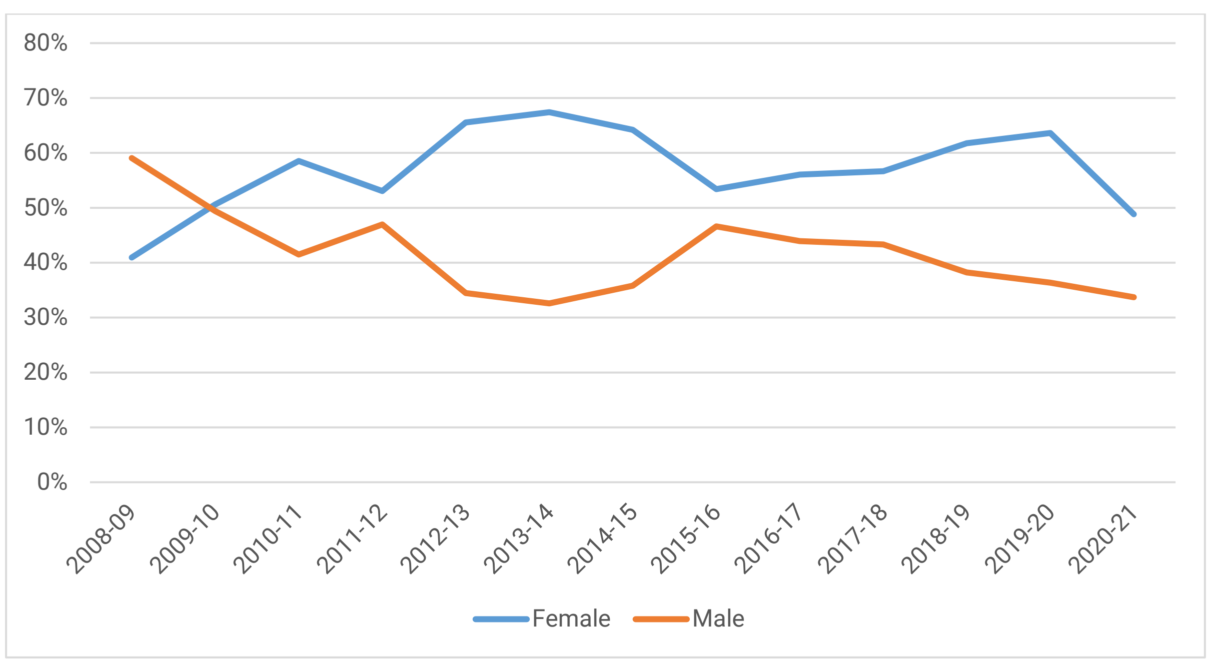


Figure 9b: Young people admitted to non-specialist wards by gender (%), by year 2008-21



Mental Welfare Commission for Scotland
Thistle House,
91 Haymarket Terrace,
Edinburgh,
EH12 5HE
Tel: 0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk
Mental Welfare Commission 2021

Child and Adolescent Mental Health Services (CAMHS)

NHS Scotland National Service Specification

February 2020

Scottish Government
Riaghaltas na h-Alba
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Child and Adolescent Mental Health Services (CAMHS)

NHS Scotland National Service Specification

Introduction

NHS Scotland Child and Adolescent Mental Health Services (CAMHS) are multi-disciplinary teams that provide (i) assessment and treatment/interventions in the context of emotional, developmental, environmental and social factors for children and young people experiencing mental health problems, and (ii) training, consultation, advice and support to professionals working with children, young people and their families.

All children and families should receive support and services that are appropriate to their needs. For many children and young people, such support is likely to be community based, and should be easily and quickly accessible.

Children, young people and their families will be able to access additional support which targets emotional distress through Community Mental Health and Wellbeing Supports and Services. Community supports and services should work closely with CAMHS and relevant health and social care partners, children's services and educational establishments to ensure that there are clear and streamlined pathways to support where that is more appropriately delivered by these services.

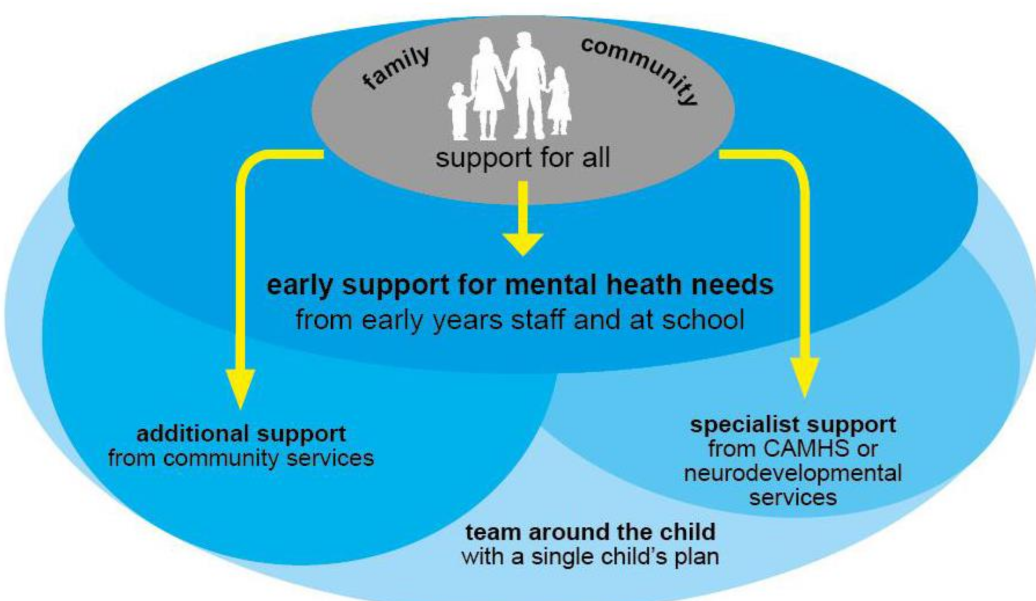
CAMHS will support both universal and additional children and young people's services, including new and enhanced Community Mental Health and Wellbeing Supports, by providing consultation, advice and training, and where appropriate, supervision of those staff providing psychological interventions. Children, young people and their families supported in CAMHS will also have access to supports provided within universal and additional services.

Most young people requiring CAMHS will present with mental health problems that are causing significant impairments in their day-to-day lives, and where the other services and approaches described above have not been effective, or are not appropriate. These presentations can result in both the need for scheduled and/or unscheduled care.

CAMHS will be available for all children and young people who are aged 0 – 18, and who meet the agreed CAMHS referral criteria in Scotland (see Annex 1 - National Referral Pro-forma for Child and Adolescent Mental Health Services (CAMHS) in Scotland). CAMHS will accept requests for assistance and referrals from all children's services professionals, adults with concerns and young people where the National Referral Criteria are met.

CAMHS are usually provided within a stepped and matched care model described in Tiers. This is consistent with the Getting it Right for Every Child (GIRFEC) model and principles (and the model agreed by The Children and Young People's Mental Health and Wellbeing Programme Board). CAMHS works within the network of children's service providers, both statutory and third sector, and will be fully engaged in Children's Services Planning Partnerships. CAMHS will aim to treat children and young people in the right place, at the right time and as close to home as possible.

Diagram 1: CAMHS within the agreed Children and Young People's Mental Health and Wellbeing model:



CAMHS supports universal and targeted community services (Tier 1 and Tier 2), but primarily works as a multi-disciplinary team within a local area - CAMHS Locality Teams (Tier 3), supported by services that have specific and additional expertise, often provided over a larger area (e.g. Forensic CAMHS, Psychiatric Inpatient Care) (Tier 4).

Sections 1 to 7 below are the minimum service standards to be delivered by all NHS Scotland CAMHS and these standards will be reviewed regularly, and in the first instance, in June 2020 on the basis of learning from the implementation process. All statements should be read with the preface "CAMHS in Scotland will":

1. High Quality Care And Support That Is Right For Me

These are the CAMHS 'experience of service' standards to be delivered for children, young people and their families:

1.1 Publish information in a clear, accessible format about what and who CAMHS is for, and how children, young people and their carers can access CAMHS.

1.2 Offer a first appointment to all children and young people who meet the CAMHS Scotland referral criteria. This first appointment, unless in unscheduled or urgent care, should be as soon as possible and no later than 4 weeks.

1.3 Provide support and personalised, meaningful signposting to the child/young person and their family/carers, with informed consent, to access other services within the children and young people's service network, in cases where families' needs are best met elsewhere.

1.4 Conduct a full initial assessment, based on the information from the referrer, and the Child's Plan where completed and available, which includes a comprehensive psychosocial assessment.

1.5 Assure that the member of staff undertaking the initial assessment is appropriately trained and experienced to undertake assessments, to identify strengths and difficulties including identification of mental health disorders, supported by formulation or diagnosis where appropriate.

1.6 Provide interventions and treatments, where required and agreed with children, young people and families/carers, as soon as possible, and no later than 18 weeks from first referral, with the median experienced wait for treatment being no longer than 12 weeks.

2. I Am Fully Involved In The Decisions About My Care

Getting It Right For Every Child (GIRFEC) stresses the importance of care planning and collaboration between professionals as the required standard for delivery of children's services in Scotland, and CAMHS will work to the GIRFEC principles on a multi professional and agency basis.

