MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

Thursday, 13 December 2018

Inkwell Main, Elgin Youth Café

NOTICE IS HEREBY GIVEN that a Meeting of the **Integration Join Board Audit, Performance and Risk Committee** is to be held at **Inkwell Main, Elgin Youth Café**, **Francis Place, Elgin, IV30 1LQ** on **Thursday, 13 December 2018** at **13:00.** to consider the business noted below.

AGENDA

MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

MEMBERSHIP

Dame Anne Begg (Chair)	Non-Executive Board Member, NHS Grampian
Councillor Tim Eagle	Moray Council
Councillor Louise Laing	Moray Council
Mrs Susan Webb	Executive Board Member, NHS Grampian

NON-VOTING MEMBERS

Ms Elidh Brown	tsiMORAY
Mr Steven Lindsay	NHS Grampian Staff Partnership Representative

ADVISORS

Ms Tracey Abdy	Chief Financial Officer, Moray Integration Joint Board
Ms Pamela Gowans	Chief Officer, Moray Integration Joint Board
Mr Atholl Scott	Chief Internal Auditor, Moray Integration Joint Board

Clerk Name: Caroline Howie
Clerk Telephone: 01343 563302
Clerk Email: caroline.howie@moray.gov.uk

MINUTE OF MEETING OF THE INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

Thursday, 27 September 2018

Inkwell Main, Elgin Youth Café, Francis Place, Elgin, IV30 1LQ

PRESENT

Ms Tracey Abdy, Ms Elidh Brown, Councillor Tim Eagle, Ms Pam Gowans, Councillor Louise Laing, Mr Steven Lindsay, Mr Atholl Scott, Mrs Susan Webb

APOLOGIES

Dame Anne Begg

IN ATTENDANCE

Mr Dafydd Lewis, Senior Auditor and Mrs Caroline Howie as clerk to the Committee, both Moray Council.

1 Chair

Mrs Webb took the position of Chair in the absence of Dame Anne Begg.

2 Declaration of Member's Interests

There were no declarations of Members' interests in respect of any item on the agenda.

3 Minute of Meeting dated 26 July 2018

The Minute of the meeting dated 26 July 2018 was submitted and approved.

4 Action Log of Meeting dated 26 July 2018

The Action Log of the meeting dated 26 July 2018 was discussed and it was noted

that all items had been completed.

5 Strategic Risk Register - September 2018

A report by the Chief Officer (CO) provided an overview of the current strategic risks, along with a summary of actions in place to mitigate those risks, updated as at September 2018.

It was advised that NHS and Moray Council use 2 different systems to record information and investigations are ongoing looking into how information can be combined.

Discussion took place on the risks involved in relation to the CO taking on an executive leadership role covering Dr Gray's Hospital. The CO advised she would present a report in November that would provide answers to queries raised.

There was further discussion on the nature of the actions and how they are being addressed and a request was made for a report to be presented in November outlining plans to refine actions and thereafter a further report being presented in March 2019 advising progress.

Thereafter the Committee agreed to:

i. note the updated Strategic Risk Register;

ii. task the CO with presenting a report in November in relation to her executive leadership role at Dr Gray's Hospital; and

iii. task the Corporate Manager with presenting a report in November on plans to address actions, with a further report in March 2019 advising progress.

6 Quarter 1 (April - June 2018) Performance Report

A report by the Chief Officer provided an update on the performance of the Moray Integration Joint Board as at Quarter 1 (April - June) 2018/19.

Lengthy discussion took place on the indicators detailed in appendix 1 of the report and how performance is visualised and a further report was requested for the next meeting in December. More detail was requested on actions to address the five indicators showing as red in the appendix.

Thereafter the Committee agreed to:

i. note the performance of local indicators, linked to strategic priorities for quarter 1 (April - June 2018) in appendix 1 of the report and the detailed analysis

contained within appendix 2 of the report;

ii. approve the proposal for a future report outlining the issues pertinent to Moray around unscheduled care; and

iii. seek a further report to the meeting in December with more detail on the five indicators showing as red in appendix 1 of the report.

7 NHS Grampian Internal Audit Report - Integration Joint Board Performance Reporting and Key Performance Indicators

A report by the Chief Financial Officer presented a summary of findings from a recent NHS Grampian internal audit review carried out by PricewaterhouseCooper. The audit assessed the performance reporting and Key Performance Indicator processes of the three Integration Joine Boards within the Grampian Health Board area.

Discussion took place on the process for bringing the report to Committee and how actions required are recorded and by exception reported back to Committee. The Chief Financial Officer agreed to consider a process for providing this assurance to the Committee.

Under the Management comment on page 3 of appendix 1 of the report it was advised that where it refers to comment by the councils this should refer to comment by the Integration Joint Boards.

The Chair undertook to write to the NHS Grampian Committee to highlight disappointment that this was noted incorrectly.

Thereafter the Committee agreed to:

i. note the findings from the audit, attached as appendix 1 to the report;

ii. note the management responses to the audit recommendations and timescales outlined in appendix 1 of the report;

iii. task the Chief Financial Officer with developing an assurance process for the Committee on monitoring and exception reporting actions arising from audits; and

iv. task the Chair with writing to the NHS Grampian Committee to highlight disappointment that the Management comment was listed as being from the council and not the Integration Joint Board.

8 Internal Audit Plan

Under reference to paragraph 5 of the Minute of the meeting of the Audit and Scrutiny Committee of Moray Council dated 23 May 2018 a report by the Chief Internal Auditor provided information on the proposed internal audit coverage for completion in the current 2018/19 financial year.

Following consideration the Committee agreed to the proposed audit coverage.

9 Internal Audit Update

Under reference to paragraph 9 of the draft Minute of the meeting of this Committee dated 26 July 2018 a report by the Chief Internal Auditor provided an update on audit work concluded since the last meeting of the Committee.

Discussion took place on what is done in respect of following up actions to ensure they have been completed. It was advised actions were followed up by the senior management team and that no formal reporting to Committee was undertaken as reporting was by exception.

Following further discussion it was agreed a further report, to the next meeting, would allow Committee to understand what needed addressed and what processes were in place to ensure actions had been undertaken.

Thereafter the Committee agreed to:

i. note the contents of the update report together with the completed audit reviews; and

ii. seek a further report, to the next meeting.

MEETING OF MORAY INTEGRATION JOINT BOARD

AUDIT, PERFORMANCE AND RISK COMMITTEE

THURSDAY 27 SEPTEMBER 2018

ACTION LOG

ITEM NO.	TITLE OF REPORT	ACTION REQUIRED	DUE DATE	ACTION BY
1.	Strategic Risk Register – September 2018	Report required in relation to Chief Officer's executive leadership role at Dr Gray's Hospital. Report to next meeting on plans to address actions. Report to meeting in March 2019 advising progress on plans to address actions.	Dec 2018 Dec 2018 Mar 2019	P Gowans J Netherwood J Netherwood
2.	Quarter 1 (April – June 2018) Performance Report	Report required outlining the issues pertinent to Moray around unscheduled care. Report giving more detail on the five indicators showing red in appendix 1 of the report.	Mar 2019 Dec 2018	P Gowans P Gowans
3.	NHS Grampian Internal Audit Report – Integration Joint Board Performance Reporting and Key Performance Indicators	Develop an assurance process for the Committee on monitoring and exception reporting actions arising from audits. NHS Grampian Committee to be written to highlighting disappointment that the Management comment was listed as being from the council and not the Integration Joint Board.	Dec 2018 Oct 2018	T Abdy S Webb
4.	Internal Audit Update	Further report to the next Committee.	Dec 2018	A Scott

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 13 DECEMBER 2018**

SUBJECT: **INTERNAL AUDIT UPDATE**

BY: **CHIEF INTERNAL AUDITOR**

1. REASON FOR REPORT

1.1 To provide an update on audit work concluded since the last meeting of this Committee.

2. RECOMMENDATION

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

i) considers and notes the contents of this update report: and

ii) notes that a further report relating to payroll testing will be presented to this committee in March 2019.

3. BACKGROUND

3.1 At the meeting of this Committee on 27 September 2018, planned internal audit coverage was considered for the remainder of financial year 2018/19 (paragraph 8 of the draft Minute refers). In forming the plan, it was recognised that the operational delivery of services within the health board and local authority as directed by the Moray Integration Joint Board (MIJB) continues to be covered by their respective internal audit arrangements.

3.2 Thus, in addition to the work of the council's internal audit team, the Committee also receive copies of audit reports completed by PricewaterhouseCoopers (PwC) for the Health Board where these have a bearing on the MIJB. Two such reports are imminent, one on Health and Social Care Governance structures and a second on the Unscheduled Care Discharge Process (including interaction with IJBs). For this latter review, consideration was given to whether some form of joint audit input would be appropriate with the discharge process extending across hospital and community services but at this stage audit plans are separately developed. It should be possible however to align audit work in the community to any outcomes from the PwC review and this will assist ultimately in bringing the audit planning arrangements closer where appropriate.

3.3 In relation to this plan an agreed audit input of 80 days was made available by the council for audits relating to the MIJB and Social Care described as follows.

- **Learning Disabilities (Commissioning):** Under the headings of Commissioning and Specialist Services internal audit selected budgets totalling £7.1 million for review and established that while there are adequate audit trails for expenditure incurred there have been delays in updating procurement contracts with service providers. Existing contracts having been extended sometimes on more than one occasion, and there is a recognition that these no longer remain fit for purpose. The service is being supported by the council's procurement team but has made limited progress in its endeavours to ensure that the services commissioned are best aligned to the needs of service users. While this work is recognised a priority area it will need to be taken forward alongside other workloads. Further information is provided as **Appendix 1**.

- **Payroll Testing:** Aside from procured services staffing costs are a major element of the MIJB's costs and typically annual audit plans will include some payroll testing to confirm the veracity of employee costs. In this current year to date the following work has been undertaken:

  - Collated overtime analysis – not of large scale and in expected areas of home care and supported accommodation facilities;
  - Looked at Independent Living Service – on analysis this is the Home from Hospital Team of Home Carers and therefore similar to mainstream Home Care covered in prior year audit;
  - Analysed staff costs for the Hospital Discharge Team – the team of social workers providing liaison from acute discharge to community. (to potentially link with the PwC work described above);
  - Analysed staff costs for council funded Mental Health care staff – This is the team at Pluscarden Clinic providing support for adults with mental health issues in the community. A service review in this area is also ongoing and progress on this will inform the timing of further testing of these costs.
  - Reviewed staff costs for Employment Support Services and Moray Resource Centre which are prominent costs in these service areas.

  With the council having recently introduced a new payroll system, a prior control that involved circulating staff lists to budget managers for checking was temporarily ceased, therefore, this coverage is designed to provide assurances that employee cost allocations in the ledger are correct. This will be the subject of a more detailed report to the March Committee.

- **Contributions Policy**: This work is to review a sample of financial assessments for service users to confirm the correct and consistent application of the contributions policy and is still to commence.

- **Governance Review**: This is an annual requirement to inform the audit opinion on the governance arrangements linked to Scottish Government guidance and best value requirements and will take place towards the end of the financial year so as to be able to conclude on governance arrangements for the full year. The work of PwC in this area will in part inform this review.

- **Self-Directed Support (SDS):** This work takes the form of ongoing participation in a service development working group. Recently this has included advice on how to progress recovery of funds from service users or their representatives where SDS funds are accumulated and are then not applied for the intended purposes, for example where a contingency element has been used for additional care not within the agreed support plan. In a single high value case an amount of £10K was recovered. A meeting also took place with inspectors from the Care Inspectorate to discuss Internal Audit involvement in the SDS process.

- **Additional Work:** unscheduled work was also undertaken to consider future management arrangements of a corporate bank account operated by the council. This is used to transact funds for service users who lack capacity and who have no personal representatives that can assist. This at a time when both the council's banking manager and community care finance officer are leaving or have left employment of the council. The audit team are also looking at non payroll costs and recoveries associated with the Employment Support Services and Moray Resource Centre given they are limited in scope and unlikely to be picked up in any other audit reviews.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 This report provides an update on audit work in progress and further information will be provided as and when projects are progressed and recommendations agreed with management.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

Internal audit work supports good governance and assists in securing appropriate systems of internal control.

(b) Policy and Legal

Internal audit provides independent assurances in line with Integrated Resource Advisory Group guidance

(c) Financial implications

No direct implications

(d) Risk Implications and Mitigation

Audit reports highlight risk implications and contain recommendations for management to address as a means of mitigating risk.

(e) Staffing Implications

No implications

(f) Property

No implications

(g) Equalities/Socio Economic Impact

No implications

(h) Consultations

Relevant staff are consulted during completion of audit work. There have been no direct consultations in respect of this report.

6. CONCLUSION

6.1 This report provides Committee with an update on progress towards completion of the audit work on topics contained within the annual audit plan.

Author of Report: Atholl Scott
Background Papers: Internal audit files
Ref: MIJB/aprc/131218

LEARNING DISABILITIES – AUDIT PROJECT 18'008

INTERIM EXECUTIVE SUMMARY

The Moray Integration Joint Board (MIJB) annual audit plan for 2017/18 included a project relative to commissioning of services; specifically for service users with Learning Disabilities (LD). The objective of the audit was to consider the effectiveness of current contracts in place and of monitoring and review procedures.

In terms of scale, the MIJB made provision of some £15 million for LD services in 2017/18 broadly split across three categories, provider services at £2.4 million, commissioning contracts being the scope of this audit at £7.1 million and specialist services at £5.3 million. Internal audit conducted an analysis of these costs to determine the scope of service provision, much of which is being delivered through contracts placed with private sector providers. These contract arrangements have been extended a number of times, and for the most part have been identified by service management as in need of urgent review due to commissioned services no longer meeting service user needs. Interim contract arrangements are currently in place due to the expiry of a vast number of contracts at the end of 17/18 and will be reviewed in line with the transformational programme being conducted for the majority of externally provided services.

The Transformation of LD services programme has been underway since 2016 and involved the engagement of specialist consultants to inform the scope of service provision the MIJB now needs to secure in order to meet future service demands. LD have prioritised the contracts which there is most need to move to a re-designed provision to meet the needs of service users, and the decommissioning of existing services and recommissioning of new services will follow according to a timeline operating until 2021. The new commissioning process will have an outcome focused approach recognising the lack of effective contract and performance monitoring in previous periods.

Change management is essentially for the service to take forward, however, internal audit can take an interest in the process as it progresses, through a review of decision making and procurement processes or testing of expenditure incurred in delivery of services. At this stage in the process, an audit exercise has been undertaken to sample expenditure incurred during 2017/18 to provide assurances that the funding used has been correctly authorised, controlled and applied to meet the assessed needs of service users. This has been done through a review of three LD contracts, costing MIJB £2.3 million for the year, and seeking confirmation that the payments made to these service providers are proper payments due and payable by the MIJB.

Work meantime continues to modernise service provision in a manner which recognises changed expectations, for example, arising from personalisation, while managing cost pressures and seeking to secure optimal care solutions for users of LD services.

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 13 DECEMBER 2018**

SUBJECT: **INTERNAL AUDIT REPORTS – FOLLOW UP PROTOCOL**

BY: **CHIEF INTERNAL AUDITOR**

1. REASON FOR REPORT

1.1 To address the request made at the last meeting of the Moray Integration Joint Board (MIJB) Audit, Performance and Risk Committee on 27 September 2018 for a follow up protocol to be drafted, covering oversight and monitoring of the implementation of audit recommendations agreed by management. (Para 9 of the draft Minute refers)

2. RECOMMENDATION

2.1 It is recommended that the Committee considers and agrees the 'follow – up' protocol for ensuring the effective implementation of internal audit recommendations.

3. BACKGROUND

3.1 Public Sector Internal Audit Standards require the Chief Internal Auditor 'to establish and maintain a system to monitor the disposition of results communicated to management'. In practical terms this means that internal audit must establish a follow up process to monitor and ensure that management actions (responses to audit recommendations) have been effectively implemented or that management has accepted the risk of not taking action.

3.2 The audit action plan prepared to accompany each audit report issued provides information on the recommendations made, the responses from management and the timescales in which the recommendations shall be implemented.

3.3 The implementation of the recommendations is for management, and it is for management to determine whether or not to report on progress being made on addressing audit points or the consequences thereof to this Committee. It

is expected that such reporting would be by exception should any issues arise, or it is agreed that Committee would benefit from regular updates on the progress undertaken around the implementation of particular recommendations.

3.4 The Chief Internal Auditor will depending on workloads, report to this Committee on follow up work undertaken ordinarily after the last date for implementation of the agreed recommendations has passed. Such reporting will detail where evidence confirms recommendations have been implemented, and also instances where the implementation has not proved possible within the agreed timescale.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 In securing good governance and ensuring recommendations arising from internal audits are implemented effectively an audit follow up process is required.

4.2 Establshment of this protocol also is good practice in terms of demonstrating compliance with the Public Sector Internal Audit Standards.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

No issues to report.

(b) Policy and Legal

An effective audit follow up process supports good governance and use of audit resources.

(c) Financial implications

There are no financial implications arising directly from this report.

(d) Risk Implications and Mitigation

Following up audit recommendations mitigates the risk that any improvements to the internal control environment arising from the audits will be lost.

(e) Staffing Implications

None arising from this report.

(f) Property

None arising from this report.

(g) Equalities/Socio Economic Impact

None arising from this report.

(h) Consultations

Consultations have taken place with Tracey Abdy, Chief Financial Officer, whose comments have been incorporated within the report.

6. CONCLUSION

6.1 The Committee is asked to consider and agree the procedure for following up the implementation of recommendations contained within internal audit reports.

Author of Report: Atholl Scott
Background Papers: Public Sector Internal Audit Standards
Ref: IJB/aprc/131218

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 13 DECEMBER 2018**

SUBJECT: **STRATEGIC RISK REGISTER – DECEMBER 2018**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1 To provide an overview of the current strategic risks, along with a summary of actions which are in place to mitigate those risks, updated as at November 2018.

2. RECOMMENDATION

2.1 It is recommended that the Audit, Performance and Risk Committee consider and note the updated Strategic Risk Register.

3. BACKGROUND

3.1 The strategic risk register is reviewed regularly as part of a robust risk monitoring framework, to identify, assess and prioritise risks related to the delivery of services in relation to delegated functions, particularly any which are likely to affect the delivery of the Strategic Plan.

3.2 The Moray Integration Joint Board (MIJB) Strategic Risk Register is attached to this report as **APPENDIX 1** which sets out the inherent risks being faced by the MIJB, together with a current assessment on the level of the risks and any mitigation actions being taken to reduce the impact of the risks.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Risk scores are weighted based on assessment according to their likelihood and corresponding impact as per Section 5 of MIJB Policy.

4.2 Changes such as inclusion or removal from the register are agreed by the Chief Officer and Senior Management Team before submission to Audit, Performance and Risk Committee for review.

4.3 Strategic Risks will be reviewed as we develop the new Strategic Plan for 2019-2022 and this document will be revised accordingly.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

The MIJB requires effective governance arrangements for those services and functions delegated to it and Risk Management systems are included in this.

(b) Policy and Legal

As set out in the terms of reference, this Committee has responsibility to provide assurance of the adequacy of the risk management framework.

There are no legal implications arising from this report.

(c) Financial implications

There are no direct financial implications arising from this report however the Committee should note the failure to manage risks effectively could have a financial impact for the MIJB.

(d) Risk Implications and Mitigation

This report forms part of the governance arrangements for identifying and managing strategic risks of the IJB.

(e) Staffing Implications

There are no staffing implications arising from this report.

(f) Property

There are no property implications arising from this report.

(g) Equalities/Socio Economic Impact

An Equalities Impact Assessment has not been completed because there are no service, policy or organisational changes being proposed.

(h) Consultations

Consultations have been undertaken with the Chief Financial Officer and Chief Internal Auditor and comments have been incorporated in this report.

6. CONCLUSION

6.1 This report recommends the Committee note the revised and updated version of the Strategic Risk Register.

Author of Report:	Jeanette Netherwood, Corporate Manager
Background Papers:	held by author
Ref:	

HEALTH AND SOCIAL CARE MORAY STRATEGIC RISK REGISTER

AS AT DECEMBER 2018

1

RISK SUMMARY

1. The Moray Integration Joint Board (MIJB) does not function as set out within the Integration Scheme, Strategic Plan and in-line with Standing Orders and fails to deliver its objectives or expected outcomes.
2. There is a risk of MIJB financial failure in that the demand for services outstripping available financial resources. Financial pressures being experienced by the funding Partners will directly impact on decision making and prioritisation of MIJB
3. Inability to recruit and retain qualified and experienced staff whilst ensuring staff are fully able to manage changes resulting from integration.
4. Inability to demonstrate effective governance and effective communication with stakeholders.
5. Inability to deal with unforeseen external emergencies or incidents as a result of inadequate emergency planning and resilience.
6. Risk to MIJB decisions resulting in litigation/judicial review. Expectations from external inspections are not met.
7. Inability to achieve progress in relation to national Health and Wellbeing Outcomes. Performance falls below acceptable level.
8. Risk of major disruption in continuity of ICT operations including data securitybeing compromised.
9. Requirements for ICT and Property are not prioritised by NHS Grampian and Moray Council.

RISK RATING	LOW	MEDIUM	HIGH	VERY HIGH
RISK MOVEMENT	DECREASE	NO CHANGE	INCREASE	

The process for managing risk is documented out with the MIJB Risk Policy.

1		
Description of Risk: *Political*	The Integration Joint Board (IJB) does not function as set out within the Integration Scheme, Strategic Plan and Scheme of Administration and fails to deliver its objectives or expected outcomes.	
Lead:	Chief Officer	
Risk Rating:	Low/ medium/ high/ very high	**HIGH**
Risk Movement:	Increase/ decrease/ no change	**NO CHANGE**
Rationale for Risk Rating:	Change in membership of IJB committees following change in Moray Council political balance in July and subsequent changes in membership due to retirals and long term sickness of two members. Management capacity to fully complement structure	
Rationale for Risk Appetite:	The MIJB has zero appetite for failure to meet its legal and statutory requirements and functions.	
Controls:	• Integration Scheme. • Strategic Plan. • Governance arrangements formally documented and approved. • Agreed risk appetite statement. • Performance reporting mechanisms. • Consultation with legal representative for all reports to committees and attendance at committee for key reports.	
Mitigating Actions:	Induction sessions will be held for new IJB members. IJB voting member briefings are held regularly. Conduct and Standards training held for IJB Members July 18 SMT regular meetings and directing managers and teams to focus on priorities. Strategic Plan is being reviewed for implementation with effect from 1 April 2019. New organisation structure and wider system re-design and transformation governance structures being developed for implementation at the same time	
Assurances:	• Audit, Performance and Risk Committee oversight and scrutiny. • Reporting to Board.	
Gaps in assurance:	None known	
Current performance:	Scheme of administration is reported when any changes are required. Report outlining the development of the transformation plan and the Strategic Planning and Commisioning Group	

	providing oversight was presented and approved by MIJB on 29 November 2018.
Comments:	Draft Performance Management Framework, aligned to strategic planning and resources was presented to MIJB (Jan 18). Framework is under further development and Implementation is being progressed through HSCM Performance meetings. The Framework will continue to be developed as we confirm our new organisational structure and alignment to the new Strategic Plan will be a key focus. A report will be presented to MIJB in March 2019.

2		
Description of Risk: *Financial*	There is a risk of MIJB financial failure in that the demand for services outstripping available financial resources. Financial pressures being experienced by the funding Partners will directly impact on decision making and prioritisation of MIJB	
Lead:	Chief Officer/Chief Financial Officer	
Risk Rating:	Low/ medium/ high/ very high	**VERY HIGH**
Risk Movement:	Increase/ decrease/ no change	**NO CHANGE**
Rationale for Risk Rating:	The impact of funding cuts from both Moray Council and NHS Grampian in previous years are still being felt. Funding cuts from Moray Council have been significant 2017/18 (£1.3m) and 2018/19 (£1.759m Gross). NHS Grampian provided no uplifts for pay and price increases in 2017/18 creating increased pressure. Financial settlements are set to continue on a one year only basis which does not support sound financial planning Demand on services continues to rise and the IJB has no remaining reserves to be utilised. At the end of Qtr 2 in the 2018/19 financial year the IJB is showing a £1.9m overspend on core services. At Qtr 2 the financial forecast to the end of the financial year shows an overspend on core services of £3m and after consideration of slippage on strategic funds this is reduced to £1.4m. A recovery plan has been developed and agreed with the Finance Directors in the partner organisations and will be monitored closely. The financial risk to the Partners in the event of an overspend has been agreed and the split of the final overspend to be met by the partners will be 63% NHSG and 37% Moray council.	
Rationale for Risk Appetite:	MIJB recognises the pressures on the funding partners but also recognises the significant range of statutory services and nationally agreed contracts it is required to deliver on within that finite budget. MIJB has expressed a zero appetite for risk of harm to people.	
Controls:	Chief Finance Officer appointed - this role is crucial in ensuring sound financial managementand supporting financial decision making, budget reporting and escalation. Savings Plan presented to MIJB in March 2018. Further Savings have been presented in June 2018 in progression towards a balanced budget for 2018/19. Corrective action has been implemented through correspondence with budget	

	holders and increased scrutiny at senior management level.
Mitigating Actions:	Risk remains that the MIJB can deliver transformation and efficiencies at the pace required. Financial information is reported regularly to both the MIJB and Senior Management Team. The Chief Officer and Chief Financial Officer (CFO) continue to engage in the budget setting processes of both NHS Grampian and Moray Council to outline the significance of reduced funding and lack of investment and the subsequent risk to the partners as part of the risk sharing arrangement that exists. In an attempt to lessen the anticipated overspend – budget restrictions have been applied and communicated to all service managers for onward distribution to budget managers. Budget restrictions include the implementation of a higher level of authorisation for single items of expenditure over 5k (head of service) and 10k (senior management team). Senior management team scrutiny of vacancies and emerging pressures. Chief Officer and CFO will continue to engage with the partner organisations in respect of the forecast of overspend, corrective action and a recovery plan during 2018/19.
Assurances:	MIJB oversight and scrutiny of budget. Reporting through MIJB, NHS Grampian Board and Moray Council.
Gaps in assurance:	None known
Current performance:	Indicative budget for 18/19 was approved to allow services to continue on 29 March 2018 by MIJB members. The indicative budget showed a budget shortfall of £4.5m. A further paper was presented to the board on 28 June 2018 displaying a reduced budget shortfall of £3.3m. The forecast overspend to the end of the financial year as at Qtr 2 after consideration of strategic funds is £1.438m
Comments:	Senior managers to work with Chief Officer and Chief Financial Officer to address the continuing financial challenge and forecast overspend. Through reporting, regular updates will be provided to the MIJB, Moray Council and NHS Grampian as part of the risk sharing arrangement in place.

3		
Description of Risk: *Human Resources (People):*	Inability to recruit and retain qualified and experienced staff whilst ensuring staff are fully able to manage change resulting from Integration	
Lead:	Chief Officer	
Risk Rating:	Low/ medium/ high/ very high	**MEDIUM**
Risk Movement:	Increase/ decrease/ no change	**NO CHANGE**
Rationale for Risk Rating:	Increasing workload experienced – being managed by recruiting to senior posts however the process for recruitment is proving timeconsuming through NHS processes, due to the number of posts required to be filled time as a result of the short term transformation funding. The impact of budgetary decisions by the Council in relation to staffing levels in some key areas for Health and Social Care Moray (HSCM) will not be fully known until after 12 December 2018	
Rationale for Risk Appetite:	The MIJB is acutely aware of the lean management team in place and the strain this can place on the wider system.	
Controls:	Management structure in place with updates reported to the MIJB. Organisational Development and Workforce Plans have been developed and aligned with service priorities. Continued activity to address specific recruitment and retention issues. Management competencies being developed. Communication Strategy developed and approved in June 2017 with the associated commitments are progressing as anticipated. Incident reporting procedures in place per NHSG and Moray Council arrangements. Council and NHS performance systems in operation with HSCM reporting being further developed. SMT review vacancies and approve for recruitment	
Mitigating Actions:	System re-design and transformation. Support has been provided from NHSG with transformation and our co-ordinated working with Dr Grays in a one system – one budget approach. Management Structure continues to be progressed and an update will be presented to the MIJB development session on 13 December. Joint Workforce Planning. Lead Managers are involved in regional and national initiatives to ensure all learning is adopted to improve this position.	

	Lead Managers and Professional Leads are linked to University Planning for intakes and programmes for future workforce development.
Assurances:	operational oversight by Moray Workforce Forum and reported to MIJB.
Gaps in assurance:	joint or single system not yet agreed for incident reporting.
Current performance:	iMatter survey undertaken during July 2018 across all operational areas. Insufficient responses from some services has meant that action plans have not been developed. This is to be addressed through Operational Management Team. Representation on NHS Grampian's HSE Expert Group and operational H&S meeting established in HSCM Organisational Development Plan presented and approved at MIJB in January 2018.
Comments:	Regular reporting and management control in place The Workforce plan will be developed and aligned with the strategic plan 2019- 2022

4		
Description of Risk: *Regulatory:*	Inability to demonstrate effective governance and effective communication with stakeholders.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Locality planning assessed as medium in relation to ability to work at the pace required and current workforce capacity. Performance framework to be further developed from a planning perspective to show the links through operational service delivery to strategic objectives.	
Rationale for Risk Appetite:	The MIJB has a low risk appetite to failure.	
Controls:	Annual Governance statement produced as part of the Annual Accounts 2017/18 and submitted to External Audit by the statutory deadline Performance reporting mechanisms in place and being further developed through operational performance management group Community engagement in place for key projects areas such as Forres with information being made available to stakeholders and the wider public via HSCM website	

Mitigating Actions:	Schedule of Committee meetings and development days in place and taking place. Good working relationship established with Audit Scotland, the MIJB's appointed external auditors since 16/17. The second Annual Performance Report published in August 2018. Lessons learned will be addressed and incorporated into the approach for the production of the 2018/19 Report.
Assurances:	Oversight and scrutiny by Clinical and Care Governance Committee, Audit Performance and Risk Committee and MIJB.
Gaps in assurance:	Development session held by Clinical and Care Governance Committee on 29 November 2018 to identify areas that they wish to see covered at Committee in future reports. This will be taken forward and a programme will be developed for 2019/20
Current performance:	Communications Strategy developed and approved by MIJB in June 2017. Annual Performance Report 2017/18 published August 2018 Draft Annual Accounts (2017/18) published by the statutory deadline of 30 June. Audited Accounts published 27 September 2018
Comments:	NHS Grampian Senior Leadership Team are developing their framework for governance and HSCM are fully engaging and participating in this process.