2.1 Build on and contribute to other parts of agreed multi-agency care pathways.

2.2 Agree through a process of shared decision making the goals of the child and family and regularly review those interventions and progress towards the goals.

2.3 Ensure that the rationale for formulation and diagnosis, evidence considered, and decisions made will be fully documented. This will be shared with the child/young person and parent/carer in writing as appropriate. Share and involve the child, young person and family/cares in the information to be shared with the referrer e.g. that the assessment has taken place and the goals of the care plan.

2.4 Develop a risk management plan, if required, in collaboration with the child/young person and their families/carers, including crisis planning where relevant.

2.5 Ensure that initial and continuous care planning involves all members of the CAMHS team providing care, the child/young person and their families/carers.

2.6 Ensure that care plans are in place for all children and young people receiving support from CAMHS.

2.7 Ensure care plans: are coordinated across agencies (using the GIRFEC principles), teams and disciplines; are clearly written; identify the case holder/care coordinator; are developed in collaboration with children/young people and families and carers (e.g. The Triangle of Care)

2.8 Provide copies of the care plan to children, young people and their families/carers, and, with informed consent, those professionals in other agencies working with the child, young person and families/carers such as social work, schools and children's services providers and primary care (e.g. GPs).

3. High Quality Interventions And Treatment That Are Right For Me

CAMHS has a specific role in the assessment and provision of interventions/treatment of children and young people's mental health problems and this section summarises the main components of CAMHS Tier 3 and Tier 4 services:

3.1 Provide recommendations for interventions and treatment options in consideration of:

- Engagement, accessibility, flexibility and choice.
- Age-appropriate best practice/evidence-based psychological intervention.
- Environmental and occupational/educational interventions or support.
- The availability of a multimedia prevention packages.
- Psychosocial and Pharmacological and interventions.

3.2 Take account of children and young people's educational needs and, with informed consent, work with school and education authority staff to contribute to the child or young person's educational support. This will include responding to requests for assistance under the terms of the Additional Support for Learning Act.

3.3 Provide specific support for the mental health of Looked After Children, including support to the system of care (e.g. advice, consultation, training) and, via the Child's Plan and requests for assistance, children and young people who are experiencing mental health problems.

3.4 Provide a liaison mental health service to all children and young people who are receiving treatment in acute settings such as hospitals, including, in partnership with acute colleagues and other agencies, a robust clinical emergency service with out of hours, weekend and bank holiday capability.

3.5 Provide and/or contribute to a 24/7 mental health crisis response service for children and young people, including support and advice to front line services, assessment and interventions/treatment for mental health crisis presentations, and access to inpatient medical and/or psychiatric care.

3.6 CAMHS Locality Teams (Tier 3) will provide services for:

- Severe Depression and Anxiety
- Moderate to severe emotional and behavioural problems, including severe conduct, impulsivity, and attention disorders
- Psychosis
- Obsessive-compulsive disorders
- Eating disorders
- Self-harm
- Suicidal behaviours
- Mental health problems with comorbid drug and alcohol use
- Neuropsychiatric conditions
- Attachment disorders
- Post-traumatic stress disorders
- Mental health problems comorbid with neurodevelopmental problems

- Mental health problems where there is comorbidity with mild/moderate intellectual disabilities and/ or comorbid physical health conditions, additional support needs and disabilities including sensory impairments
- Children and young people in the above categories and who require Intensive Home Treatment and Support

3.7 CAMHS Locality Teams (Tier 3) response to the above, but will also be supported by services providing additional and specific expertise to children and young people supported in CAMHS who, have more complex and/or specific difficulties. These services are often delivered across board boundaries, regionally or nationally and include Psychiatric In Patient Units. The areas of specific expertise required are children and young people with mental health problems and

- an intellectual disability
- forensic risks and needs
- experience of complex trauma
- an eating disorder
- an admission to an acute hospital
- substance misuse
- questioning or experiencing distress about their gender
- placement in secure care (where secure care facilities are within the relevant NHS Board)
- a complex neurodevelopmental problems
- an early onset psychosis
- a need for inpatient psychiatric care

4. My Rights Are Acknowledged, Respected and Delivered

CAMHS will commit to working within a rights based approach and, given the impact of inequality and discrimination on positive mental health, it’s important that children, young people and their families know the actions taken to ensure their rights are respected and they are included. Partner organisations are reminded of their duties under the Equality Act 2010 and the Equality Act 2010 (Specific Duties) Regulations (Scotland) to assess the impact on persons who share a protected characteristic in the delivery of this service.

4.1 Ensure CAMHS are available to all children and young people, taking into account all protected characteristics. Where it is deemed clinically appropriate, alternative services may be established that meet the specific needs of one or more groups within a community. Such services will enhance rather than detract from the minimum standards.

4.2 Ensure CAMHS is delivered in timely, age-appropriate, accessible, and comfortable settings, as close to home as possible, and that meet the needs of children and young people.

4.3 Ensure that informed consent issues around both sharing of information within the family and with other agencies and around interventions/treatment are clearly explained and documented.

4.4 Provide care/interventions that will reduce the risk of and/or prevent unnecessary admission to an inpatient bed and promote safe discharge and recovery.

4.5 Ensure that all service developments and/or redesigns are undertaken using best standards of engagement, involvement of children, young people and their families including co-production.

4.6 Provide and act upon a risk assessment for all those children who did not attend/were not brought, including, implementation of local 'unseen child' protocols and standards. (NB: CAMHS should not close a case due to non-attendance/engagement without discussion with the referrer that the child or young person has not attended/was not brought. See Child Protection Guidance for Health Professionals SG 2013)

4.7 Publish clear re-engagement policies and make them available to referrers, children/young people and families and carers.

4.8 Offer creative and acceptable alternatives to face to face clinical work where the children and young people live at a distance from clinical bases e.g. the use of approved technology like Attend Anywhere or advice to a local professional who is working with the child, young person and their family.

5. I Am Fully Involved In Planning And Agreeing My Transitions

Transitions for children and young people are known to increase risks, particularly for the most vulnerable. The Scottish Government published the Transition Care Planning Guidance in 2018 and this describes the standards required in the planning of good transitions for young people moving from CAMHS to Adult Mental Health Services. The Principles of Transition guidance is relevant in planning and supporting all transitions for children and young people.

5.1 Implement the Scottish Government's Transition Care Planning Guidance. CAMHS will have protocols in place to ensure that transitions between CAMHS and other services are robust and that, wherever possible, services work together with the service user and families/carers to plan in advance for transition (this is especially critical in the transfer from CAMHS to adult mental health services and primary care or other services, e.g. voluntary/third sector).

5.2 Ensure the Transition Care Plan provides children and young people with continuity of care and that any risks and child and adult support and protection concerns are clearly identified and documented.

Groups of children and young people who are more at risk to adversity during transitions and require robust transition plans include:

- Looked after children
- Care leavers moving to independent living
- Young people entering or leaving inpatient care

- Young people entering or leaving prison
- Young offenders
- Children and young people with intellectual disabilities
- Unaccompanied asylum-seeking minors
- Children and young people with caring responsibilities
- Those not in education, employment or training
- Children supported under the Additional Support for Learning Act
- Young Parents
- Young people entering college or university study and, in particular, those moving health board area

6. We Fully Involve Children, Young People And Their Families And Carers

The Children and Young People's Mental Health Programme has been built on and informed by significant involvement of children, young people and their families: in particular, but not limited to, the Rejected Referrals Report, The Youth Commission on Mental Health and the Children and Young People's Mental Health Taskforce. CAMHS will work in partnership with children, young people and their families in all aspects of service design and delivery.

6.1 Provide clear ways and simple to use means for children, young people and/or families/carers to provide regular feedback or to complain. This feedback should be used to improve the support offered.

6.2 Ensure independent advocacy and support services to the whole system are well signposted and children, young people and/or families/carers are supported to access the help available.

6.3 Seek feedback from children, young people and/or families/carers, and other professionals involved with the child or young person with agreement, each time they are supported and are involved in reviewing progress, goals and outcomes.

6.4 Involve children, young people and/or families/carers in all decisions/plans that affect them. This includes the design, planning, delivery and review of services.

6.5 Develop leaflets, websites, social media and other communications aimed at children, young people and/or families/carers in partnership with them.

7. I Have Confidence In The Staff Who Support Me

No public service can provide quality of care without a commitment to develop and sustain a high quality workforce. The variation in workforce levels, professional mix, skill mix, activity, productivity and outcomes in CAMHS was noted in both the Rejected Referrals report and the Audit Scotland report. CAMHS workforce development is a critical element of the delivery of high quality and consistent care across Scotland.

7.1 Provide sufficient staff resources to meet the recommended standards for:

(i) minimum critical mass for CAMHS Tier 3 and Tier 4 services, taking into account specific local circumstances;

(ii) demand and capacity, taking into account wider provision for children and young people's mental health care, and current demand for locality CAMHS teams, ensuring Fair Work standards, and quality of care standards, are met;

(iii) an assessment of population level need.

[NB: Further guidance will follow on Scottish Government's recommended CAMHS capacity and workforce model which will include Fair Work Standards, and the Health and Care (Staffing) Scotland Act]

7.2 Involve children, young people and/or their families/carers, and their views taken into account, in recruitment and appointment of staff.