5		
Description of Risk: *Environmental:*	Inability to deal with unforeseen external emergencies or incidents as a result of inadequate emergency planning and resilience.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**INCREASED**
Rationale for Risk Rating:	Resilience standards and implementation plan agreed however progress is behind target. Potential impact of Brexit is being assessed at a National level and have highlighted key areas for assessment. Work is being undertaken by NHS Grampian and Moray Council to assess potential issues on workforce and potential impacts resulting from supply chain disruption (medical supplies, energy/fuel supplies) as well as potential for increased civil disruption.	
Rationale for Risk	The MIJB understand the requirement to meet the statutory obligations set out within the Civil Contingencies Act.	

Appetite:	
Controls:	Surge Plan in place and has been tested alongside NHSG plans for winter. Lead Officer identified working alongside Emergency Planner. Local resilience plan developed. NHS Grampian Resilience Standards Action Plan approved (3 year). Business Continuity Plans in place for most services. Surge Plan developed and approved by MIJB 29 November 2018
Mitigating Actions:	Meeting of HSCM resilience group held on 4 December to consider and prioritise actions in relation to the Resilience standards. Pandemic awareness briefing by Maha Saeed, Consultant Lead, scheduled for 12 December for service managers across HSCM.
Assurances:	Audit, Performance and Risk Committee and NHS Grampian Civil Contingencies Group oversight and scrutiny.
Gaps in assurance:	Programme and implementation of Table top exercises for business continuity. Some progress has been made however further work required to address the targets in the implementation plan that have not been met. NHSG Civil Contingencies Group have highlighted some areas for action in relation to the Resilience standards
Current performance:	Many services have business continuity arrangements however the majority are overdue for an update. These updates will include consideration of the impact of a Pandemic following a briefing session to be held on 12 December 2018.
Comments:	Planning assumptions will be clarified to facilitate the production of service business continuity arrangements with regard to loss of electricity as a result of the increased risk assessment. The HSCM resilience group will schedule and review progress in achieving the NHSG resilience standards, reporting updates to Operational Management Team and by exception to Senior Management Team.

6		
Description of Risk: *Reputational*	Risk to MIJB decisions resulting in litigation/judicial review. Expectations from external inspections are not met.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Considered medium risk due to the reporting arrangements being relatively new	
Rationale for Risk Appetite:	The MIJB has some appetite for reputational risk relating to testing change and being innovative. The MIJB has zero appetite for harm happening to people.	
Controls:	Clinical and Care Governance (CCG) Committee established and future reporting requirements identified Links for operational Risk Registers being developed Complaints procedure in place Adverse events and duty of candour procedures in place and being actioned where appropriate. Reports from external inspections reported to appropriate operational groups and by exception to SMT for subsequent reporting to CCG or Audit Performance and Risk Committee as appropriate.	
Mitigating Actions:	This is discussed regularly by the three North East Chief Officers. Additional resource has been allocated to support the analysis of information for presentation to CCG committee	
Assurances:	Audit, Performanceand Risk and Clinical and Care Governance Sub-Committees oversight and scrutiny.	
Gaps in assurance:	Process for highlighting recurring themes or strategic expectations from external inspections requires further development to ensure Committee has sight of significant issues.	
Current performance:	External inspection reports are reviewed and actions identified.	
Comments:	Self Directed Support Thematic review by the Care Inspectorate took place during October 2018, awaiting the report	

7		
Description of Risk: *Operational Continuity and Performance:*	Inability to achieve progress in relation to national Health and Wellbeing Outcomes. Performance falls below acceptable level.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Potential impacts to the wide range of services in NHS Grampian and Moray Council commissioned by the MIJB arising from reductions in available staff resources as budgetry constraints impact. Unplanned admissions or delayed discharges place additional cost and capacity burdens on the service.	
Rationale for Risk Appetite:	Zero tolerance of harm happening to people as a result of action or inaction.	
Controls:	Performance Management reporting framework. Strategic Plan and Implementation Plan developed and approved. Performance regularly reported to MIJB. Revised Scorecard being developed. Best practice elements from each body brought together to mitigate risks to MIJB's objectives and outcomes. Chief Officer and SMT managing workload pressures as part of budget process.	
Mitigating Actions:	Service managers monitor performance regularly. Operational Performance Management Group are reviewing key performance indicators across HSCM services Delayed discharges and associated indicators are monitored closely via weekly "huddle" meetings and there is a monthly focus on aspects of unscheduled care.	
Assurances:	Audit, Performance and Risk Committee oversight. Operationally managed by OMT with strategic direction provided by SMT.	
Gaps in assurance:	None known	
Current performance:	Close monitoring and performance management in place. The process for production of the Strategic Plan 2019-22 is underway and will facilitate further linkages across	

	operational, Local and National Performance Indicators with progress in delivery of the National Outcomes as a clear focus.
Comments:	Regular and ongoing reporting. Performance monitoring and reporting under review to identify key performance indicators and appropriate owners.

8		
Description of Risk: *ICT*	Risk of major disruption in continuity of ICT operations, including data security, being compromised	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**MEDIUM**
Risk Movement:	increase/decrease/no change	**INCREASED**
Rationale for Risk Rating:	Corporate Information Security policies in place and staff are required to complete training and confirm they have read, understood and accept the terms of use.Impact of Brexit may result in disruption to energy supplies which could impact on continuity of ICT operations in the short term	
Rationale for Risk Appetite:	MIJB has a low tolerance in relation to not meeting requirements.	
Controls:	Computer Use Policies and HR policies in place for NHS and Moray Council. Business Continuity Plans being updated to fully reflect ICT disruption. PSN accreditation secured by Moray Council Guidance regularly issued to staff. Guidance on effective data security measures issued to staff.	
Mitigating Actions:	Protocol for access to systems by employees of partner bodies to be developed. Information Management arrangements to be developed and endorsed by MIJB. Integrated Infrastructure Group established, with ICT representation from NHSG and Moray Council, to consider and provide solutions to data sharing issues and ICT infrastructure matters. Linkages to Infrastructure board and Information sharing groups are being developed and communicated to staff.	
Assurances:	Strict policies and protocols in place with NHS Grampian and Moray Council.	
Gaps in	None known	

assurance:	
Current performance:	Training programme to be developed on records management, data protection and related issues for staff working across and between partners.
Comments:	Data sharing groups for Grampian and Health and Social Care Moray have been established and meetings held. They will have oversight of any issues arising from Data protection and GDPR matters from either Council or NHS systems. Business Continuity arrangements are being reviewed with a focus on impact of loss of energy and consequential impact on ICT

9		
Description of Risk: *Infrastructure*	Requirements for ICT and Property are not prioritised by NHS Grampian and Moray Council.	
Lead:	Chief Officer	
Risk Rating:	low/medium/high/very high	**HIGH**
Risk Movement:	increase/decrease/no change	**NO CHANGE**
Rationale for Risk Rating:	Changes to processes and necessary stakeholder buy-in still bedding in. Moray Council, in predicting a budget deficit for the current financial year have implemented special arrangements to ensure only essential expenditure is incurred. This includes the consideration to the deferring of projects already in the Capital plan. Interim Premises,Infrastructure and Digital Manager in place to provide additional leadership in relation to major infrastructure projects.	
Rationale for Risk Appetite:	Low tolerance in relation to not meeting requirements.	
Controls:	Chief Officer has regular meetings with partners Infrastructure Programme Board established with Chief Officer as Senior Responsible Officer/Chief Officer member of CMT. Process for submission of projects to the infrastructure board is being refined to ensure appropriate oversight of all projects underway in HSCM.	
Mitigating Actions:	Dedicated project Manager in place – monitoring/managing risks of the Programme Membership of the Board reviewed and revised to ensure representation of all existing infrastructure processes and funding opportunities.	

	Process for ensuring infrastructure change/investment requests developed Infrastructure Manager linked into other Infrastructure groups within NHSG & Moray Council to ensure level of 'gatekeeping'
Assurances:	Infrastructure Programme Board function to provide robust governance and assurance that proposed projects have a robust business case and meets requirements of the respective partner organisations. This board reports to Strategic Planning and Commissioning Group.
Gaps in assurance:	Further work is required on developing the process for approval for projects so that they are progressed timeously. Need to review all existing processes in relation to infrastructure changes/projects/investments and streamline to avoid duplication of effort.
Current performance:	The board has not met in the past quarter. A meeting is being scheduled.
Comments:	The development of the processes around the Infrastructure Board and its governance positioning are still a work in progress. Interim Premises, Infrastructure and Digital Development manager appointed as lead with further resource being funded by NHS to take forward transformation projects in the next 12 months.

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 13 DECEMBER 2018**

SUBJECT: **QUARTER 2 (JULY – SEPTEMBER 2018) PERFORMANCE REPORT**

BY: **CHIEF FINANCIAL OFFICER**

1. REASON FOR REPORT

1.1 To update the Audit, Performance and Risk Committee on the performance of the Moray Integration Joint Board (MIJB) as at Quarter 2 (July – September) 2018/19.

2. RECOMMENDATION

2.1 It is recommended that the Audit, Performance and Risk Committee consider and note the performance of local indicators, linked to strategic priorities for Q2 (July – September 2018) in APPENDIX 1 and detailed analysis contained within APPENDIX 2.

3. BACKGROUND

3.1 The purpose of this report is to ensure the MIJB fulfils its ongoing responsibility to ensure effective monitoring and reporting on the delivery of services and on the programme of work as set out in the Strategic Plan 2016-19.

3.2 **APPENDIX 1** identifies local indicators that are linked to the strategic priorities for the MIJB and the delegated responsibilities by NHS Grampian and Moray Council for the wider Community Planning Partnership, to allow wider scrutiny by this Committee across publicly accountable indicators.

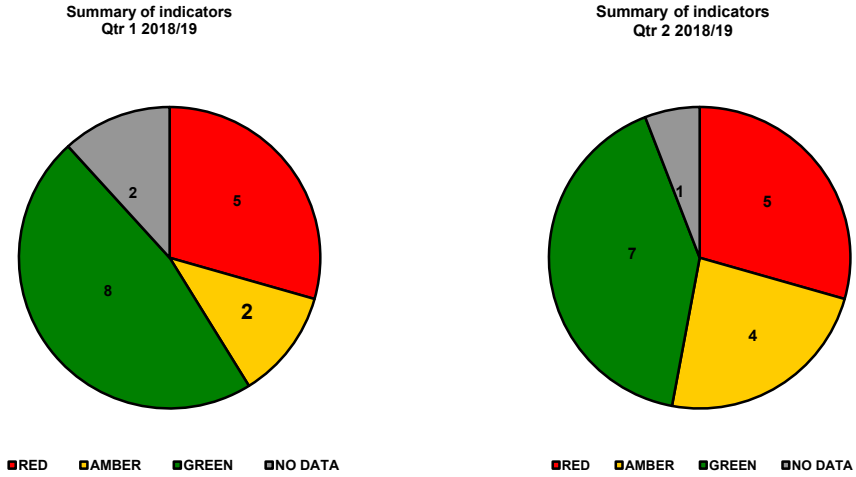
3.3 The development of the performance management framework and associated reporting of indicators continues to progress and the reporting context contained within **APPENDIX 1** will be reviewed in line with the development of the MIJB Strategic Plan for 2019-22 and proposals for monitoring reports will be reported prior to the end of March 2019.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 Indicators are assessed on their performance via a common performance monitoring Red, Amber, Green (RAG) traffic light rating system.

RAG scoring based on the following criteria:	
GREEN	If Moray is performing better than target.
AMBER	If Moray is performing worse than target but within 5% tolerance.
RED	If Moray is performing worse than target by more than 5%.
▲ – ▼	Indicating the direction of the current trend.

4.2 Moray currently has 17 local indicators with 5 indicators showing their status as red and 4 amber. There are 7 indicators which are green and one outstanding indicator (L21) is still in development. Refer to **APPENDIX 1** for the indicators and **APPENDIX 2** for analysis on the red indicators.



4.3 Indicators which are currently a RED status (not meeting local targets and outwith tolerances) are reviewed and analysed by the Adult Services Performance Management Group who then identify where closer monitoring or action is required.

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

Performance management reporting is a legislative requirement under section 42 of the Public Bodies (Joint Working) (Scotland) Act 2014.

In addition to publishing an Annual Performance Report, the Moray Integration Scheme requires that the MIJB will "monitor the performance of the delivery of integrated services using the Strategic Plan on an ongoing basis" (para 5.2.2 of the Moray Integration Scheme refers).

(b) Policy and Legal

None directly associated with this report.

(c) Financial implications

None directly associated with this report. .

(d) Risk Implications and Mitigation

MIJB Strategic Risk Register Risk 1: To monitor service performance against an agreed set of performance measures and to ensure appropriate information is presented to IJB to allow it to deliver this function.

(e) Staffing Implications

None directly associated with this report.

(f) Property

None directly associated with this report.

(g) Equalities/Socio Economic Impact

An Equality Impact Assessment is not required for the Performance Framework because its purpose is to underpin the strategic direction for the service and there will be no differential impact, as a result of the report, on people with protected characteristics.

(h) Consultations

Consultation on this report has taken place with the following staff who are in agreement with the content in relation to their area of responsibility:-

- Legal Services Manager (Licencing & Litigation)
- Caroline Howie, Committee Services Officer
- Chief Financial Officer, MIJB
- Service Managers, Health and Social Care Moray
- MIJB Corporate Manager

6. CONCLUSION

6.1 This report requests the Audit, Performance and Risk Committee comment on performance of local indicators and actions summarised in the highlight report and approve the recommendations for a future report.

Author of Report: Bruce Woodward
Background Papers:
Ref:

Moray Health and Social Care Partnership: Performance at a Glance Quarter 2 (July to September 2018) **Item 8** **APPENDIX 1**

Local Indicators

RAG scoring based on the following criteria		
Performance Against Previous Period	G	If Moray is performing better than target
	A	If Moray is performing worse than target but within 5% tolerance
	R	If Moray is performing worse than target by more than 5%
	▲ – ▼	Indicating direction of current trend

ID.	Indicator Description	Source	Performance Current Quarter	Target	Previous Quarter	Against Previous Quarter	Trend line	Trend Period	Current Quarter
L07	Rate of emergency occupied bed days for over 65s per 1000 population	NHS	**2375**	2360	2380	A▼		5 Quarters	Jul-Sep 18
L08	Emergency Admissions rate per 1000 population for over 65s	NHS - PMS	**189**	193	191	G▼		5 Quarters	Jul-Sep 18
L09	Number of people over 65 years admitted as an emergency in the previous 12 months per 1000 population	NHS - PMS	**130**	125	132	A▼		5 Quarters	Jul-Sep 18
L10	Number of Bed Days Occupied by Delayed Discharges per quarter (inc code 9) per 1000 18+ population	NHS	**45**	-	42	R▲		5 Quarters	Jul-Sep 18
L11	Number of delayed discharges inc code 9 (Census snapshot, monthly average for quarter)	NHS	**39**	35	32	R▲		5 Quarters	Jul-Sep 18
L12	A&E Attendance rates per 1000 population (All Ages)	NHS	**62.6**	-	63.8	G▼		5 Quarters	Jul-Sep 18
L13	A&E Percentage of people seen within 4 hours, within community hospitals	NHS	**100.0% (681)**	98%	100.0% (825)	G -		5 Quarters	Jul-Sep 18
L14*	Percentage of new dementia diagnoses who receive 1 year post-diagnostic support	ISD	**62.2%**	70%	90.7%	R▼		3 Financial Years	Apr16-Mar17
L15	Smoking cessation in 40% most deprived areas after 12 weeks (number of individuals)	NHS	**21**	-	49	R▼		5 Quarters	Apr-Jun 18
L16	Percentage of clients receiving alcohol treatment within 3 weeks of referral	NHS	**100.0%**	90%	98.0%	G▲		5 Quarters	Jul-Sep 18
L17	Percentage of clients receiving drug treatment within 3 weeks of referral	NHS	**100.0%**	90%	100.0%	G -		5 Quarters	Jul-Sep 18
L18	Number of Alcohol Brief Interventions being delivered *(includes ABIs in priority and wider settings where data can be aligned to HSCPs)*	NHS	**184**	259	208	R▼		2 Quarters	Jul-Sep 18
L19A	Number of complaints received and % responded to within 20 working days - NHS	NHS	**55.0% (11)**	-	50.0% (8)	G▲		5 Quarters	Jul-Sep 18

RAG scoring based on the following criteria		
Performance Against Previous Period	G	If Moray is performing better than target
	A	If Moray is performing worse than target but within 5% tolerance
	R	If Moray is performing worse than target by more than 5%
	▲ – ▼	Indicating direction of current trend

ID.	Indicator Description	Source	Performance Current Quarter	Target	Previous Quarter	Against Previous Quarter	Trend line	Trend Period	Current Quarter
L19B	Number of complaints received and % responded to within 20 working days - Council	SW	**80% (10)**	-	100% (6)	G▼		2 Quarters	Jul-Sep 18
L20	NHS Sickness Absence % of Hours Lost	NHS	**4.6%**	4.0%	4.9%	A▼		5 Quarters	Jul-Sep 18
L21	Council Sickness Absence (% of Calendar Days Lost)	SW	No data available at the moment						
L41	Percentage of patients commencing Psychological Therapy Treatment within 18 weeks of referral	NHS	**100.0%**	90%	93.5%	G▲		5 Quarters	Jul-Sep 18

*** An additional date field has recently been added to the collection template, previously this date was assumed to be within a timescale however after receiving the updated file some patients did not receive PDS**

MIJB Q2 PERFORMANCE HIGHLIGHT REPORT

1. Local Indicators - Red

L10 Number of Bed Days Occupied by Delayed Discharges per quarter (inc code 9) per 1000 18+ population

L11 Number of delayed discharges inc code 9 (Census snapshot, monthly average for quarter)

Delayed Discharge continues to be a focus and the Weekly Huddle has been expanded to include representatives from all areas of Dr Gray's and Community hospitals as well as District Nurses and Allied Health Professionals which is improving flow and giving everyone a greater understanding of individual patient needs. This meeting now also has more direct links with the weekly Resource Allocation Meeting.

Daily Dynamic Discharge huddles are also taking place at Community hospitals that looks at reasons for delay and provide real-time patient feedback.

L14 Percentage of new dementia diagnoses who receive 1 year post-diagnostic support

An additional date field has recently been added to the collection template, previously this date was assumed to be within a timescale however after receiving the updated file some patients did not receive Post Diagnostic Support within the required timescales during this period.

Now that the indicator has been refined, better monitoring of this measure can be made and improvements made where it has not been met.

L18 Number of Alcohol Brief Interventions being delivered *(includes ABIs in priority and wider settings where data can be aligned to HSCPs)*

NHS Grampian has a target of delivering 6,658 interventions per year. This figure is divided across the partnerships based on GP practice adult population size. Based on population size it is anticipated that 1,028 ABIs would be delivered in Moray each year (approx. 257 per quarter).

Whilst Moray has not achieved the indicative target allocated, in previous years Aberdeenshire and Moray did not achieve the targets allocated, but the target for Grampian as a whole was achieved.

Progress has been made and services report that work is undertaken in a wide variety of settings such as GP practices and local Pharmacies. One issue that has been highlighted is that the mechanism for recording this work is not always accessible. This is being investigated further through the Grampian wide ABI strategy covering the next 3 years. The strategy will be signed off Grampian wide strategy group on the 13th of December 2018 and will then be coming to the MADP in January.

L19A Number of complaints received and % responded to within 20 working days - NHS

There were 11 complaints received during Q2 with 6 responded to within 20 days. Of the 5 remaining, 4 were responded to within 30 days with one at 43 days, however this complaint and one of the others within 30 days was not upheld.

REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 13 DECEMBER 2018**

SUBJECT: **AUDIT SCOTLAND – UPDATE REPORT ON HEALTH AND SOCIAL CARE INTEGRATION**

BY: **CHIEF FINANCIAL OFFICER**

1. REASON FOR REPORT

1.1 To provide the Audit, Performance and Risk Committee with the opportunity to discuss and comment on the update report published November 2018 by Audit Scotland on Health and Social Care Integration.

2. RECOMMENDATION

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

i) discuss and comment on the report attached at Appendix 1; and

ii) note the intention to utilise the document as a self-assessment tool in relation to the progress of the Moray Integration Joint Board (MIJB) and present a report back to this Committee on 28 March 2019.

3. BACKGROUND

3.1 In December 2015, Audit Scotland published a report of Health and Social Care Integration, being the first of three planned audits for this area. This first audit, provided a progress report during what was considered the transitional year, prior to the majority of Integration Authorities becoming formally established and highlighted the risks to be addressed as a priority to ensure the success of this major reform.

3.2 The MIJB considered the recommendations made by Audit Scotland in this first report and monitored its progress by way of self-assessment. It worked towards the recommendations made and progress reports were presented to the MIJB at regular intervals.

4 KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The Audit Scotland 'Health and Social Care Integration – Update of progress' report was published on 15 November 2018 and is the second of three planned audits of integration. The key objective of this audit was to examine the impact public bodies are having as they work together to integrate health and social care services in line with the Public Bodies (Joint Working) (Scotland) Act 2014. The audit considered in detail:

- What impact integration is having and what the barriers and enablers are to change;
- how effectively Integration Authorities are planning sustainable, preventative and community-based services to improve outcomes for local people;
- how effectively Integration Authorities, NHS Boards and Councils are implementing the reform of health and social care integration; and
- how effectively is the Scottish Government supporting the integration of health and social care and evaluating its impact.

4.2 Key Points from the Report

4.2.1 The resources being directed by Integration Authorities across Scotland is almost £9 billion in the context of £15 billion of the total Scottish Government budget being allocated to Health and Social Care.

4.2.2 The review noted that the introduction of more collaborative ways of delivering services has brought with it improvements in several areas, including reducing unplanned hospital activity and delayed discharges.

4.2.3 The report acknowledged the financial pressures across health and social care and highlighted a fundamental issue in the absence of integrated financial planning which is focussed on the best outcomes for people who need support. The issue around the 'Set Aside' budget was also outlined as being a key part of the legislation that has not been enacted in most areas.

4.2.4 A need for improved strategic planning was considered a crucial factor in speeding up the change process, addressing the issue of the capacity and high turnover amongst leadership teams.

4.2.5 The audit report reiterated the message that significant changes are required in the way that health and care services are delivered with improvements required to engagement amongst staff, communities and politicians at both national and local level. It emphasised the need for working together, being open and honest about the changes required to sustain health and care services in Scotland.

4.3 Audit Scotland Recommendations

4.3.1 The report was very clear in the sense that for meaningful address of the issues raised throughout the report, it would require integration authorities, NHS Boards, Local Authorities, Scottish Government and COSLA to work together. The recommendations made were for :

- Commitment to collaborative leadership and building relationships
- Effective strategic planning for improvement
- Integrated finances and financial planning
- Agreed governance and accountability arrangements
- Ability and willingness to share information
- Meaningful and sustained engagement

4.4 MIJB Development

4.4.1 The report acknowledged the progress made to date and the reality that further progress will be impossible without all parties working together to address the areas outlined in the recommendations. With this in mind it is considered a reasonable approach for the MIJB through the Audit Performance and Risk Committee to address the recommendations made in the Audit Scotland report by conducting a self-assessment of the perceived position to date and then reporting back at regular intervals to monitor progress but also to identify areas where concentrated focus would be beneficial.

4.4.2 At the time of writing this report, Audit Scotland were preparing for discussions with Scottish Government and key groups to establish how the recommendations might be addressed at the highest level. Outcomes will be considered and incorporated into a self-assessment and monitoring process for the MIJB where the intention is to present a report to the next meeting of the Audit Performance and Risk Committee on 28 March 2019.

5 SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

Close monitoring of progress of the recommendations made in the Audit Scotland update report of Integration will support delivery of the Board's Strategic Plan.

(b) Policy and Legal

The Audit Scotland update report on health and social care integration retains the Public Bodies (Joint Working) (Scotland) Act 2014 as its key focus establishing the progress of Integration Authorities.

(c) Financial implications

None arising directly from this report

(d) Risk Implications and Mitigation

Consideration of the recommendations made by Audit Scotland in the update report will ensure the MIJB are remaining consistent with

legislation and are actively addressing the findings being reported on a Scotland-wide basis.

(e) Staffing Implications

None arising directly from this report

(f) Property

None arising directly from this report.

(g) Equalities/Socio Economic Impact

None arising directly from this report.

(h) Consultations

Consultation has taken place with Caroline Howie, Committee Services Officer and the Legal Services Manager (Litigation and Licencing), Moray Council and the MIJB Chief Internal Auditor. Any comments received have been considered in writing this report.

6 CONCLUSION

6.1 The Audit Scotland update report of Health and Social Care Integration is the second of three planned audits on integration. A self-assessment approach against the recommendations made is considered proactive in addressing the national issues being highlighted to date.

Author of Report: Tracey Abdy, Chief Financial Officer, MIJB
Background Papers: http://www.audit-scotland.gov.uk/uploads/docs/report/2018/nr_181115_health_socialcare_update.pdf
Ref:

Health and social care series

Health and social care integration

Update on progress

ACCOUNTS COMMISSION

AUDITOR GENERAL

Prepared by Audit Scotland
November 2018

The Accounts Commission

The Accounts Commission is the public spending watchdog for local government. We hold councils in Scotland to account and help them improve. We operate impartially and independently of councils and of the Scottish Government, and we meet and report in public.

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- securing and acting upon the external audit of Scotland's councils and various joint boards and committees
- assessing the performance of councils in relation to Best Value and community planning
- carrying out national performance audits to help councils improve their services
- requiring councils to publish information to help the public assess their performance.

You can find out more about the work of the Accounts Commission on our website: www.audit-scotland.gov.uk/about-us/accounts-commission

Auditor General for Scotland

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- examine how public bodies spend public money
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- NHS bodies
- further education colleges
- Scottish Water
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Audit Scotland is a statutory body set up in April 2000 under the Public Finance and Accountability (Scotland) Act 2000. We help the Auditor General for Scotland and the Accounts Commission check that organisations spending public money use it properly, efficiently and effectively.

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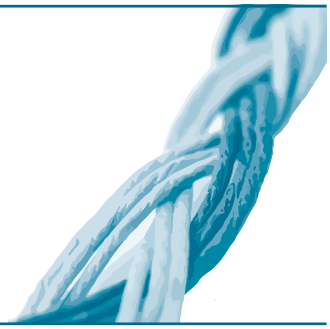


Links

PDF download

Web link

Exhibit data

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

Audit team

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

Key facts

Savings Integration Authorities needed to achieve in 2017/18

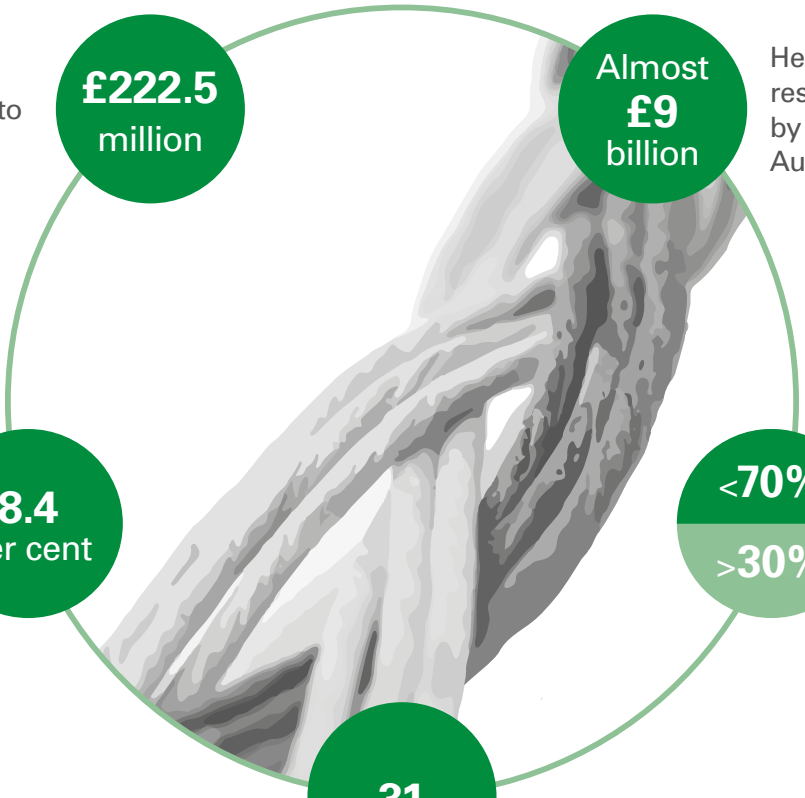
£222.5 million

Almost **£9 billion**

Health and social care resources directed by Integration Authorities

Increase in required savings from 2016/17

8.4 per cent



<70%

>30%

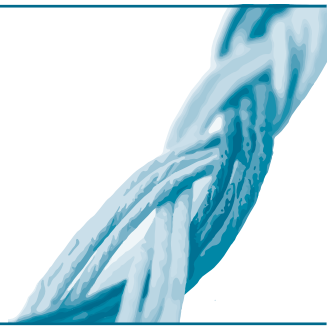
Integration Authority funding comes from the NHS

Funding comes from local authorities

31

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

Summary



Key messages

1 Integration Authorities (IAs) have started to introduce more collaborative ways of delivering services and have made improvements in several areas, including reducing unplanned hospital activity and delays in discharging people from hospital. People at the end of their lives are also spending more time at home or in a homely setting, rather than in hospital. These improvements are welcome and show that integration can work within the current legislative framework, but IAs are operating in an extremely challenging environment and there is much more to be done.

2 Financial planning is not integrated, long term or focused on providing the best outcomes for people who need support. This is a fundamental issue which will limit the ability of IAs to improve the health and social care system. Financial pressures across health and care services make it difficult for IAs to achieve meaningful change. IAs were designed to control some services provided by acute hospitals and their related budgets. This key part of the legislation has not been enacted in most areas.

3 Strategic planning needs to improve and several significant barriers must be overcome to speed up change. These include: a lack of collaborative leadership and strategic capacity; a high turnover in IA leadership teams; disagreement over governance arrangements; and an inability or unwillingness to safely share data with staff and the public. Local areas that are effectively tackling these issues are making better progress.

4 Significant changes are required in the way that health and care services are delivered. Appropriate leadership capacity must be in place and all partners need to be signed up to, and engaged with, the reforms. Partners also need to improve how they share learning from successful integration approaches across Scotland. Change cannot happen without meaningful engagement with staff, communities and politicians. At both a national and local level, all partners need to work together to be more honest and open about the changes that are needed to sustain health and care services in Scotland.

several significant barriers must be overcome to speed up change

Recommendations

It is not possible for one organisation to address all the issues raised in this report. If integration is to make a meaningful difference to the people of Scotland, IAs, councils, NHS boards, the Scottish Government and COSLA need to work together to address six areas outlined below.