7.3 Involve children, young people and/or families/carers in the design, delivery and/or evaluation of staff training.

7.4 Provide opportunities for team / service away days to build team relationships, facilitate learning and service development. This should be done on a multi professional/agency basis wherever possible.

7.5 Develop effective relationships and pathways with key local organisations to ensure the holistic needs of children, young people and/or families/carers are met in a timely and appropriate manner, in line with the GIRFEC National Practice Model, The Child's Plan (where completed).

7.6 Clearly describe the roles of professionals in CAMHS, including the capacity for supporting children, young people and their families, and including administration support, team meetings and supervision, and make this information available in a range of audiences and formats.

7.7 Ensure sufficient resources are available for professional, clinical and managerial supervision, including supervision regarding the arrangements for the safety of children and young people.

7.8 Provide opportunities for CAMHS professionals to participate in small group case discussions about case goals and outcomes, and on a multi-agency basis where possible.

7.9 Include children, young people and/or families/carers' views of their experience in CAMHS professional appraisals, and provide systems and processes to gather views appropriately, and with consent, for this purpose.

7.10 Ensure systems and processes are in place (IT and others) to monitor, report on, analyse and respond to, fluctuations in the local planned capacity calculations, but also to report on outcomes of interventions and treatment.

7.11 Ensure CAMHS staff are supported to grow and develop the necessary compassion, values and behaviours to provide person-centred, integrated care and enhance the quality

of experience through education, training and regular continuing personal and professional development that instils respect for children/young people and families/carers.

7.12 Ensure the workforce capacity, current and for the future, is sufficient ensuring an appropriate skill mix and scope of practice to deliver a range of recommended evidence-based interventions within the recommended delivery and capacity model.

ANNEX 1 - National Referral Pro-forma for Child and Adolescent Mental Health Services (CAMHS) in Scotland

Child and Adolescent Mental Health Services (CAMHS) are core clinical multi-disciplinary teams with expertise in the assessment, care and treatment of children and young people experiencing serious mental health problems. Specialist services for those at risk and with specific conditions are also provided, including inpatient care. CAMHS works with and provides support to the wider system of mental health care for children, young people and their families within the Getting It Right For Every Child (GIRFEC) model.

Specialist CAMHS are for children and young people age 0 – 18th birthday with clear symptoms of mental ill health which place them or others at risk and/or are having a significant and persistent impact on day-to-day functioning. While some children and young people will need to come straight to CAMHS i.e. those requiring urgent mental health care, most will require this service when an intervention within primary care, education or a community-based service has not been enough.

Name and demographics of the child or young person - including contact details and Next of Kin – as per ISD requirements.

Who has given consent for this referral?

If the young person is alone, how should we contact them for appointments?

Reason for referral; please specify:
mental health symptoms, risk to child or young person and/or others and impact on day to day life.

Are there any child protection concerns about the child or young person?

What else has been done to address the problem? Please give details e.g. the name of the service, intervention etc.

Past medical history *Physical and Mental Health*
Medication *Current & Past*
Allergies
Family History

If referral relates to a suspected eating disorder:
Physical health data: HR, BP, Height, Weight, BMI, date and results of any recent investigations.

Please ask child or young person to add any further information from them and school/college if appropriate about the difficulties and add this to your referral.

Are there any special requirements for appointments e.g. wheelchair access, interpreter Y/N
If Yes, please specify:

Referrer's details…………………………………………………………

ANNEX 2

Definition of CAMHS Professionals and Services

Tier 3 CAMHS

Tier 3 CAMHS works with children and young people from 0 years up to the age of 18 years who present with significant mental health problems. The team is based in a local area, is multi-disciplinary, made up of nurses, clinical and applied psychologists, social workers, psychiatrists and occupational therapists as the main professions, with access to systemic and family psychotherapists, child and adolescent psychotherapists, speech and language therapists and dieticians as required. These professionals provide consultation and advice to other professional groups and agencies. CAMHS provides specialist diagnostic assessment and provides psychological, systemic and/or pharmacological therapy. They also work with other the staff in the other services out with CAMHS. CAMHS is available for consultation to other professionals concerned about children and young people's emotional wellbeing and mental health issues. CAMHS Tier 3 teams deliver the National Referral to Treatment Standard so are key to delivering the CAMHS Service Specifications.

Substance Misuse Service

CAMHS substance abuse services provide support for the management and treatment of children and young people with co-morbid mental health and substance misuse problems. This may be provided with the Tier 3 CAMHS team, or by a more specialist Tier 4 team over a larger area. CAMHS substance abuse services will work along with other community based agencies that deliver services to help young people who are misusing substances whether legal or illegal. Therapeutic intervention will be aimed at reducing or stopping substance misuse through discussion on the physical, psychological, social, educational, systemic and legal issues related to their substance misuse. CAMHS substance abuse services also offers opportunities for consultation and educational group sessions to professionals, children and young people their families and carers.

Eating Disorders Service

CAMHS Eating Disorders services treat children and young people under 18 years who have difficulties with their eating patterns. Examples of eating disorders are Anorexia Nervosa, Bulimia Nervosa and Eating Disorders Not Otherwise Specified (EDNOS). This can be provided within a Tier 3 CAMHS team, or by a dedicated Tier 4 team working across a larger area. CAMHS/Eating Disorders services will provide a family and individual assessment and a range of interventions are available, such as Motivational Work, Individual Therapy, Family Therapy (e.g. Family Based Treatment), Individual Nutritional Assessment, education and reviews. Various group supports may also be provided such as nutritional education and carers support which may be provided over a specific number of weeks.

Intensive Home Treatment Service

A CAMHS nursing/medical/AHP team available in the community to reduce and/or manage children and young people who are at immediate risk or who need intensive therapeutic care. The primary objective of this service is to prevent admissions to acute hospital care. Where admission is required, this service is aimed to provide earlier step down from in-patient psychiatric care.

Crisis Service

CAMHS crisis services provides a 24/7 emergency/crisis response assessment and management service, working alongside other agencies (Police, ED, SWS etc.) and may provide support as required to these agencies. CAMHS Crisis services work intensively with children and young people and their families/carers as required to respond to mental health crisis immediately. CAMHS crisis services ensure children and young people are safe and receive appropriate follow up care, including medical and psychiatric inpatient care where require, social work and other services response. CAMHS crisis services will work closely with the Crisis supports under development for the Children and Young People's Mental Health and Wellbeing Programme Board.

Gender Identity Service

This service will provide assessment, specialist interventions/treatment and therapeutic support to young people who have issues regarding their gender and also includes work with families. These services often work over a larger area, and works in collaboration with Tier 3 CAMHS teams offering consultation and liaison (and with wider children's services) as necessary and appropriate. Gender identity services link with and/or signpost users and carers to other relevant voluntary/community sector organisations for additional information and support. This service could be delivered on a regional or a national basis.

Forensic CAMHS

This service supports a range of agencies and professionals in addressing the mental health and risk management needs of young people presenting with high risk behaviors. This is conducted through clinical consultations and specialist assessments. This will often include young people in the criminal justice system, prison and secure care. This service should be delivered on a regional basis with links to and from the National Secure Inpatient Psychiatric Service (opening in 2022).

LD/Intellectual Disability CAMHS Service

This service works with children and young people with Intellectual Disabilities/Learning Disabilities (ID/LD) and mental health difficulties or complex behavioral difficulties. It provides comprehensive assessment and specialist, multidisciplinary, therapeutic interventions, broadly similar to mainstream CAMHS, with additional interventions/treatment approaches tailored to the needs of children young people with ID/LD e.g. behavioral and communication interventions. ID/LD CAMHS understands the complex genetic, neurological or physical health difficulties which often impact on the mental health and development of children and young people with ID/LD and tailor their approach accordingly.

ID/LD CAMHS work along with other specialist services involved with children and young people with ID/LD particularly education, social work and community paediatric teams. NHS Scotland are considering the case for a National CAMHS Inpatient Service. Children and Young People with Complex Neurodevelopmental Problems and mental health risks and impact may also be referred to this team where the risks and impact are beyond the supports available in Core CAMHS and wider children's services.

Liaison CAMHS

This service provides CAMHS input to acute physical healthcare settings, recognising that children and young people who are frequent attenders and in-patients have a higher incidence of mental health disorders. This is particularly the case for children and young people with neurological conditions and chronic health conditions. Psychiatrists, nurses and clinical psychologists work with paediatric and adult healthcare colleagues to provide mental health promotion, early intervention and treatment services so that children and young people receive high quality holistic care for emergency and routine presentations. They also support children and young people admitted to acute healthcare settings as a consequence of mental health disorders e.g. for physical stabilisation of a child or young person with an eating disorder or where they present with an acute crisis. Therapeutic work comprises of psychological and psychopharmacological therapies based on careful assessments and joined up working with acute physical healthcare colleagues.

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Aberdeen City Health & Social Care Partnership
A caring partnership

RISK, AUDIT AND PERFORMANCE COMMITTEE

Date of Meeting	6 June 2022
Report Title	Justice Social Work Annual Performance Report and Delivery Plan Update
Report Number	HSCP22.042
Lead Officer	Claire Wilson, Lead Officer (Social Work)
Report Author Details	Lesley Simpson Service Manager LSimpson@aberdeencity.gov.uk Liz Cameron Service Manager ElCameron@aberdeencity.gov.uk
Consultation Checklist Completed	Yes
Appendices	Appendix A - Annual Performance Report 2021-22 Appendix B - Delivery Plan Update

1. Purpose of the Report

1.1. The purpose of this report is to present the Risk, Audit and Performance Committee (RAPC) with the Justice Social Work Annual Performance Report 2021-22 and also an update in respect of the Delivery Plan 2021-2024.