Commitment to collaborative leadership and building relationships

The Scottish Government and COSLA should:

- ensure that there is appropriate leadership capacity in place to support integration
- increase opportunities for joint leadership development across the health and care system to help leaders to work more collaboratively.

Effective strategic planning for improvement

Integration Authorities, councils and NHS boards should work together to:

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

The Scottish Government should:

- ensure that there is a consistent commitment to integration across government departments and in policy affecting health and social care integration.

Integrated finances and financial planning

The Scottish Government should:

- commit to continued additional pump-priming funds to facilitate local priorities and new ways of working which progress integration.

The Scottish Government and COSLA should:

- urgently resolve difficulties with the 'set-aside' aspect of the Act.

The Scottish Government, COSLA, councils, NHS boards and Integration Authorities should work together to:

- support integrated financial management by developing a longer-term and more integrated approach to financial planning at both a national and local level. All partners should have greater flexibility in planning and investing over the medium to longer term to achieve the aim of delivering more community-based care.

Integration Authorities, councils and NHS boards should work together to:

- view their finances as a collective resource for health and social care to provide the best possible outcomes for people who need support.

Agreed governance and accountability arrangements

The Scottish Government and COSLA should:

- support councillors and NHS board members who are also Integration Joint Board members to understand, manage and reduce potential conflicts with other roles.

The Scottish Government, COSLA, councils, NHS boards and Integration Authorities should work together to:

- agree local responsibility and accountability arrangements where there is disagreement over interpretation of the Public Bodies (Joint Working) (Scotland) Act 2014 and its underpinning principles. Scenarios or examples of how the Act should be implemented should be used which are specific to local concerns. There is sufficient scope within existing legislation to allow this to happen.

Ability and willingness to share information

The Scottish Government and COSLA should:

- monitor how effectively resources provided are being used and share data and performance information widely to promote new ways of working across Scotland.

The Scottish Government, COSLA, councils, NHS boards and Integration Authorities should work together to:

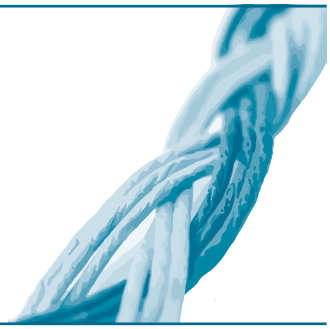
- share learning from successful integration approaches across Scotland
- address data and information sharing issues, recognising that in some cases national solutions may be needed
- review and improve the data and intelligence needed to inform integration and to demonstrate improved outcomes in the future. They should also ensure mechanisms are in place to collect and report on this data publicly.

Meaningful and sustained engagement

Integration Authorities, councils and NHS boards should work together to:

- continue to improve the way that local communities are involved in planning and implementing any changes to how health and care services are accessed and delivered.

Introduction



Policy background

1. The Public Bodies (Joint Working) (Scotland) Act, 2014 (the Act) is intended to ensure that health and social care services are well integrated, so that people receive the care they need at the right time and in the right setting, with a focus on community-based, preventative care. The reforms affect everyone who receives, delivers and plans health and care services in Scotland. The Act requires councils and NHS boards to work together to form new partnerships, known as Integration Authorities (IAs). There are 31 IAs, established through partnerships between the 14 NHS boards and 32 councils in Scotland.

2. As part of the Act, new bodies were created – Integration Joint Boards (IJBs) (Exhibit 1, page 9). The IJB is a separate legal entity, responsible for the strategic planning and commissioning of the wide range of health and social care services across a partnership area. Of the 31 IAs in Scotland, 30 are IJBs and one area, Highland, continues with a Lead Agency model which has operated for several years. In Highland, the NHS board and council each lead integrated services. Clackmannanshire and Stirling councils have created a single IA with NHS Forth Valley. You can find more information about integration arrangements in our short guide.

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

3. Each IA differs in terms of the services they are responsible for and local needs and pressures. At a minimum, IAs need to include governance, planning and resourcing of social care, primary and community healthcare and unscheduled hospital care for adults. In some areas, partners have also integrated children's services and social work criminal justice services. Highland Lead Agency, Dumfries and Galloway IJB, and Argyll and Bute IJB have also integrated planned acute health services. IAs became operational at different times but were all established by April 2016. The policy context for IAs is continually changing, and many policies have an impact on IAs, such as the new GP contract and changes to payments for social care services.

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

About this audit

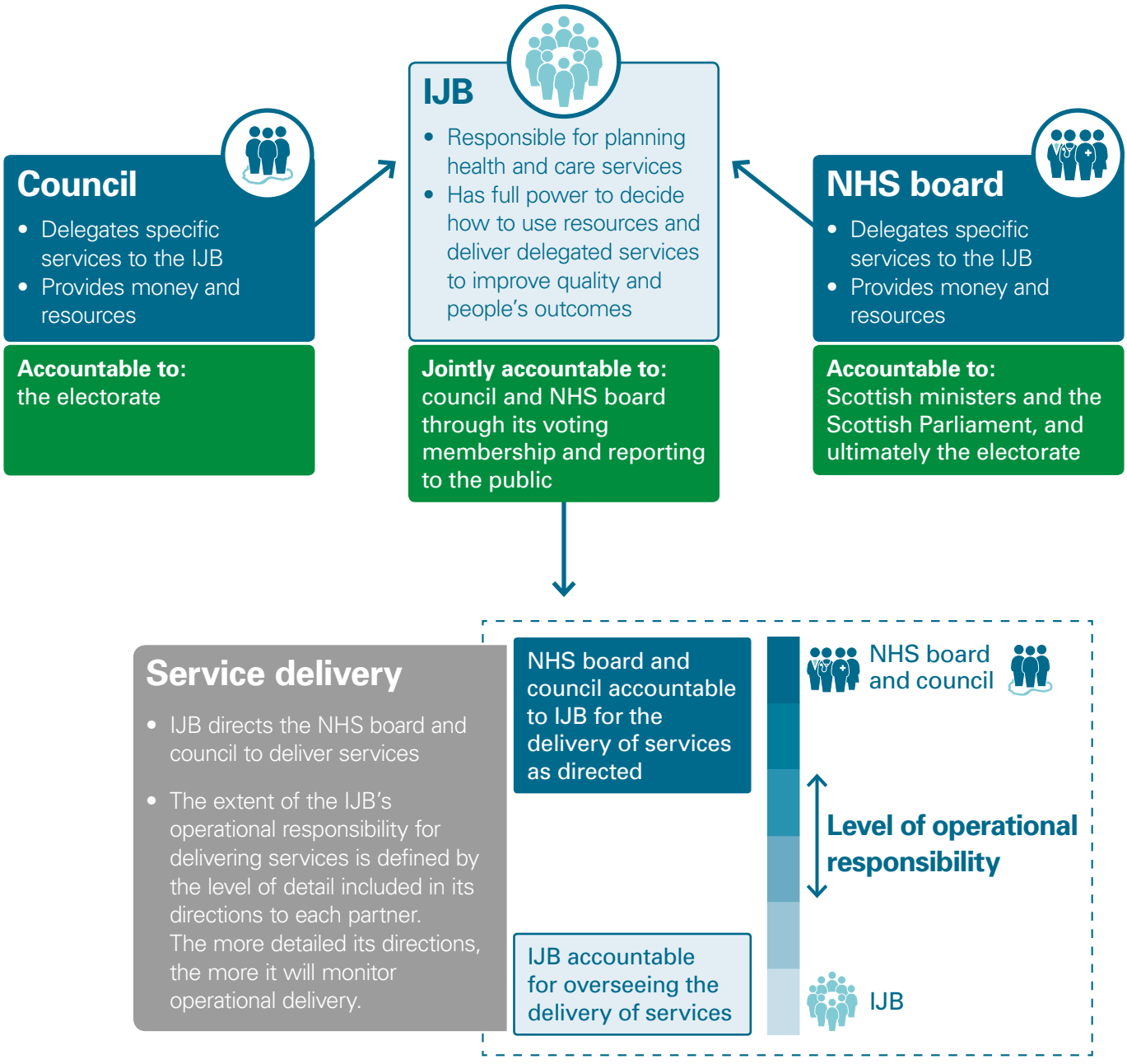
4. This is the second of three national performance audits of health and social care integration following the introduction of the Act. The aim of this audit is to examine the impact public bodies are having as they integrate health and social care services. The report sets out six areas which need to be addressed if integration is to make a meaningful difference to the people of Scotland. This audit does not focus in detail on local processes or arrangements and it complements the programme of strategic inspections by the Care Inspectorate and Healthcare Improvement Scotland.[1] Appendix 1 (page 41) has more details about our audit approach and Appendix 2 (page 42) lists the members of our advisory group who provided help and advice throughout the audit.

5. Appendix 3 (page 43) summarises progress against the recommendations in our first audit, which looked at transitional arrangements and highlighted several risks that needed to be addressed.[2] We will carry out a third audit in this series later in our work programme, which will report on the impact that integration has had and how health and social care resources are used.

Exhibit 1

Integration Joint Boards

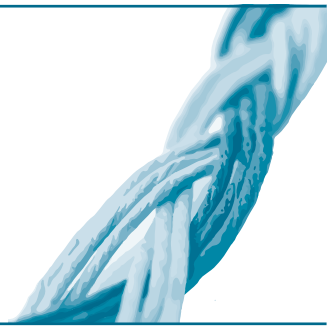
There are 30 Integration Joint Boards across Scotland.



Source: Audit Scotland

Part 1

The current position



Integration Authorities oversee almost £9 billion of health and social care resources

6. Our findings show that integration can work and that the Act can be used to advance change. Although some initiatives to integrate services pre-date the Act, there is evidence that integration is enabling joined up and collaborative working. This is leading to improvements in performance, such as a reduction in unplanned hospital activity and delays in hospital discharges. But there is much more to be done.

7. IAs are responsible for directing almost £9 billion of health and social care resources, money which was previously separately managed by NHS boards and councils (Exhibit 2, page 11). Over 70 per cent of this comes from the NHS, with the remainder coming from councils. As with councils and NHS boards, IAs are required to find efficiency savings from their annual budgets to maintain financial balance. Demands on services combined with financial pressures have led to many IJBs struggling to achieve this balance, with many needing additional financial contributions from partner organisations.

there is evidence that integration is enabling joined up and collaborative working

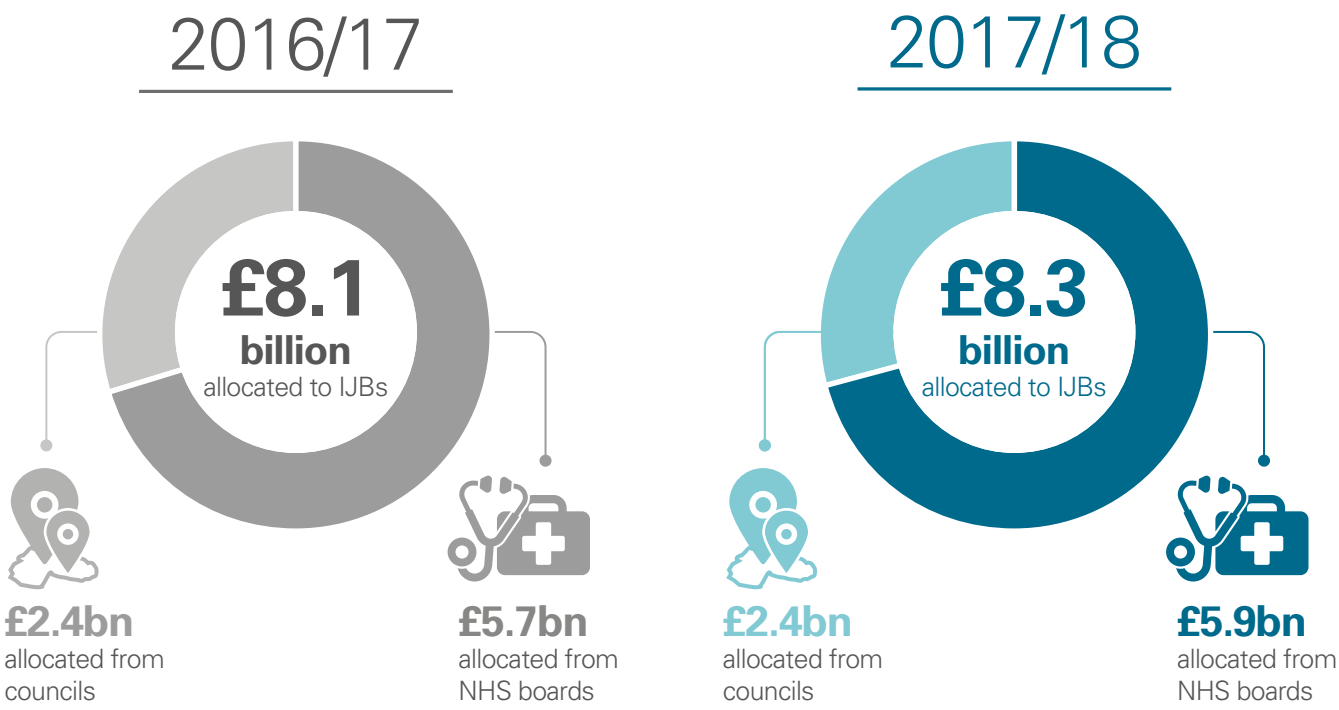
8. Each IA is underpinned by an integration scheme. This is the agreement between the council and the NHS board which shows how the IA will operate. For example, the scheme sets out arrangements for dealing with any budget overspends, which usually involves implementing a recovery plan. As local government bodies, IJBs can hold reserves if permitted by their integration schemes, although not all schemes allow this. Reserves are amounts of money that are built up from unspent budgets for use in future years. Generally, reserves are used for one of three purposes:

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

Exhibit 2

Resources for integration

IAs are responsible for directing significant health and social care resources.



Lead Agency – the allocation for Highland Health and Social Care Services was:
£595 million in 2016/17 | £619 million in 2017/18

Note: Council allocations in 2016/17 and 2017/18 include criminal justice social work contribution.

Source: Audit Scotland, 2018

Financial pressures make it difficult for IAs to make sustainable changes to the way services are delivered

9. The Act was intended to help shift resources away from the acute hospital system towards preventative and community-based services. However, there is still a lack of agreement about whether this is achievable in practice – or whether rising demand for hospital care means that more resource is needed across the system. We have seen some examples of small-scale changes in the balance of care, which are explored further in Part 2 (page 23). These examples show that change can be achieved, but IAs now need to take the next steps to achieve wider-scale impact on outcomes over the coming years.

10. IAs needed to achieve savings of £222.5 million in 2017/18. This is an increase of 8.4 per cent on the previous year and is 2.5 per cent of the total allocation to IAs from NHS boards and councils. The level of savings, as a percentage of IA income, varied from 0.5 per cent in Moray, Orkney, Renfrewshire and South Lanarkshire, to 5.3 per cent in Shetland and 6.4 per cent in Highland Lead Agency. In several instances, budgets were agreed at the start of the financial year based on achieving savings which had yet to be identified.

Financial position

11. It is not easy to set out the overall financial position of IAs. This is due to several factors, including the use of additional money from partner organisations, planned and unplanned use of reserves, late allocations of money and delays in planned expenditure. This makes it difficult for the public and those working in the system to understand the underlying financial position.

12. In 2017/18, IJBs reported an overall underspend of £39.3 million. This represented 0.4 per cent of their total income allocation for the year.[4] However, this masks a much more complex picture of IJB finances. Appendix 4 (page 47) sets out more details about the financial position of IJBs in 2017/18. Many IAs have struggled to achieve financial balance at the year-end. The reasons for this vary but include rising demand for services, financial pressures and the quality of financial planning. In 2017/18, this resulted in several IJBs needing additional, unplanned allocations from their partners and adding to, or drawing on, reserves as follows:

- 16 needed additional money from NHS boards amounting to £32.8 million
- ten needed additional money from councils amounting to £18.6 million
- eight drew on reserves amounting to £9.1 million
- 14 put money into reserves, amounting to £41.9 million.

13. Twenty-two IJBs are required by their integration schemes to produce a recovery plan if they forecast an overspend on their annual budget. Several IAs have had to produce recovery plans and are finding it harder to achieve the actions contained within them:

- In 2016/17, 11 IJBs needed to draw up a recovery plan. Of these, four IJBs achieved the actions set out in their recovery plans, but the remaining seven needed additional allocations from either their council or NHS board.
- In 2017/18, 12 IJBs needed to produce a recovery plan but only two achieved their recovery plans in full. In some cases, where additional allocations are required, the integration scheme allowed the NHS board or council to reduce the following year's allocation to the IJB by the same amount. In these circumstances there is a risk that IJBs will not have sufficient resources to deliver the services needed in future years.

14. An IA's integration scheme states how the IA will manage any year-end overspend and the responsibilities of the NHS board and council. For example, Fife IJB's integration scheme states that any overspend will be funded by partner bodies based on the proportion of their current year contributions to the IJB. In 2017/18, this meant that NHS Fife and Fife Council agreed to make additional contributions of 72 per cent and 28 per cent respectively.

15. The Highland Lead Agency model is also facing financial pressures. In 2017/18, NHS Highland overspent on adult social care services by £6 million. This was largely due to pressures on Highland Lead Agency adult social care services. This contributed to NHS Highland needing a loan of £15 million from the Scottish Government in 2017/18. Due to the way the Lead Agency model was established and the underlying agency agreement, the risks all rest with NHS Highland. Any increases in costs must be met by the NHS board.

16. Fourteen IJBs reported underspends in 2017/18 and these have arisen for a variety of reasons, for example: achieving savings earlier than expected; contingencies not being required; slippages in spending plans and projects; and staff vacancies.

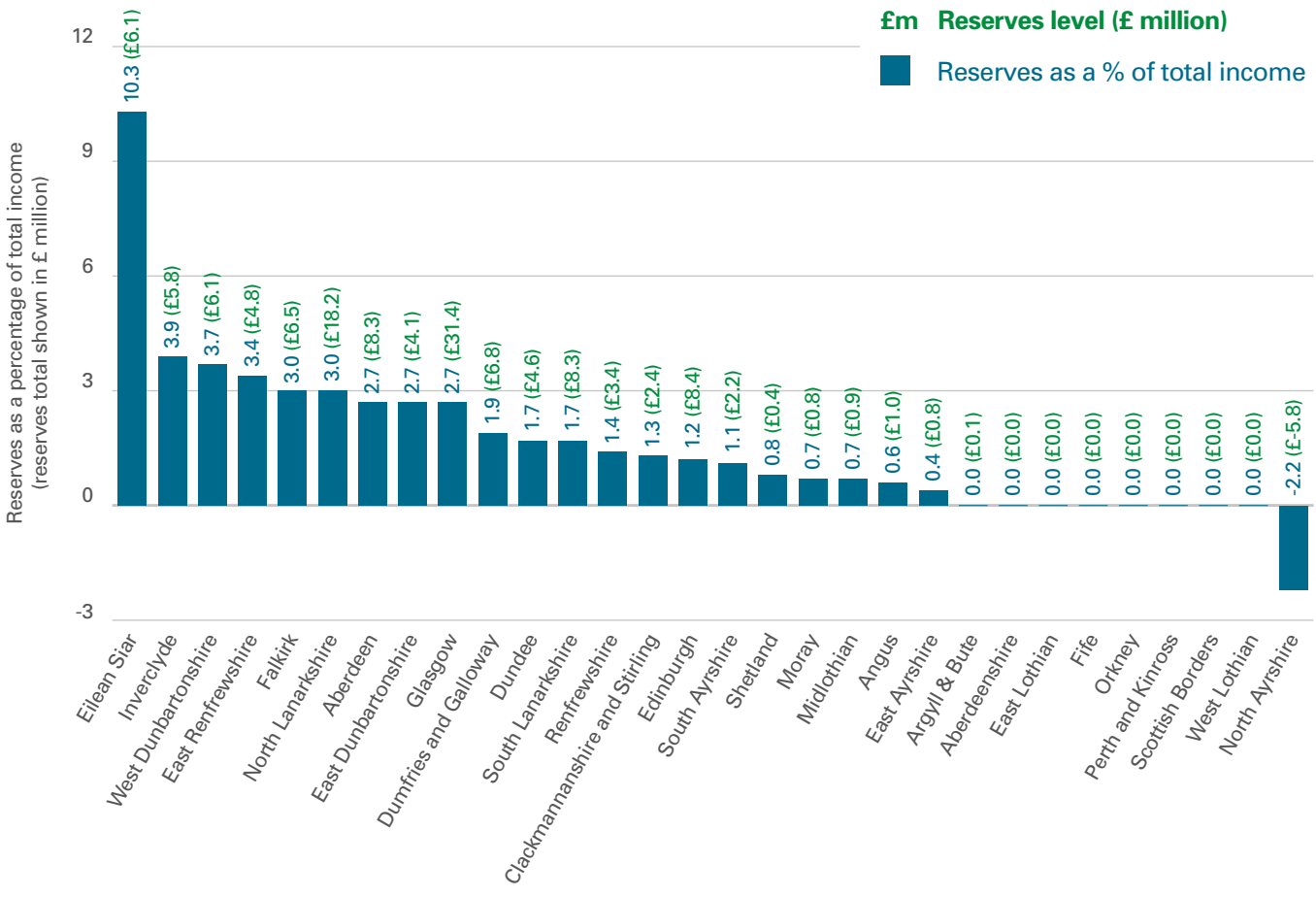
Reserves

17. The level of reserves held varies across IJBs, and not all integration schemes allow IJBs to hold reserves (Exhibit 3). In 2017/18, IJBs had built up reserves of £125.5 million, 1.5 per cent of their total income. This is not always a planned approach, and in some areas, reserves have arisen for several reasons including: the IJB receiving a late allocation of money; unspent strategic funding; staff vacancies; or year-end timing differences where money is received and allocated but unspent. Eilean Siar held the highest level of reserves as a percentage of its income at 10.3 per cent. The pressures on IJB budgets and the savings they need to achieve are significant, therefore the level of reserves in 2017/18 is not forecast to continue in future.

Exhibit 3

Reserves held by IJBs in 2017/18

There are significant differences in the levels of reserves held by IJBs.



Source: Integration Authority annual accounts, 2017/18

Hospital services have not been delegated to IAs in most areas

18. A key part of the reforms is that IJBs would direct some services provided directly within acute hospitals, to move care closer to people's homes and provide more joined-up care. Integration schemes, as approved by ministers, state that hospital services will be delegated to the IJB, as required under the Act. However, in practice, in most areas, the services have not been delegated. This has been a major source of debate and disagreement at a national and local level and is a fundamental issue which will hinder IJBs' ability to change the system.

19. The money for functions that are provided by large hospitals but are delegated to IJBs, such as unplanned care, is referred to as a 'set-aside' budget. Instead of paying this money to the IJBs along with payment for other delegated services, it is identified as a budget which should be directed by the IJB. The complexities around accurately preparing set-aside budgets has presented challenges to fulfilling this element of the Act. To date, the set-aside aspect of the Act is not being implemented. In line with Scottish Government guidance, NHS boards continue to manage the set-aside as part of their own resources.

20. In 2017/18, £809.3 million was included within IJBs' budgets for set-aside (where they were able to include a set-aside figure). This is 9.0 per cent of IJBs' income and is therefore a significant element of the health and social care budget that is not being directed by the IJBs. If IJBs are to use resources more strategically to prioritise prevention and care in a community setting, this issue needs to be resolved.

21. There are several reasons why all partners have struggled with this aspect of the Act, including fundamental issues in the data available to analyse set-aside-related activities. However, these technical issues do not appear to be the main issue. The main problem is a lack of common understanding and agreement on how to identify the set-aside budget and shared agreement on how to implement this aspect of the legislation.

Monitoring and public reporting on the impact of integration needs to improve

22. The context for integration is challenging, with many public bodies trying to work in partnership to achieve major changes while at the same time managing rising demand for services, financial pressures and continuing to deliver services and treat people. As we reported in *NHS in Scotland 2018*, the number of patients on waiting lists for treatment continues to rise while performance against targets is declining and an increasing number of NHS boards are struggling to deliver with the resources they have.[5] We have also reported that local government operates in an increasingly complex and changing environment with increasing levels of uncertainty.[6]

23. A significant number of measures are being used to monitor national and local progress which means IAs are reporting against a range of different measures to demonstrate progress (Exhibit 4, page 16). For the public to understand how the changes are working at a Scotland-wide level, these indicators need to be presented in a clear and transparent way.

24. It is important that the Scottish Government can demonstrate that resources provided have led to improvements in outcomes, in line with its national health and wellbeing outcomes. These outcomes are the Scottish Government's high-level statements of what health and social care partners are attempting to achieve through integration. These national outcomes are not being routinely reported at a national level, although IAs refer to them as part of their annual performance reports.

25. The Scottish Government introduced the National Performance Framework (NPF) in 2007 and launched a new framework in 2018. The NPF is made up of 11 national outcomes, each with indicators and aligned to the United Nations' sustainable development goals. There is a clear alignment between the aims of integration and several of the outcomes and indicators.[7]

26. The Ministerial Strategic Group for Health and Community Care brings together representatives from the Scottish Government, NHS, local government and IAs to monitor a set of six national indicators. These are used as indicators of the impact of IAs (Exhibit 5, page 18). These measures focus on the aim of integration helping to care for more people in the community or their own homes and reducing unnecessary stays in hospital. While these measures focus on health, performance can only improve with input from health and social care services. One of the six national indicators is supported by two measures: A&E attendances and achievement of the four-hour A&E waiting time target (3a and 3b at Exhibit 5, page 18).

27. Four of the indicators show improved performance, but there is significant local variation in performance between IAs. The performance measures do not themselves provide a direct indication of whether people's outcomes have improved, although they do represent key aspects of care which should ultimately improve people's lives.

Exhibit 4

Health and wellbeing outcomes and indicators

A significant number of measures are being used to monitor local and national progress.

National Performance Framework

Purpose

To focus on creating a more successful country, with opportunities for all of Scotland to flourish, through sustainable and inclusive economic growth

Values

We are a society which treats all our people with kindness, dignity and compassion, respects the rule of law, and acts in an open and transparent way

11 outcomes and 81 national indicators, for example:

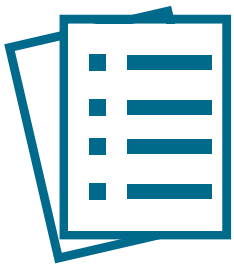
- **Outcome:** We are healthy and active
- **Indicators:** Healthy life expectancy, mental wellbeing, healthy weight, health risk behaviours, physical activity, journeys by active travel, quality of care experience, work-related ill health, premature mortality
- **Sustainable development goals:** gender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

9 national health and wellbeing outcomes

- People are able to look after and improve their own health and wellbeing and live in good health for longer
- People, including those with disabilities or long-term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
- People who use health and social care services have positive experiences of those services, and have their dignity respected
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
- Health and social care services contribute to reducing health inequalities
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing
- People using health and social care services are safe from harm
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
- Resources are used effectively and efficiently in the provision of health and social care services

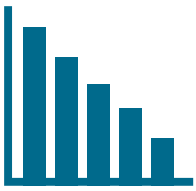
Cont.

Exhibit 4 (continued)



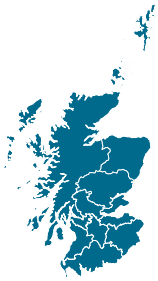
12 principles within the Act

- Be integrated from the point of view of the people who use services
- Take account of the particular needs of service users in different parts of the area in which the service is being provided
- Respect rights of service users
- Protect and improve the safety of service users
- Improve the quality of the service
- Best anticipate needs and prevent them arising
- Take account of the particular needs of different service users
- Take account of the particular characteristics and circumstances of different service users
- Take account of the dignity of service users
- Take account of the participation by service users in the community in which service users live
- Is planned and led locally in a way which is engaged with the community
- Make best use of the available facilities, people and other resources



6 national indicators

- Acute unplanned bed days
- Emergency admissions
- A&E performance (including four-hour A&E waiting time and A&E attendances)
- Delayed discharge bed days
- End of life spent at home or in the community
- Proportion of over-75s who are living in a community setting



Various local priorities, performance indicators and outcomes

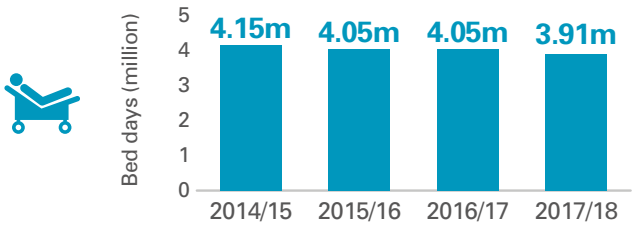
Source: Audit Scotland

Exhibit 5

National performance against six priority areas

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

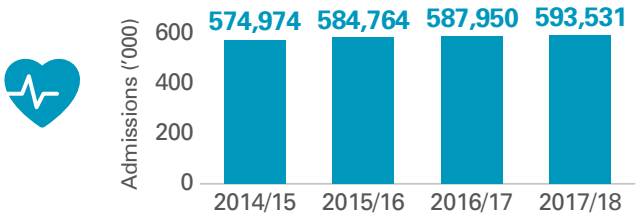
1. Acute unplanned bed days



Integration aims to reduce unplanned hospital activity

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

2. Emergency admissions

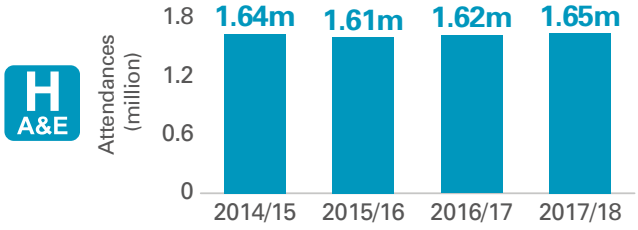


Integration aims to ensure that people's health and care needs are anticipated and planned appropriately, reducing unplanned hospital activity

The number of emergency admissions has risen each year since 2014/15

In 2017/18, local performance varied from 0.08 emergency admissions per head of population in NHS Orkney to 0.15 in NHS Ayrshire and Arran

3a. A&E attendances

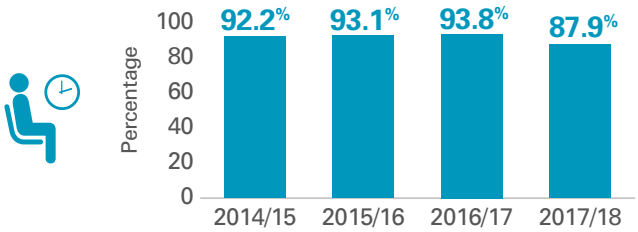


A&E attendances can be an indication of the degree to which community services are helping people receive care in the right place at the right time.