2. Recommendations

2.1. It is recommended that the Risk, Audit and Performance Committee:

a) Note the Annual Performance Report 2021-22.

b) Note the update provided in respect of the Delivery Plan 2021-2022.

RISK, AUDIT AND PERFORMANCE COMMITTEE

3. Summary of Key Information

3.1. A draft performance framework and a draft Delivery Plan were submitted to the Care Inspectorate in 2020 as part of the evidence portfolio supporting the self-evaluation of the justice service.

As previously reported to the Committee, the inspection outcome was very positive with only two recommendations to be taken forward by the service, one of which said:

"To enable robust oversight and increased ability to demonstrate outcomes and impact, senior officers should ensure that the justice service delivery plan and performance management framework are agreed and implemented and associated reporting cycles established".

3.2. The revised Performance Management Framework was presented to the Committee on 22 June 2021. The Framework was approved, and the Chief Officer was instructed to use this as the basis for a report outlining the performance of the justice service and for this to be presented to the Committee no later than the end of Q1 2022-2023 and then similarly on an annual basis thereafter.

3.3. The revised Delivery Plan was presented to the IJB on 6 July 2021. The IJB approved the Delivery Plan, and the Chief Officer was instructed to present an annual update to the Risk, Audit and Performance Committee on the progress being made with the implementation of this delivery plan.

3.5 The performance report reflects the effectiveness of the justice service in 2021-22, however operational activity in the service and across the wider justice sector was significantly affected by lockdown measures and other public health interventions that were in place during this year.

3.6 The pandemic affected the volumes of justice social work reports that were required to be submitted and also the Community Payback Orders (CPOs) that were issued. This did not necessarily mean that staff workloads were reduced as the normal service delivery models had to be reshaped to a different provision that were in many respects, more labour intensive, for example, support groups being replaced by 1:1 supports.

RISK, AUDIT AND PERFORMANCE COMMITTEE

3.7 The report shows that there was a welcome increase in the numbers of Diversion from Prosecution and Structured Deferred Sentencing. JSW is very mindful about not 'up-tariffing' into statutory orders and have placed an appropriate emphasis on the support provided to these other options. In addition, the Unpaid Work Team produced creative solutions to enable individuals to complete their orders from home and helping ensure that JSW did not have a backlog of orders to complete. There has however been an increase in the number of domestic abuse cases that is being closely monitored by the service and its multi-agency partners.

3.8 The pandemic has also had a significant impact on the implementation of the Delivery Plan with there being little capacity available within the service to progress development matters. That said, the Delivery Plan Update shows that some progress has been made across most initiatives and activities. A review of the Delivery Plan will be undertaken in 2022-23 as it is possible that some of its expressed ambitions are no longer as relevant because of the impact of the pandemic.

4. Implications for IJB

4.1. **Equalities** - There are no direct Equalities implications arising from this report.

4.2. **Fairer Scotland Duty** - There are no implications arising from the IJB's Fairer Scotland Duty in respect of this report.

4.3. **Financial** - There are no financial implications arising from the recommendations of this report.

4.4. **Workforce** - There are no workforce recommendations arising from this report.

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

4.6. **Other** - It is a regulatory requirement from the Care Inspectorate for the justice service to have an 'agreed and implemented' performance framework. Failure to do so would have a detrimental reputational impact.

RISK, AUDIT AND PERFORMANCE COMMITTEE

5. Links to ACHSCP Strategic Plan

5.1. The JSW Delivery Plan 2021-24 and the Justice Performance Management Framework both have a strong alignment with all the Aims set out in the HSCP Strategic Plan, under the headings of Prevention, Resilience, Personalisation, Connections and Communities.

6. Management of Risk

6.1. Identified risks(s)

Not implementing a justice service-specific performance framework as required by an inspection report recommendation would very likely have a detrimental impact on the partnership's reputation and that of the service also with the Care Inspectorate. This outcome is not very likely given the effective management and oversight of the service by its Service Managers and the Lead for Social Work and the preparations that were put in place to ensure positive inspection outcomes in the first instance.

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

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

6. There is a risk of reputational damage to the IJB and its partner organisations resulting from complexity of function, delegation, and delivery of services across health and social care.

RISK, AUDIT AND PERFORMANCE COMMITTEE

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

The oversight of the justice service that is undertaken by its Programme Management Board, will ensure that this performance framework is implemented and that there is regular KPI reporting to the PMB as well as an annual submission to the RAP Committee of the performance report and delivery plan update.

Approvals	
[signature]	Sandra Macleod (Chief Officer)
[signature]	Alex Stephen (Chief Finance Officer)

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Justice Social Work

Annual Performance Report 2021-22

1) Introduction

The Justice Social Work (JSW) service is diverse, complex and busy and consists of Caledonian, Community Payback Orders (CPO), Connections (Women's Centre), Pre-Disposal, Throughcare, Unpaid Work, Support Work and Admin. teams. Its primary remit is to provide statutory supervision and support to individuals who have offended, using interventions which are proportionate to risk and need. This supervision ranges from low level for those on Diversion to very high level, usually with multi-agency support, for the "critical few" who pose significant public protection concerns.

The individuals with whom the service works may have mental health problems, learning difficulties, personality disorders, drug and/or alcohol problems, behavioural/anger management problems, neurodiversity issues etc., often undiagnosed, and a poverty of aspiration for themselves. JSW staff are responsive to these increasingly complex needs and risks and accept their professional responsibilities to respond accordingly in a person-centred manner in order to deliver individual and statutory outcomes.

This Annual Report reflects the performance and effectiveness of the service in 2021-22, the second year of the Covid pandemic. It was a challenging year in many respects for the individuals that we work with, the workforce across all teams and all roles and the other agencies with whom we collaborate. The report demonstrates the continuing commitment that the service has to fulfilling the JSW Delivery Plan's vision that "Every person that we work with achieves the best possible individual and statutory outcomes".

2) Background

The Justice service Performance Management Board (PMB) first initiated the development of a service-specific performance management framework in 2019 as a means of highlighting the effectiveness of the diverse, complex and busy service.

A draft performance framework was submitted to the Care Inspectorate as part of the evidence portfolio supporting the service self-evaluation that was required by the inspection methodology. The Care Inspectorate inspection of the Justice service commenced in late 2019 however this was paused at the beginning of March 2020 because of the first Covid lockdown. The inspection restarted on a virtual basis in October 2020 and the report was published in February 2021.

The inspection outcome was very positive – "service users experience compassionate, consistent, focused and flexible support which frequently exceeds their expectations and is enabling positive change" - with only two recommendations to be taken forward by the service

1) To enable robust oversight and increased ability to demonstrate outcomes and impact, senior officers should ensure that the justice service delivery plan and performance management framework are agreed and implemented, and associated reporting cycles established.

2) To ensure key processes are effective, senior managers should further strengthen quality assurance to support consistent, confident and timely risk assessment and case planning processes, particularly those relating to risk of serious harm.

The inspection action plan which the partnership was required to submit to the Care Inspectorate no later than six weeks after the publication of the official inspection report said that a completed performance management framework would be submitted to the Risk, Audit and Performance (RAP) Committee. To add further assurance, the action plan also stated that an annual report in respect of justice social work performance and effectiveness would be submitted to the RAP Committee.

The Risk, Audit and Performance Committee agreed in June 2021 that the Performance Framework should be used as the basis for a report outlining the performance of the justice service and that this should be presented to the committee on an annual basis for its consideration and scrutiny.

3) Strategic Context

Justice social work is delegated by Aberdeen City Council to the Aberdeen Health and Social Care Partnership's (ACHSCP) Integration Joint Board (IJB) as set out by the Public Bodies (Joint Working) (Scotland) Act 2014. The partnership's Strategic Plan 2019-22 sets out the priority objectives (Prevention; Resilience; Personalisation; Connections; Communities) for all of the delegated functions and services. In addition, the Scottish Government have outlined those national health and wellbeing outcomes which all partnerships must strive towards.

ACHSCP is a statutory member of the local community planning partnership, 'Community Planning Aberdeen'. The Community Empowerment (Scotland) Act 2015 sets out how public bodies should work together with their local communities to design and deliver better services. There is a strong alignment between the integration partnership's strategic plan and the community planning partnership's Local Outcome Improvement Plan 2016-26. This improvement plan outlines the "Prosperous People" stretch outcomes that will be sought to promote the safety and wellbeing of the local population and contribute to the city's overall prosperity.

AHSCP is also a statutory community justice partner and as such has a shared responsibility for the strategic planning and delivery of local community justice services. The new community justice model is underpinned by the Community Justice (Scotland) Act 2016 which sets out the Outcomes, Performance and Improvement Framework as guidance to community justice partners on how to improve their local outcomes. Community Justice Scotland, the national corporate body has also produced a National Strategy for Community Justice designed to help community justice partners prioritise key areas, facilitate

improvement and support communities to realise its vision of the country being safer, fairer and more inclusive.

4) Covid Impact

The pandemic has had a significant impact on the JSW ambition to build on the very positive Care Inspectorate inspection report and put in place further developments and improvements for the benefit of the individuals that the service works with, the service workforce and other stakeholders.