The number of A&E attendances has marginally increased since 2014/15

In 2017/18, local performance varied from 0.2 A&E attendances per head of population in NHS Grampian to 0.4 in NHS Greater Glasgow and Clyde

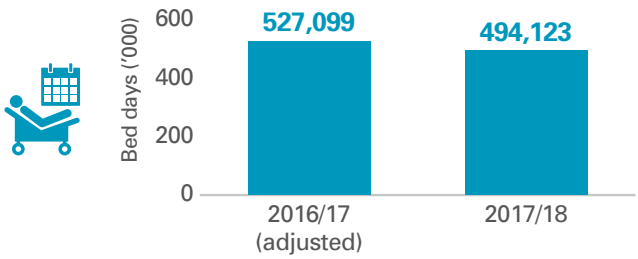
3b. Achievement of the four-hour A&E waiting time target



The achievement of the four-hour waiting time target has declined since 2014/15

Local performance varied in 2017/18 from 98.0% NHS Tayside to 75.4% NHS Lothian

4. Delayed discharge bed days (for population aged 18+)



Reducing delays in discharging people from hospital has been a long-standing aim for health and care services. With rising demand, some areas have struggled with this. Due to changes in data collection, comparable data is only available for two years.

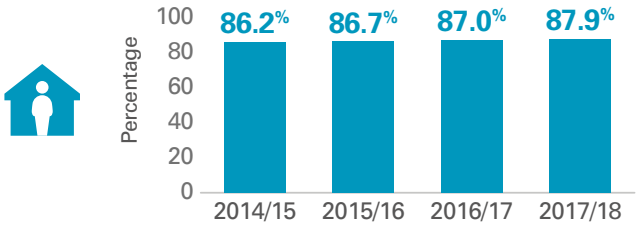
Delayed discharge rates have fallen since 2016/17

In 2017/18, local performance varied from 2.5% in Inverclyde to 26.5% in Eilean Siar delayed discharge bed days as a percentage of their population (18+)

Cont.

Exhibit 5 (continued)

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

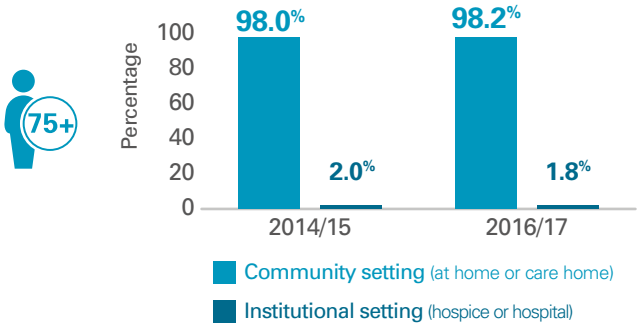


Integration aims to support people with health and care needs in their own home or in a community setting, especially at the end of life.

A gradual increase in the percentage of people's time spent at home or in a homely setting at the end of their life

In 2017/18, local performance varied from 95.1% of people's time spent at home or in a homely setting at the end of their life in Shetland to 85.2% in East Renfrewshire

6. Percentage of 75+ population in a community or institutional setting



Integration aims to shift the balance of care from an institutional setting to a community setting.

There has been a slight increase in the percentage of individuals aged over 75 who are living in a community setting. This is in line with the intentions of the Act.

Notes:

Indicator 1
1. These statistics are derived from data collected on discharges from non-obstetric and non-psychiatric hospitals in Scotland. Only patients treated as inpatients or day cases are included. The specialty of geriatric long stay is excluded.
2. Bed days for each year have been calculated based on the year in which the bed days were occupied. This differs from other analysis where length of stay or occupied bed days are reported by the year of discharge.
3. Unscheduled bed days relate to all occupied bed days within a continuous hospital stay following an emergency or urgent admission.
4. The Scotland total presented is the sum of all those resident in IA areas and excludes non-Scottish residents.
5. Approximately a quarter of IAs returned figures for people aged over 18 only. Where this is the case, bed days from 2016/17 for people aged under 18 in those partnerships have been applied to 2017/18 figures.
6. Based on data submitted to ISD in August 2018.

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

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

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

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

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

Indicator 6
1. Percentage of 75+ population in a community or institutional setting:
   - Community includes the following:
     - Home (unsupported) – refers to the percentage of the population not thought to be in any other setting, or receiving any homecare, on average throughout the year.
     - Home (supported) – refers to the percentage of the population estimated as receiving any level of homecare. Estimated from social care census carried out at the end of the reporting year (eg, Census carried out in March 2014 used to estimate home (supported) population during 2013/14).
     - Resident in a care home – based on care home census at the end of the reporting year (eg, Census at 31 March 2014 used to estimate 2013/14 care home population). The care home data is based on long-stay residents only. The proportion of incomplete long-stay residents aged 75+ cannot be calculated. Therefore, a scaling factor, based on the 65+ proportions, has been employed for the 75+ data. This assumes that there is the same degree of incompleteness in the census data returned for adults in each of the age bands.
   - Institutional includes the following:
     - Average population in hospital/hospice/palliative care unit throughout the year.
     - Hospital includes both community and large/acute hospitals.
     - Hospice activity is based on SMR records and will be incomplete as not all hospices submit this information.
2. Figures provided by ISD.

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

Source: Information Services Division (ISD) and Scottish Government

Integration Authorities' performance reports show local improvement

28. IAs are required to publish annual performance reports which contain information on local priorities and a range of local initiatives (Exhibit 6). These reports are an important way for IAs to inform the public about how well they have been performing against their stated priorities. The improvements that are set out in the performance reports are welcome and current pressures across the system have made them difficult to achieve. However, core indicators of performance are not improving in all areas of Scotland and nationally it is clear that there is much more to be done.

Exhibit 6

Examples of impact from integration

IAs have set out a number of local improvements in their performance reports.

Prevention and early intervention

Dumfries and Galloway

The D&G Handyvan provides information, advice and practical assistance with adaptations to people's homes. This is available to disabled people of any age and older people aged 60 and over. People are also supported to access financial assistance for major adaptations. This service helps people to feel more confident about continuing to live independently in their own home and to feel safe and secure in their home. People are less likely to have a fall, have improved health and wellbeing, and have a better quality of life. Often adaptations support people to be better connected with their friends and family and their wider community. 1,626 referrals were received during 2017/18. These resulted in 2,149 tasks being carried out by the service. 808 people were referred to prevent a fall, 577 people for home security, 16 people for minor adaptations and 225 people for small repairs.

Dundee

Social prescribing 'Sources of Support' (SOS) is one means of supporting people to better manage their health conditions. Link workers, working within designated GP practices, take referrals for people with poor mental health and wellbeing affected by their social circumstances and support them to access a wide range of non-medical services and activities that can help. In 2017/18, 256 patients were referred to three link workers and 220 people were supported. An external evaluation demonstrated that the service had a positive impact on both clients and on GPs themselves. 65 per cent of patient goals were met and 84 per cent had some positive outcome, including decreased social isolation, improved or new housing, financial and benefits issues being addressed, and increased confidence, awareness and self-esteem.

Outcomes from a GP perspective include reduced patient contact with medical services, providing more options for patients, raising awareness of non-clinical services, and increased GP productivity. 2017/18 saw a major scale-up of the SOS scheme through the Scottish Government Community Link Worker programme, extending the service from four GP practices to 16.

Delays in people leaving hospital

East Ayrshire

The Red Cross Home from Hospital Service supported about 1,700 people in 2017/18. The service is delivered across Ayrshire and Arran from University Hospitals Crosshouse and Ayr and supports people to be discharged as early as possible, reducing their length of stay and re-settling them in their home. Once home, the service helps to prevent falls and reduce social isolation, supporting people to regain their confidence, skills for living independently and organises telecare to support families to continue to care. A total of 1,730 bed days have been saved, equivalent to £302,750. 73 admissions to hospital have been avoided, and 625 bed days saved, equivalent to £109,375.

Perth and Kinross

There have been increases in staffing within social care discharge teams, Perth Royal Infirmary liaison services, and care home nursing. This, alongside improved funding procedures for care home placements, has supported speedier discharge to a care home setting or repatriation to such. There has been a reduction of 2,391 (12.5 per cent) delayed discharge bed days between 2016/17 and 2017/18 to 16,785.

Cont.

Exhibit 6 (continued)

Preventing admission to hospital

East Dunbartonshire

Rapid Response Service has established a different referral route for patients between A&E and the Community Rehabilitation Team to provide next-day response. During 2017/18, the service prevented approximately 33 per cent of people referred being admitted to hospital.

South Ayrshire

The Intermediate Care Team provide rapid multidisciplinary team support to people to support them to return home from acute hospital and to remain at home through GP referral. In particular, they have worked closely to establish pathways with the Combined Assessment Unit to prevent admission. The service provided by the Intermediate Care Team resulted in 674 hospital admissions being avoided and 301 early supported discharges during 2017/18. It is estimated locally that each avoided hospital admission saves five hospital bed days and each supported discharge saves three hospital bed days. Overall, it is estimated that the intervention provided by the Intermediate Care Team saved 3,370 bed days due to avoided admissions and 903 bed days due to early supported discharges.

Aberdeenshire

Set up in 2016, Aberdeenshire's Virtual Community Ward (VCW) aims to avoid unnecessary hospital admissions through bringing together multidisciplinary health and social care teams who provide care for patients who need regular or urgent attention. This GP-led approach involves the teams working closely together, generally meeting daily under a huddle structure. They identify and discuss vulnerable/at risk patients and clients, and coordinate, organise and deliver services required to support them. The VCW identifies individuals who need health and social care services at an earlier stage, which can improve patient outcomes and experience. Based on an evaluation carried out by the VCW team, 1,219 hospital admissions have been avoided because of the VCWs .

Referral/ care pathways

Aberdeenshire

During 2017/18 a test of change was carried out in one GP practice to trial people's first appointment with a physiotherapist rather than a GP. Ongoing evaluation suggests that this has been successful and has proved popular with patients who now have immediate access to a physiotherapist for assessment and advice. If follow up is required, this can be booked at the time. 221 people have been directed to the physiotherapist first; only 58 per cent required a face-to-face appointment and 26 per cent were discharged following telephone advice.

Renfrewshire

Over the past three years, the Primary Care Mental Health Team (Doing Well) has introduced a self-referral route to the service. This has led to a decrease in clients attending a GP to be referred to the mental health team. The number of self-referrals to the service has increased from 207 in 2013/14 to 1,237 in 2017/18. This self-referral route has successfully redirected work away from GP surgeries.

Midlothian

An advanced practitioner physiotherapist for Chronic Obstructive Pulmonary Disease (COPD) was appointed to support people attending hospital frequently because of their COPD to help them manage their symptoms at home and avoid admission to hospital. In the first year the service has worked with 65 patients and successfully avoided 30 hospital admissions. This delivered a potential reduction of 520 days spent in hospital by Midlothian residents and a much better patient experience. It was also a more cost-effective approach to delivering services for the partnership.

Cont.

Exhibit 6 (continued)

Reablement

Falkirk

A Reablement Project Team (RPT) was developed in Social Work Adult Services Assessment and Planning service in January 2017 to test out various reablement approaches and processes. The team consists of occupational therapists (with community care worker background) and social care officers. The reablement team support service users for up to six weeks. Individuals are reviewed on a weekly basis and care packages are adjusted as the person becomes more independent. Fewer people required intensive packages at the end of six weeks, which has freed up staff time and has reduced the use of external providers. Early indications suggest this work has led to a £200,000 reduction in purchasing care from external homecare providers.

Scottish Borders

The Transitional Care Facility based within Waverley Care Home is a 16-bed unit which allows older people to regain their confidence and independence so that they can return to their own homes following a stay in hospital. The facility is run by a multidisciplinary team of support workers, allied health professionals and social workers. 81 per cent of individuals discharged from Transitional Care return to their own homes and the hospital readmission rate for these individuals is six per cent.

Pharmacy

South Lanarkshire

The pharmacy plus homecare initiative has created an opportunity to amend consultant and GP prescribing practices. A reduction in prescribing can lead to less homecare visits. The IA estimates that savings could be in the region of £1,800 per patient (within the trial).

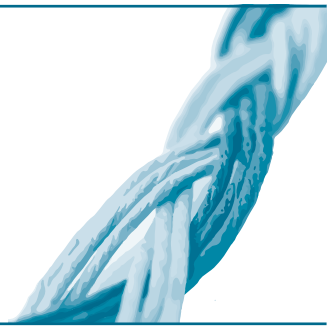
Angus

The Angus IA has improved how care homes manage medication. A new process developed by a Locality Care Home Improvement Group with GPs and pharmacy has led to zero medication waste in care homes.

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

Part 2

Making integration a success

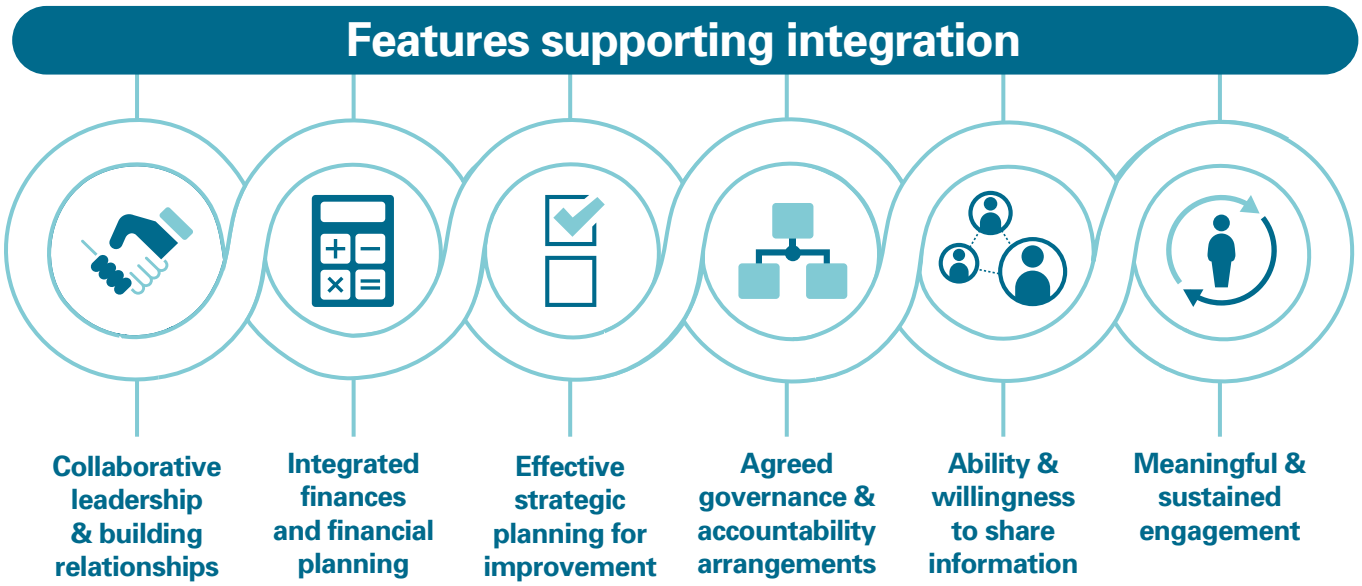


29. IAs are addressing some significant, long-standing, complex and inter-connected issues in health and social care. Our work has identified six key areas that, if addressed, should lead to broader improvements and help IAs to take positive steps toward making a systematic impact on health and care outcomes across their communities (Exhibit 7).

Exhibit 7

Features central to the success of integration

Six areas must be addressed if integration is to make a meaningful difference to the people of Scotland.