In addition to that very welcome Care Inspectorate report, it is worth noting that prior to the pandemic, JSW had also been positively referenced in the Hard Edges report (Robertson Trust and Lankelly Chase, 2019) as Aberdeen had one of the highest prevalence rates for the three-dimensional model of homelessness-substance dependency-offending. Justice social workers were praised by some people with lived experience as the most consistent and helpful service they had encountered. Front-line service providers too, generally acknowledged, that justice teams provided the 'stickiest' and most pro-active support that adults facing significant multiple disadvantages could expect.

The various public health measures that were implemented over the course of the past two years not only impacted, of course, on our own service delivery models but also on the wider justice system. As a result, the service has had to respond to legislative and operational changes brought in by other agencies, including the Scottish Government, the Justice Directorate, the Procurator Fiscal Service, Police Scotland, the court, prisons, housing, health and different third sector organisations.

There has been little opportunity for service development activities because of the pandemic's impact but more positively, the collaborations with these other agencies, which were already of a high standard became even more closer and productive especially between JSW and HMP Grampian, ACC Housing, and the integrated Substance Misuse services.

Table 1 below gives an indication of the effects of the pandemic on some aspects of the JSW workload with 2019/20 as the pre-Covid benchmark (see also Appendix 1 for the 2020-21 CPO Annual Report).

Table 1: Covid Impact on Service Volumes

	2019/20	2020/21	2021/22
Justice Social Work Reports	1,126	715	935
Community Payback Orders	1,055	506	667
Diversion commenced	114	150	168
Bail Supervision commenced	45	4	26
Structured Deferred Sentence	25	11	30
Throughcare cases commenced in the community	32	38	40
Total no. of hours of Unpaid Work completed	52,854	32,153	36,683

As these figures suggest, continuing to manage and support people to complete their orders during the pandemic was challenging. Limitations on interview facilities, workshops, work parties and even van space meant that the service had to be even more creative and flexible in developing alternatives. Our inability to facilitate groupwork meant that there was increased one-to-one arrangements to organise and oversee and extensions to many orders had to be requested. Even when groupwork was restarted on a capacity limited and distanced basis, there were difficulties in re-engaging clients due to Covid infection, the need to self-isolate, supporting family members and general anxieties.

Court and Town House closures meant that the service was unable to meet national/local targets such as the number of first Community Payback Order contacts within one working day. In addition, changes in the length of remands and virtual custody courts held in prison have also impacted on sentencing, early engagement in building relationships with clients, the ability to undertake post sentence interviews, induction of new orders and post-release planning.

The Justice Social Work service continued to deliver face to face contact throughout the pandemic to individuals coming out of court/custody, those considered to pose a high risk of harm to others and those considered to be particularly vulnerable. Wherever possible social workers maintained contact with clients via phone, WhatsApp, doorstep visits and socially distanced walks. Clients were provided with mobile phones if needed so that contact could be maintained.

The Scottish Government allocated additional funding to JSW in May 2021 to address backlogs and support recovery with an additional amount specifically for third sector. The funding was only available to 31st March 2022 which meant that the recruitment of additional staff could only be on a fixed-term basis and, as the recruitment to vacancies already in establishment was difficult during Covid, recruiting additional posts for a short time proved even more challenging.

In order to keep track of the ongoing service 'recovery' and associated staff workloads and to identify any emerging concerns or trends as quickly as possible, the service has been gathering weekly data benchmarked against pre-Covid figures as well as a wider suite of quarterly data including a tally of footfall in JSW premises. Sitrep data was submitted regularly to the Justice Directorate, and it is evident that the Aberdeen Justice Social Work experience was broadly similar to the rest of Scotland.

5) Headlines

Despite the significant and sustained impact of the pandemic on our service delivery over the past two years there have still been notable aspects that are worth highlighting and commenting upon.

The continued increase in Diversion from Prosecution is very positive. While it may be indicative of the need to reduce court backlogs by using alternatives to prosecution, it enables individuals who have committed offences and have significant underlying needs to be diverted into support and, ideally out of offending and Court processes, at an early stage.

The use of Structured Deferred Sentences dropped during 20/21 but increased slightly last year and is continuing to rise. This disposal, particularly when imposed by the Problem-Solving Court, is again intended both as a lower level, albeit intensive, intervention and as a diversion from custody.

Covid legislation allowed for a number of unpaid work hours to be written off in certain circumstances and for orders to be extended beyond initial completion dates. Even so, lockdown measures, and the impact of these on placement opportunities, other activity options, transport and staffing meant it was more difficult than usual to get people through their orders.

The Unpaid Work Team therefore developed some creative solutions to enable unpaid workers to undertake their orders at home. One such solution was Blended Learning Packs, an educational approach that enabled individuals to reflect on how participating in Unpaid Work (UPW) can be of benefit to themselves and to the wider community. Other learning packs were developed - some with the assistance of Adult Learning and Development colleagues – and woodwork projects, including materials and instructions, were designed in our UPW workshop. Many of these completed projects produced outdoor equipment which has since benefitted nurseries across the city. This evident creativity and flexibility has enabled some individuals to complete their UPW Requirements despite these challenging circumstances and, unlike many other authorities, Aberdeen JSW does not have a backlog of Unpaid Work Requirements.

It is believed that domestic offences increased during the pandemic, but this has not increased the number of Caledonian Programme assessments undertaken nor requirements imposed. There is, however, a 35% increase in the number of Caledonian cases on workers caseloads which is reflective of the difficulty in delivering programmatic groupwork in the last two years and the timescale of orders having to be extended to complete. This has put considerable pressure on social workers and is compounded by the loss of Caledonian trained workers, the inability to recruit already trained workers, and the inability to access training for workers new to Justice Social Work or recently qualified.

6) Objectives

The JSW Delivery Plan 2021-2024 has four key objectives which seek to make Aberdeen a safer place in which to live, and which the service is working towards although again, the specific activities and initiatives aligned to each objective have been significantly impacted by the pandemic. These four objectives also form the basis of the Performance Framework together with a number of relevant, objective-specific metrics to enable the service to reflect on how well it is meeting or progressing towards each particular objective.

Please note that national data from 2021-22 has not yet been collected by the Scottish Government so 2020-21 has been referenced for comparative purposes.

To contribute to the creation of safer and fairer communities

One of the wider outcomes from supporting individuals with their assessed needs, helping them complete their orders and in doing so, assessing, and managing any risks that present themselves is the positive impact on our communities with the result that Aberdeen is a safer place to live and work.

A) Delivery of Community Payback Orders was a huge challenge during Covid. We prioritised workloads in respect of risk and need with those assessed as highest risk, most vulnerable, released from custody and those who did not have telephones being seen face to face. Wherever possible contact was maintained virtually with everyone else but many of our client group are "digitally poor" so had no access to computers and sometimes phones. We provided mobile phones where necessary so that contact could be maintained plus food parcels and practical support.

The behaviour of many of our clients did however surprise us as the majority abided by Covid rules, stayed at home, and wore masks when required. This is perhaps reflected in the 52% drop in numbers between 19/20 and 20/21 although we would like to think that the tenacious approach taken by social workers and support workers in keeping in touch with clients throughout the pandemic also had a beneficial impact. See also Table 4: Successful Completions and Table 7: Exit Questionnaires.

Table 2: Number of Community Payback Orders

	Scotland			Aberdeen			
	19/20	20/21	Change	19/20	20/21	Change 19/20 to 20/21	21/22
Orders	16,800	8,169	-41%	1,055	506	-52%	669
Male	14,299	6,987	-38%	894	441	-51%	570
Female	2,501	1,182	-42%	161	65	-60%	99
Under 18	349	151	-57%	17	7	-59%	5

B) Our Unpaid Work Team was closed down during lockdowns and, once reopened, was only able to deliver very limited work placements due to restrictions in workshops, van capacity and the absence of individual placements. Order Supervisors did however maintain telephone contact with clients throughout and, through the provision of Learning Packs and home working projects, they and Task Supervisors enabled some clients to successfully complete their orders and produce craft and joinery work beneficial to the community. Despite Covid, 36,683 hours of unpaid work were undertaken in 20/21 (Table 1). See also Table 4: Successful completions and Table 7: Exit Questionnaires

C) The number of individuals in custody on 31st March 2022 where Aberdeen have Throughcare supervision responsibility was 151 and those in the community subject to licence conditions and Supervised Release Orders was 40. As of 31 March 2022 there were 90 registered sex offenders subject to supervision in Aberdeen, 16 subject to Throughcare Release Licence and 74 on Community Payback Orders.

There is an increasingly high percentage of remand prisoners and the Government and the Scottish Prison Service were taking steps to reduce this pre-Covid with a push to increase Supervised Bail as an alternative to remand. We successfully increased the number of Bail Supervision Orders imposed in Aberdeen to 45 in 19/20 but Covid Court closures etc. reduced that to 4 in 20/21and 26 in 21/22 (See Table 8: Other Interventions).

Table 3: Number of Individuals Released on Licence

	2019/20	2020/21	2021/22
Female	1	1	1
Male	37	39	32

D) Multi-Agency Public Protection Arrangements (MAPPA) places a statutory duty on the responsible authorities in a local authority area to jointly establish arrangements for assessing and managing the risk posed by certain categories of offenders.

The MAPPA Co-ordination Unit provided statistics which reflect that on 31st March 2022 there were 8 active cases managed under MAPPA Level 2 Category 3 for violent offending in Aberdeen (29 in Scotland).and 11 over the whole year 2021-22. On 31st March there were 4 active cases managed under Mappa Level 2 Category 1 for sexual offending, and10 throughout the year.

We are seeing a significant increase in MAPPA Category 3 referrals for domestic abuse offenders, primarily from HMP Grampian which, anecdotally, is at odds with the national picture. This may be explained by changes in practice within prison based social work at HMP Grampian who are very pro-active in undertaking Risk of Serious Harm Assessments and referring into MAPPA

E) Our scheduled programme of Quality Assurance oversight was one of the casualties of Covid. Delivery of a busy justice service at all in a pandemic was all consuming. Teams developed office rotas to ensure any crisis situation could be responded to with face-to-face appointments being available within social work buildings, virtual team meetings were held a minimum of weekly to ensure ongoing communication, updates and sharing of Health information, community programmes and supports for clients were maintained and maximised to support clients and their families. We ensured that there were always two duty senior social workers available and, where 3-month reviews were able to be held (difficult on face time but virtually impossible on phone), we undertook a QA Light to ensure that standards had been met up to that point. The QA programme will be fully re-established as soon as is reasonably practicable.

To fairly, effectively, and proportionately implement court orders and release licences

This objective is largely process-driven but in saying that, being able to say that JSW, as diverse, complex, and busy as it is, is an efficient service and that this contributes very significantly, to the effectiveness of the service and the achievement of positive individual and statutory outcomes is a noteworthy statement to make.

F) In 2020/21, 75.6% of Community Payback Orders (CPOs) were completed successfully, above the Scottish average of 73%. In 21/22 we increased this to 78.5% (Scotland data not yet available). It is however difficult to draw meaningful conclusions from CPO data (Table 4) as the imposition of orders was significantly affected by the pandemic such that numbers were down compared with pre-pandemic years. For example, the number of women made subject to orders decreased from 17% to 13% but was that because: the tenacious outreach and support delivered by the staff in the Connections Women's Centre was successful; women complied with lockdown so offended less; or the Courts were prioritising higher risk cases. The answer may be any one of these explanations but is more likely to be a weighted combination of them all. Similarly, the reduction in the number of orders issued to under 18s is to be welcomed but invites more questions than answers; were they offending less, were more police warnings issued, were they being diverted from prosecution, or as court business was very limited were they prioritising higher risk/custody cases? As above, the answer is likely to be a weighted combination of all of these.

Table 4: Number of Successful CPO Completions

	Scotland		Aberdeen		
	2019/20	2020/21	2019/20	2020/21	2021/22
Total	16,271	10,034	976	680	652
Successful	66.62%	72.93%	73.4% (716)	75.6% (514)	78.5% (512)
Breach	16.35%	10.95%	10.5% (102)	7.9% (54)	5.67% (37)
Other	17.02%	16.12%	16.2% (158)	16.5% (112)	15.8% (103)

G) The Court and associated Pre-Disposal Team is effectively the front door to the Justice Social Work service and the importance of that first contact with cannot be under-estimated. That front door was literally closed for most of Covid which has impacted on our First Contact/ Induction/ Case Management figures. This is particularly unfortunate as, pre-Covid, we had made considerable improvements in these areas (approx. 80% of first contacts were immediately after court). Footfall through the Court door is now increasing, and we are working towards our pre-Covid level of first contacts, although realistically this may take some time.

Table 5: Number of First Induction/Case Management Meetings within 5 Days

	Scotland		Aberdeen		
	2019/20	2020/21	2019/20	2020/21	2021/22
Total	16,800	8,169	1,055	506	669
On time	72.4%	61.0%	719 (68.2%)	245 (48.4%)	409 (61.1%)
Late	18.3%	28.6%	229 (21.7%)	215 (42.5%)	196 (29.3%)
Information not available	9.3%	10.5%	107 (10.1%)	46 (9.1%)	64 (9.6%)

H) We continued to deliver MAPPA, MARAC and any other multi agency public protection meetings throughout the pandemic, in collaboration with partner agencies to achieve the best possible outcomes during challenging times for clients and communities. The number of MARAC meetings has by necessity increased considerably.

I) JSW in Aberdeen is accredited to deliver the Caledonian System which includes a Men's Programme for higher risk perpetrators of domestic abuse in tandem with a support service for women and children harmed. The majority of Justice Social Work reports to court for offences of a domestic nature are assessed for Caledonian with approximately a third resulting in the imposition of Community Payback Orders with 2-year Caledonian Requirements. Where a Supervision Requirement is imposed without a Caledonian requirement me will still be supervised by Caledonian trained workers because of the nature of the offence.

Table 6 shows the drop in assessments in 20/21 when court business was greatly reduced and a gradual increase in assessments and orders the following year. Domestic abuse accounts for a significant amount of the workload across the service for Admin, support work, social work, MARAC, MAPPA and Throughcare.

Table 6: Number of Caledonian Assessments undertaken, and Requirements imposed

	2019/20	2020/21	2021/22
Assessments	225	171	202
Orders	42	49	64

J) The national LS/CMI risk/needs assessment tool for JSW has been the subject of investigation following the discovery of glitches in the system and is under review by the Risk Management Authority and the Scottish Government. Aberdeen Justice Social Work have representation on the national LS/CMI user group to ensure appraisal of updates on tasks and progress as well as remedial actions for the Scottish Government to get back on track are undertaken, understood, and shared appropriately,

The computer-based system has been closed down since 01 March 2022 and we have been informed that the reporting function cannot be relied upon at this stage or until the outcome of the review and adaptations to the system complete. The current practice as advised by the Scottish Government is to utilise the paper-based system for this risk assessment. This has implications for resources as this takes considerably more time and the system will have to be updated with the paper-based assessments once operational. However, we are undertaking these assessments as required, the focus remains on completion of the LSCMI risk assessment within 20 days and the LSCMI case management plan being agreed with the individual accordingly.

Progress has been made in these areas but again affected by Covid and a lack of access to training which is a national issue. We have requested training from the Risk Management Authority in respect of assessment of Risk of Serious Harm Assessments and associated Risk Management Plans, but no dates have yet been offered.

To reduce offending by promoting desistance

The essence of this objective is our JSW value base. This is what we do day-in and day-out and what we did to the best of our ability despite the impact of the pandemic. We prioritised, assessed, supported and sometimes fed. We gave out phones so that we could remain in contact with individuals. When we couldn't do home visits we chapped on doors and remained at a social distance as required, sometimes we walked and talked together. We worked creatively to overcome Covid challenges including unpaid workers making garden play equipment for nurseries in their homes. We delivered food for CFine and Social Bite. We also worked alongside SPS, Housing and Substance Misuse services to ensure that everyone leaving prison had accommodation, medication, and support.

K) "Desistance is the process of abstaining from crime amongst those who previously had engaged in sustained offending." It is neither quick nor easy and can take a considerable time to change thinking, behaviours and underlying problems. Desistance research emphasises the need to: adopt an individualised approach; develop positive relationships as individuals are influenced to change by those whose advice they respect and whose support they value; recognise and build on people's strengths.

L) It is important that individual outcomes as well as statutory outcomes are achieved as a result of the engagement between our staff and the individuals that they supervise and support. We know that many, if not most of our clients have experienced bereavement and adversity in childhood which has significantly impacted on their thinking and behaviour. We are very aware of the need to listen to our clients as to what works for them and seek their views on how they think services could be improved. We are also very mindful of the factors that have led people to offend and seek to reduce the influence of these on an individual's behaviour. Getting feedback about what has worked is beneficial to the ongoing improvement of our person-centred service delivery.

M) For Covid related reasons we were only able to gather feedback from 80 Exit Questionnaires in 2020-21 (51 Supervision and 29 Unpaid Work) and 157 Exit Questionnaires in 2021-22 (56 Supervision and 101 Unpaid Work) and the content may

be skewed by changes to JSW service delivery and difficulty in accessing other services during the pandemic.

The Exit Questionnaire stand out headline would have to be that be that in 2021/22, 90% of JSW clients reported improvement in at least one area. It is also significant that, in a time of considerable stress, clients reported that their mental health and coping skills had improved, likely attributable to the support that they had received. There was a drop in improvements in relation to Drugs and Alcohol, possibly due to increased use during Covid and /or difficulty in accessing specialist services, and a reported deterioration in Personal Relationships, again likely to be Covid related. Some improvements are also potentially attributable to Covid, so, for example Education and Employment scored highly in 21/22 when we were "opening up" services again.

Table 7: Number of Exit Questionnaires and comparison of 'Before' and 'After' Supervision Improvements

	2020-21		2021-22	
UPW responses	29		101	
Supervision responses	51		56	
	People	Improvement	People	Improvement
People with issues at start of order/ % reporting improvement in at least one area	40	85%	42	90%
Housing	13	56%	20	66%
Education and Employment	7	46%	17	70%
Drugs	13	93%	13	77%
Alcohol	13	82%	8	75%
Personal Relationships	18	81%	25	62%
Self Esteem	25	73%	23	79%
Mental Health	27	53%	33	82%
Physical Health	8	50%	11	59%
Money Issues	10	52%	17	71%
Coping Skills	24	76%	25	89%

To promote the social inclusion of people with convictions

This objective is about improving outcomes for people in the justice system by intervening at the lowest possible level, providing both supervision and support, linking into other services and agencies as appropriate and, ideally, linking individuals into community supports in the longer term.

N) A Fiscal Work Order is a Direct Measure offered by the Procurator Fiscal as an alternative to Court and the numbers of these tend to fluctuate. Diversion from Prosecution is also an alternative to Court and in Aberdeen all 16/17 year olds are referred to Barnardo's while individuals aged 18 and over will be offered a bespoke service tailored to their individual needs. This is overseen, and may be delivered by JSW but clients are referred on to whatever service best meets their needs e.g. mental health, Children's services, ADA, housing. One of the Covid positives is that, in trying to reduce court backlogs, individuals

with slightly higher risk/ needs offending than previously are now being referred thus allowing us to assess and address underlying needs at an early stage. The use of Structured Deferred Sentences dropped during 20/21 but increased slightly last year and is continuing to rise. This disposal, particularly when imposed by the Problem-Solving Court, is again intended both as a lower level, albeit intensive, intervention and as a diversion from custody.

Table 8: Other Interventions

	19/20	20/21	21/22
Fiscal work orders	13	16	7
Diversion From Prosecution	114	150	168
Structured Deferred Sentence	25	11	30
Bail Supervision	45	4	26
Drug Treatment and Testing Order	7	0	13

O) One of the benefits of the past two years has been improved partnership working across a range of services and the challenge will now be to build on this further by developing a shared care model with mental health and substance misuse services. We have also commissioned services from Aberdeen Foyer to deliver Other Activity and Employability services and there are opportunities for wider collaboration and development through this service and Community Education and Learning.

7) Conclusion

As the report shows, we did our best in exceptionally challenging circumstances and due to the committed endeavours of the entire justice workforce, kept the service open throughout the year and prioritised the individuals we support according to the highest risk and greatest vulnerability.

As has been referenced earlier, particular highlights included an increase in diversion from prosecution, and structured deferred sentences, Unpaid Work striving to adjust its supports to meet the needs and requirements of the individuals that it works with, and the ongoing challenge posed by a significant increase in Caledonian caseloads.

The flexibility, pragmatism and innovative practice that was evident during this time was commendable even though every member of staff had their own personal pandemic circumstances to navigate.

As the country learns to live with Covid, it is worth acknowledging that we are not out of the woods yet as we continue to be impacted by court backlogs, the impact of new legislation and guidance, the recruitment and training issues, implications of the national breakdown of the LSCMI Risk/ Needs assessment database, the resource implications of introducing D365 and more.

However, on the plus side we have learned a lot from the past two years – some people communicate better on the phone, some can undertake unpaid work at home and there is likely to be more that we don't yet know.

It is likely that pandemic-related, whole-sector changes that are remaining in place and the introduction of new legislation in 2022 will mean that the Delivery Plan and the Performance Framework may need to be revised so that they continue to highlight the future direction of travel for the service and its continued effectiveness.

In conclusion, the justice social work service is confident that it will continue to provide robust, person-centred support that will keep our communities safe through the effective assessment and management of risk and also deliver positive individual and statutory outcomes by helping individuals address the impacts of the multiple disadvantages that they have experienced in and throughout their lives.

COMMUNITY

PAYBACK ORDER

ANNUAL REPORT

FINANCIAL YEAR: **2020/21**

LOCAL AUTHORITY: **Aberdeen City**

In this section, please report on the following:

- **The total number of unpaid work hours completed during the year;**
- **Types of unpaid work projects which have been carried out (list of bullet points will suffice); and**
- **One example that helps to demonstrate how communities benefited from unpaid work.**

We recognise that compliance with pandemic restrictions and related SG guidance significantly impacted on the capacity of services during the reporting year. (Max 300 words.)

- 32,153 – The total number of unpaid work hours on the 302 UPW and OA Requirements which were completed in the year, albeit that many of these orders will have been imposed in the previous year or before.
- The majority of these (74.2%) were completed before the reduction in hours applied.
- 30,000 – the actual number of "participation hours" undertaken in the year, a drop of approx. 47% on last year for Covid related reasons.
- Blended Learning Packs (BLP) - an educational approach allowing the individual the opportunity to reflect on how participating in UPW can be of benefit to the wider community and how being subject to an order helps the individual to appreciate the impact of their own behaviour upon their community.
- Woodwork design project – the success of the BLPs led to the development of other packs, both educational (with the help of our Adult Learning & Development colleagues) and practical woodwork projects designed in our UPW workshop, all of which could be completed at home.
- Home knitting projects – a niche project
- Landscaping, gardening, environmental projects
- Home workers also upcycled furniture, undertook blended learning packs, worked on art therapy books and undertook other projects as appropriate. We also restarted outdoor work as soon as we could in August 2020. Our thinking was that if we could support people to continue with their Unpaid Work and Other Activity and get them to complete their orders, then we wouldn't have so much of a backlog in the long run.

Example

- Our building is looking much better both inside and out. The garden is a safer area for children using it. We have also had lots of positive feedback from staff and service users about the improvement in the environment.

Quotes from both people subject to CPOs and the beneficiaries about the impact of the unpaid work on them and/or the community. (Again, bullet point will suffice - max 300 words.)

People Subject to CPOs

- "I really enjoyed my time at both Somebody Cares and the other place. Both were welcoming and made me feel like any volunteer. I am staying on as a volunteer as I enjoyed it so much. Something good came out of my personal nightmare."

- “Glad to be done and now get a job thanks to team.”
- “Was good to work with my task supervisor as he has changed my way of thinking. If I have done this for nothing he said I should be working even a job like we have been doing. Hope I won't be back.”
- “Gave me a sense of wellbeing and makes me want to get back to a full time job.”
- “Learn't to work in groups as a team and time is easier when you get the work done. I wasn't good in groups before. Now I want to work after doing that for nothing”
- “Enjoyed being helpful to elderly people and liked to interact with public service.”
- “Feeling good helping less fortunate people”
- “Art work can be given to community and sold etc. Community see I am paying price of offence etc”

Beneficiaries

The Team supported us by delivering hundreds of food parcels to our vulnerable beneficiaries across Aberdeen during Covid. It was an essential service that would not have been possible without the support of the UPW Team.

Outdoor benches were upgraded/repaired and additional items were made to support our Early Years practice outdoors. These included alphabet and number boards, wooden insect boards (children use these every day on their bug hunts), measuring sticks and boards for children to throw balls and beanbags through. These are also very well used. Pallets were also sanded and painted to ensure they were safe and protected.
The team went above and beyond making outstanding items for the nursery. They were very helpful and offered ideas and possibilities that we had not considered.
Our children have high quality bespoke resources that are supporting their continued learning and have improved our environment. I have already recommended the Team to other managers.

Types of "other activity" carried out as part of the unpaid work / other activity requirement. You may want to reflect on learning from new ways of working within other activity and the benefits of this. (Again, bullet point will suffice - max 300 words.)

- Blended Learning Packs
- Adult education
- Deliver food parcels
- Volunteer at gym
- Volunteer at playgroup
- Volunteer at charity
- Coaching young people
- Forklift training course
- Attendance at drug/ alcohol/ mental health services
- Online courses and activities – Resource library set up for workers to use with, or send to, clients

1. It is acknowledged that pandemic restrictions will have limited the local opportunities to consult on both the nature of/reduction in the capacity of unpaid work – however, if you were able to undertake this, how did you do so?
2. If you were unable to undertake this type of consultation, please advise how you organised the available unpaid work activity over the year, e.g. responding to requests from local COVID resilience committees, etc. (max 300 words).

- Sheriffs were updated regularly by email on status and delivery of JSW services.
- Covid related information in all JSWRs.
- Some consultation from January to March 2021 but less to do with requests for service and more to do with availability of suitable projects i.e. those that had sufficient space to maintain 2 metres, accessible on foot or by public transport, availability of welfare facilities etc. Projects identified by ACC Environmental Manager, schools and third sector.

The pandemic restrictions also affected access to wider support services which are provided by partners (e.g. drug and alcohol services, etc.). Please outline any significant issues which were identified for people involved with Justice Services and what was put in place to resolve matters relating to these issues, e.g. access to services, etc. (max 300 words).

JSW maintained face to face service for individuals who were high risk, vulnerable, released form court/custody throughout pandemic. Most other services were closed but evidence of good communication and information sharing to provide wraparound support for those in need. Weekly meetings with Prison, Housing, JSW, Drug/Alcohol services to ensure that accommodation, medication/ food in place on release.
When UPW closed to clients, Task Supervisors delivered food parcels across the city for Social Bite and CFine foodbank.

Any other relevant information not previously highlighted - this may include:

- **Learning from and/or comment on new ways of working and different benefits which were achieved.**
- **Examples of any work carried out with people on CPOs to address their offending behaviour.**
- **Examples of work carried out in partnership with 3rd Sector partners.**
- **Any other areas identified for improvement and planned next steps**
- **Any other relevant points you wish to highlight.**

(max. 300 words – bullet points only if preferred.)

Our learning / new ways of working / different benefits which were achieved and the changes we have incorporated into our daily practice.

Using our WFH approach, we found that certain individuals who would not normally have managed traditional placements in traditional settings completed many more

hours and completed their orders. This was successful with both men and women and specifically those with health, mental health, drug/alcohol and childcare issues.

Order supervisors maintained, and in some cases increased, contact by telephone with unpaid workers during lockdowns. This led to improved relationships as conversations were more about welfare and less about compliance.

Our WFH options also worked well for women who often do not manage male dominated settings. This has resulted in us creating a women's only Order/ Task Supervisor hybrid worker who only holds women's orders and has a much more hands on approach.

In addition, our move from a central sign in locus to a project locality sign in resulted in improved attendance of some clients due to smaller groupings.

COMPLETED BY: Lesley Simpson

DATE: 29th October 2021

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Delivery Plan Update June 2022

Objectives	Themes	Quality Indicators	Actions	Date	Comments
To contribute to the creation of safer and fairer communities	Collaboration with other Community Justice partners Community Empowerment Victim/Family/ Community Experiences and Opinions Contribute to prevention and early intervention	2.2 Impact on victims 2.3 Impact on families 4.1 Impact on the Community 9.4 Leadership of improvement and change	• The JSW service will continue to play a full and active part in appropriate Community Justice discussions and activities in relation to the LOIP.	2021-24	The JSW is actively contributing to the following charters: • My Way to Employment • Ensuring people on community sentences and liberated from prison have better access to services • Changing attitudes about domestic abuse in all its forms and ensuring victims receive access to the right support • Tackling Domestic Abuse • Access to mental health support • Increase [proportion of reported] Hate Crime • Reduce drug related deaths from custody
			• The JSW service will support the implementation of the partnership's new three-locality model so that it best meets the needs of JSW clients, victims and communities.	2021-24	Developments so far include: • JSW representatives attend locality meetings • Senior Social Workers from 3 CPO Teams aligned with localities • Unpaid Work Team undertaking work across all localities in response to need • Clients/ victims seen in their own localities as appropriate
			• We will seek the appropriate involvement of victims and families of the individuals with whom we work.	2022	Caledonian Women's Support Workers currently support 264 women in City and Shire. The number of Caledonian Programme Requirements on caseloads has increased by 35% in the past year with all associated victims (partners and ex-partners) offered support.

Objectives	Themes	Quality Indicators	Actions	Date	Comments
			• We will seek to increase staff confidence in the use of accredited assessment tools including the assessment and analysis of serious harm.	2021-22	Contact has been made with the Risk Management Authority and we await further training. Difficulties in accessing training is part of a national agenda.
			• Undertake a whole service needs analysis including a review of currently commissioned services to determine future third sector provision.	2021-22	Currently commissioned services will be gradually reviewed during the year to establish whether they are still fit for purpose in the post-Covid justice system and identify areas for change, development and improvement. The issue of commissioned services is part of the national agenda with consideration being given to national commissioning.
To fairly, effectively and proportionately implement court orders and release licences	Timely, person-centred and effective interventions Managing risk and maintaining close working relationships with partners in	5.1 Providing help and support when it is needed 5.2 Assessing and responding to risk and need 5.3 Planning and providing effective intervention	• We will strengthen our compliance in meeting expected timescales for assessments and case management plans.	2021	LSCMI risk/needs assessment should ideally be completed within 20days, although the system itself does not include a means to collect this information. LSCMI has now been moved from local authorities to a national server and we have asked the Justice Directorate to adapt the system so as to produce meaningful data reports for JSW Service Managers including compliance with 20 day timescales. Current glitches in the national system have meant that we have had to revert to paper-based assessments which will then have to be manually input when the issues are resolved. This has resource implications.
			• We will improve our consistency in undertaking 1st reviews within expected timescales.	2021	We are unable to demonstrate improvement in this area as yet due to Covid. We have however introduced new Review and QA Light processes in which are intended to improve the Review process.

Objectives	Themes	Quality Indicators	Actions	Date	Comments
	relation to individuals who pose high risk of harm and issues of public protection Fulfilling statutory duties	5.4 Involving people who have committed offences and their families 6.1 Policies, procedures and legal measures 6.4 Performance management and quality assurance	• We will improve our consistency in undertaking home visits in response to risk/ needs / disengagement	2022	The QA Light and Review process is intended to pick up issues around the appropriate use of home visits as early as possible.
			• We will improve the numbers of first induction/case management meeting taking place with 5 days of an Order being imposed.	2022	Improvement in this area has not been possible for Covid related reasons. More specifically because first contacts usually take place in the JSW office adjacent to the court and the court and office were closed for lengthy periods during lockdowns; working from home; limited interview space; staff/ client sickness; delays in paperwork; virtual court complications etc. Whilst we had managed to achieve 80% in 19/20, this was reduced to 60% in 21/22. We would hope to improve this in the current year as restrictions are relaxed but other changes to the system may have an impact.
			• Service effectiveness will be reported regularly to the JSW Best Practice group and Performance Management Board and appropriate improvements agreed in respect of this.	2021-24	These groups were impacted upon by Covid but are now set to be re-established on a quarterly basis. Previously identified improvements will require to be reviewed in the light of changes in the justice system; the introduction of new legislation and guidance (most notably around electronic monitoring and bail); staffing issues; backlogs and fatigue.
			• To improve their individual effectiveness, JSW teams will develop, where desirable/necessary, their own team-specific Improvement Plan. These will be monitored by the	2021-24	Improvement Plans are currently in place for Women's Services and Unpaid Work. These need to be reviewed post-Covid to ensure that their respective ambitions remain appropriate and achievable.

Objectives	Themes	Quality Indicators	Actions	Date	Comments
			Performance Management Board.		
			• We will be more consistent with our Quality Assurance and will strengthen our reporting of service matters to the Clinical and Care Governance group and committee and also the IJB as appropriate.	2021-24	Quarterly Audits are planned for 2022. There is an enhanced SW report, including the justice service provided regularly to the CCG group for its consideration and scrutiny.
To reduce offending by promoting desistance	Involvement of clients in service development/ improvement activities Building towards desistance	2.1 Impact on people who have committed offences	• We will improve the capture, analysis and use of qualitative data.	2022	Weekly, quarterly, annual and team specific data is currently produced but it is anticipated that the introduction of D365 in July 2022 will enable the production of more qualitative information.
			• We will improve our completion rates for Exit Questionnaires. We will also seek to capture better the views of those individuals who do not complete their Orders. We will evidence the improvements we are making from EQ and other feedback discussions.	2022	This is ongoing as the number of Exit Questionnaires completed in 2021/22 has been low – Unpaid Work 101; Supervision 56. Responses reflect people's experience of both JSW and the pandemic but the number of people who had issues at the start of their CPO and who reported improvement in at least one domain at the end was high at 88%. Highlights – the areas where most people reported improvement were: Drugs, Mental Health, Self-Esteem, Coping Skills Lowlights – least reported improvements were: Personal Relationships, Physical Health We are planning to review the format and use of the Current Exit Questionnaire system and to better involve service users in the development of the service.

Objectives	Themes	Quality Indicators	Actions	Date	Comments
			• We will improve the quality of our drug and alcohol assessments.	2022	Training to assist with this is planned for 2022.
			• Our social work practice will continue to be person-led, structured, resilient and flexible; Staff supervision will ensure that this practice is appropriate, supportive and working in the best interests of the individual whether statutory or voluntary.	2021-24	Staff supervision has been maintained throughout the pandemic, albeit virtually, plus a Senior Social Worker is available at all times for support, advice and guidance.
To promote the social inclusion of people who have committed offences	Complex, inter-dependent needs Alternatives to statutory orders	1.1 Improving the life chances and outcomes of people in the justice system	• We will seek to provide as part of our UPW Improvement Plan, more learning opportunities and placements which encourage meaningful links with the local community.	2021-24	Opportunities in this area were extremely limited due to the pandemic when third sector providers were for the most part closed. Whilst our Unpaid Work Team premises were closed during total lockdown, we attempted to restart activities as soon as it was safe to do so, albeit on a very limited basis. The UPW staff team were very creative in developing materials and meaningful tasks to enable unpaid workers to complete their Orders despite the pandemic. Please see attached CPO Annual Report which focuses primarily on the Unpaid Work element of Community Payback Orders in 20/21. The fact that some we managed to support some individuals to complete their orders has meant that we have less of a backlog than some other authorities.
			• Drugs and Alcohol training will be provided to the JSW workforce.	2021-24	As above, training is planned for 2022.

Objectives	Themes	Quality Indicators	Actions	Date	Comments
			• Mental Health training will be provided to the JSW workforce.	2021-24	This forms part of a LOIP Charter and is ongoing.
			• We will link with other services as appropriate to improve in particular, housing, health, employment and financial outcomes for the individuals with whom we work.	2021-24	The pandemic has had a positive effect on some aspects of joint working, most notably between JSW, Scottish Prison Service, Substance Misuse and third sector.
			• We will promote alternatives to statutory orders such as Bail Supervision, Diversion, Fiscal Work Orders, Problem-Solving and Structured Deferred Sentences.	2021-24	Covid had a major impact on all of these areas of work such that, numbers are only now picking up. New legislation and guidance around the use of Electronic Monitoring in a number of areas of work is due to commence on 17th May 2022. We will monitor the use, implementation, practice and wider impact on a quarterly basis.
			• Seek to raise public awareness of the role, remit and scope of Justice Social Work	2021-24	Community Justice Scotland is undertaking a profile-raising exercise in 2022 which will include JSW.