Source: Audit Scotland

A lack of collaborative leadership and cultural differences are affecting the pace of change

30. High-quality leadership is a critical part of the success of an organisation or programme of reform. Given the complexity of health and social care integration, it is important that leaders are highly competent, have capacity to deliver and are well supported. For transformation to succeed, the right leadership and strategic capacity need to be in place. Without this, the reforms will not succeed. We identified several risks in this area which need to be addressed:

- A significant number of IAs have had leadership changes with 57 per cent having had changes in their senior management team. As at October 2017, seven IJBs have a different Chief Officer (CO) in post than two years previously.

- There is significant variation in the role and remuneration of COs and Chief Financial Officers (CFO). Many have dual roles with positions held in partner organisations and there is a mix of full and part-time CFOs. This is a significant challenge, given the scale of the task facing IAs and the strategic role COs and CFOs have in directing change. In 2017/18, £3 million was spent on IJBs' CO remuneration and there are differences in salary levels, in part reflecting differences in roles and responsibilities.

- There is evidence of a lack of support services for IAs, in relation to HR, finances, legal advice, improvement, and strategic commissioning. This will limit the progress that they are able to make. It is important that the partner bodies support the IJB, including support services.

31. Top-down leadership which focuses on the goals of a single organisation does not work in the context of integration. NHS Education Scotland has described 'systems leaders' as having an ability to 'have a perspective from the wider system. They recognise that it is necessary to distribute leadership responsibilities to bring about change in a complex interdependent environment…They change the mind-set from competition to cooperation. They foster dialogue… which can result in new thinking… When leadership involves such a collective endeavour, the way people see their accountability matters.'[8] A lack of collaborative systems leadership and difficulties in overcoming cultural differences are proving to be significant barriers to change.

32. Leaders from all partners are operating in a complex and continually changing landscape and, without appropriate support in place, cannot fulfil their role effectively. Leaders need support if they are to deliver public services to improve wider outcomes and work collaboratively across organisational boundaries. This is hard to achieve, especially where there have been changes in key staff and local politicians, and in the context of the current financial and performance pressures. Accountability arrangements are important to encourage and incentivise the right kinds of leadership characteristics.

33. Cultural differences between partner organisations are proving to be a barrier to achieving collaborative working. Partner organisations work in very different ways and this can result in a lack of trust and lack of understanding of each other's working practices and business pressures. In better performing areas, partners can identify and manage differences and work constructively towards achieving the objectives of the IA. Overcoming cultural differences and improving understanding of each other's businesses will help partner organisations progress towards integration, particularly regarding integrated finances. Joint leadership development for people working in NHS boards, councils and IJBs can help with this. Exhibit 8 (page 25) provides an overview of the common leadership traits which are important in integrating health and social care services.

Exhibit 8

Traits of effective collaborative leaders

There are a number of leadership traits which are important in integrating health and social care services.

Influential leadership

- Clear and consistent message
- Presents a positive public image
- Ability to contribute towards local and national policy
- Shows an understanding of the value of services

Ability to empower others

- Encourages innovation from staff at all levels
- Non-hierarchical and open to working alongside others
- Respectful of other people's views and opinions
- Inspiring to others
- Creates trust
- Willing to work with others to overcome risks and challenges

Promotes awareness of IA's goals

- Confidence and belief in new technology to facilitate progress
- Facilitates planning of sustainable services
- Recruitment of staff to fit and contribute to a new culture
- Sets clear objectives and priorities for all
- Develops widespread belief in the aim of the integrated approach to health and social care

Engagement of service users

- People who use services feel able to contribute to change
- Ability to facilitate wide and meaningful engagement
- Open to and appreciative of ideas and innovation
- Ensures voices are heard at every level
- Transparent and inclusive

Continual development

- Encourage learning and development, including learning from mistakes
- Belief in training and understanding of who could benefit from it
- Encourage innovation, debate and discussion
- Driven to push for the highest quality possible

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

34. We have seen examples of good collaborative and whole-system leadership, including in Aberdeen City, where relationships have been built across the partnership. Although differences of opinion still exist and there is healthy debate, Aberdeen City is now better placed to implement widespread changes to improve outcomes. We saw:

- the promotion of a clear and consistent message across the partnership
- a willingness to work with others to overcome differences
- recruitment of staff to fit and contribute to a new culture
- development of openness and appreciation of ideas
- encouragement of innovation, learning and development, including learning from mistakes.

35. The Scottish Government and COSLA are co-chairing a group involving leaders from across councils and NHS boards. The aim of the group is to identify and overcome barriers to integration. The group has produced a joint statement on integration, confirming the shared responsibility of the Scottish Government, NHS Scotland and COSLA for ensuring the successful integration of Scotland's health and social care services. The statement acknowledges that the pace of integration needs to improve, and that the group needs to work together to achieve integration and to overcome challenges to better meet people's health and social care needs. The group is developing further support and training to support leadership for integration. The Scottish Government and COSLA are also co-chairing an Integration Review Reference Group. This group is reviewing progress on integration and will report its findings to the Ministerial Strategic Group for Health and Community Care. The group will conclude its work in January 2019. We will continue to monitor any actions resulting from the work of the group.

Integration Authorities have limited capacity to make change happen in some areas

36. IJBs are very small organisations, all of which have a CO and a CFO. Not all IJBs have the support they need, for example only half of IJBs have a full-time CFO and there have been difficulties in filling those posts in some areas. Each IJB has a chair and vice chair, but we have been told that many IJBs rely on its members working much more than contracted hours, and chairs and vice chairs have told us that they struggle to attend to IJB business during contracted time. Each IJB is made up of voting and non-voting members.

37. Typically, an IJB meets about six times a year. The IJB also has one or more Strategic Planning Group, which are consulted and give feedback on strategic plans and significant changes to integrated functions. For this structure to work, the IJB needs to draw on, and be supported by, skills and capacity from its partner NHS board and council. This can lead to a reliance on information and advice being provided by the statutory partner organisations which influences the decisions made by the IJB. In areas where information is being shared across the partnership, we can see that more progress is being made with integration. We saw this happening in Aberdeen City IJB, where senior officer and finance officer groups bring together staff from across partner organisations to share information and skills which are essential for joint decision-making. If this does not happen, the IJB has less capacity to make change and address challenges.

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

IJB membership
(page 10)

38. We saw several barriers affecting the way that IJBs are operating, and more action is needed to increase knowledge and understanding of those involved in the decision-making process:

- Topics for discussion at IJB and committee meetings are affected by problems with both the lack of time available and with people's knowledge.
- IJB papers are often lengthy and issued to members within timescales that do not allow for proper consideration.
- Papers are often technical and contain complicated financial information that lay representatives and representatives from voluntary sector bodies may struggle to understand.
- Officers are limited in the time available to provide IJBs with information. Many officers of the IJB fulfil their role alongside roles held within statutory partner bodies.
- High turnover of people in key positions in IJBs has affected the skills available and has led to a lack of continuity and extra time being spent in building trust and relationships.

Good strategic planning is key to integrating and improving health and social care services

39. In the past, health and social care services have not linked the resources they have to their strategic priorities or longer-term plans. IAs still have work to do to ensure that priorities are linked to available resources, and to demonstrate that new ways of working will be sustainable over the longer term. IAs can only achieve this change with the support and commitment of NHS boards and councils.

40. IJBs, with the support of council and NHS board partner bodies, should be clear about **how** and **when** they intend to achieve their priorities and outcomes, in line with their available resources; and ultimately how they intend to progress to sustainable, preventative and community-based services. This includes working with NHS boards and councils to: agree which services will be stopped or decommissioned to prioritise spend; plan effective exit strategies from current ways of delivering services; and being clear how they will measure improvements in outcomes. Exit strategies are an important element in the ability to move from one service provision to another.

41. Scenario planning will help IAs build a picture of what they will need in the future. This involves looking at current trends, such as the effects of an ageing population, current lifestyles and future advances in health and social care. IAs should then use this analysis to anticipate potential changes in future demand for services and any related shortfalls in available finances. Strategic planning groups of the IJB have a role to play in ensuring the needs of the community are central to service decisions (Case study 1, page 28).

Case study 1

Shetland Scenario Planning

As part of its Strategic Commissioning Plan, the Shetland IA identified a growing gap between service demand and resources. To support strategic planning, NHS Shetland hosted a session with health and social care staff, IJB representatives, NHS board representatives, councillors, community planning partners, third-sector organisations and representatives of people using services. It considered several high-level scenarios:

1. the lowest level of local healthcare provision that it could ever safely and realistically imagine being delivered on Shetland 5-10 years from now
2. a lower level of local healthcare provision in 5-10 years than it has now on Shetland – a 'step down' from where it is now in terms of local service delivery
3. a higher level of local healthcare provision in 5-10 years than it has now on Shetland – a 'step up' from where it is now in terms of local service delivery
4. a future that describes the highest level of local healthcare provision that it could ever realistically imagine being delivered on Shetland 5-10 years from now.

The group then concentrated on scenarios 2 and 3 and explored them in more detail.

This systematic approach towards strategic planning, involving a wide variety of stakeholders, allowed them to build consensus on the main priorities of the IJB. The key outputs from the scenario planning exercise involved clear actions that were linked to a wide range of plans and policies. The key messages from the scenario planning formed discussion points within the IJB meetings. Actions identified were then incorporated into the business programme and an action tracker is a standing agenda item.

Source: Shetland IJB, 2018

42. Although strategic planning is the statutory responsibility of the IAs, councils and NHS boards should fully support the IJB and provide the resources needed to allow capacity for strategic thinking. In addition, the Scottish Government has an important role to play in leading and enabling change to take place. There must be a consistent message and understanding of integration, but this is not always the case. For example, the current move towards some aspects of health planning taking place at a regional level is causing uncertainty for IAs. Many IAs are unclear as to how this fits with the need for local strategic planning and decision-making. For IAs to think long term, they must have confidence that Scottish Government policy will support integrated thinking.

43. Strategic planning also helps to encourage and promote joined-up working and a commitment to scaling up new ways of working. Angus IJB has shown a strong long-term commitment to its enhanced community support model. This has now been implemented in three of its four locality areas and therefore has the potential for long-term impact on people's outcomes (Case study 2, page 29).

Case study 2

Angus – Enhanced community support model

Angus IJB's Enhanced Community Support (ECS) workstream involves several multi-professional teams working together, including the third-sector. The teams provide care and support in people's own homes so that, where possible, hospital admission is avoided. As a result, staff can be more proactive, coordinate care and make referrals for additional support more quickly. The teams also hold weekly meetings to review the care that is being provided in a more coordinated way.

ECS has increased community and primary care capacity leading to an average of 37 empty hospital beds across Angus per day in 2017. This helped the IJB to close 21 of its 126 community hospital inpatient beds which are no longer needed. ECS has improved hospital readmission rates. It has also improved prevention and early intervention activity through an increase in the number of anticipatory care plans.

ECS has led to a more joined-up approach between the professional disciplines which has improved referral times and access to support. This has allowed people to be more independent, access local services and be supported to stay in their homes or a homely setting for longer.

The success of this approach has allowed the IJB to roll ECS out to three of its four localities, with plans to roll out to the final locality during 2018/19. The localities that have adopted this approach for the longest have seen improvements in the average length of stay and a reduction in the number of hospital admissions for people aged over 75.

Source: Angus IJB, 2018

44. A small number of IAs do not have detailed implementation/commissioning plans to inform their strategic plan. Of those which do, about half of these provide a link to resources. More needs to be done to show how the shift from the current ways of working to new models of care will happen and when positive changes to people's lives will be achieved.

45. Workforce pressures are a clear barrier to the implementation of integration plans and workforce planning is a particularly important element of strategic planning. Workforce planning remains the formal responsibly of councils and NHS boards. However, IJBs need to work closely with their partners to ensure that their plans for service redesign and improvement link with and influence workforce plans. IAs must be able to demonstrate what skills are required to ensure they can deliver services in the right place at the right time. IAs identify not being able to recruit and retain the workforce they need as a risk. The contribution of the third and independent sector should be part of workforce planning.

46. All three parts of the Health and Social Care National Workforce Plan have now been published, with the final part on the primary care workforce published in April 2018.[9] In our 2017 report, *NHS workforce planning*, we recommended that there is a need to better understand future demand and to provide a breakdown of the cost of meeting this demand.[10] We will publish a further report on workforce planning and primary care in 2019.

Housing needs to have a more central role in integration

47. Not enough links are being made between housing and health and social care which will improve outcomes and wellbeing. Housing services are an integral part of person-centred approaches and the wider delivery of health and social care integration. All IAs are required to include a housing contribution statement in their strategic plans and housing representation is mandatory on Strategic Planning Groups. Case study 3 illustrates strategic thinking within Glasgow City IJB which has used housing as a central aspect of health and social care. Three-quarters of IJBs reported some involvement of housing services in the planning of integrated health and social care services, although we found that the extent of this involvement varied greatly between partnerships.

Case study 3

The Glasgow Housing Options for Older People (HOOP) approach

The HOOP approach involves a small team working closely with social work, health and Registered Social Landlords (RSLs). The approach aims to: ensure a smooth transition for people from hospital to a homely setting; work closely with RSLs to prioritise people who are experiencing a delay in being discharged from hospital; develop knowledge of housing stock availability; and provide reciprocal information about RSLs tenants in hospital.

The team has worked on about 1,200 cases with surgeries in 19 sites across seven hospitals, six social work offices and six intermediate care units. The outcomes of the approach include helping:

- older people make informed choices along with their families, irrespective of tenure issues
- older people to return home or to community settings supported by a care package
- to reduce delayed discharge where there are housing issues
- prevent hospital admission and readmission, supporting older people with housing issues remain in the community
- secure appropriate accommodation for older people across the city suitable for their medical needs
- to increase knowledge of Glasgow's complex housing landscape among social workers and health professionals
- housing colleagues increase their knowledge about social work and health assistance to support older people returning home from hospital
- to future proof the city's new build investment by sharing information on customer needs and demand.

Source: Glasgow City IJB, 2018

Longer-term, integrated financial planning is needed to deliver sustainable service reform

48. Partners are finding it very difficult to balance the need for medium- to long-term planning, typically three to five years and five years plus, alongside annual settlements, current commitments and service pressures. We have called for longer-term financial planning in the health sector and local government for many years. While all IAs have short-term financial plans, only a third have medium-term plans and there were no longer-term plans in place at the time of our fieldwork. This is a critical gap as the changes under integration are only likely to be achieved in the longer term.

49. The Accounts Commission has previously reported that the 'Evidence from councils' annual audit reports generally demonstrates good medium-term (three to five years) financial planning, with some councils using scenario planning to provide a range of options'.[11] IAs should draw on the experience from councils to inform development of longer-term financial plans.

50. There is little evidence that councils and NHS boards are treating IJBs' finances as a shared resource for health and social care. This is despite the requirement to do this in the legislation, and budget processes set out in integration schemes describing budget-setting based on need. Partners must work with the IJBs to establish an approach to financial planning that considers the priorities of health and social care in the local community. Councils and NHS boards can be unwilling to give up financial control of budgets and IJBs can struggle to exert their own influence on the budget-setting process.

51. National data on the balance of spending between institutional care and care in the community is only available up to 2015/16. While this does not reflect any impact from IAs, it shows that the balance of spending changed little between 2012/13 to 2015/16 (Exhibit 9, page 32). Although this data is still collated, it is no longer published. This data should be publicly available and is a helpful indicator of whether IAs are influencing the shift of resources.

52. In October 2018, the Scottish Government published its *Medium Term Health and Social Care Financial Framework*.[12] The Framework is intended to help partners to improve strategic planning. It covers the period 2016/17 to 2023/24, and sets out trends in expenditure and activity, future demand and the future shape of health and social care expenditure.

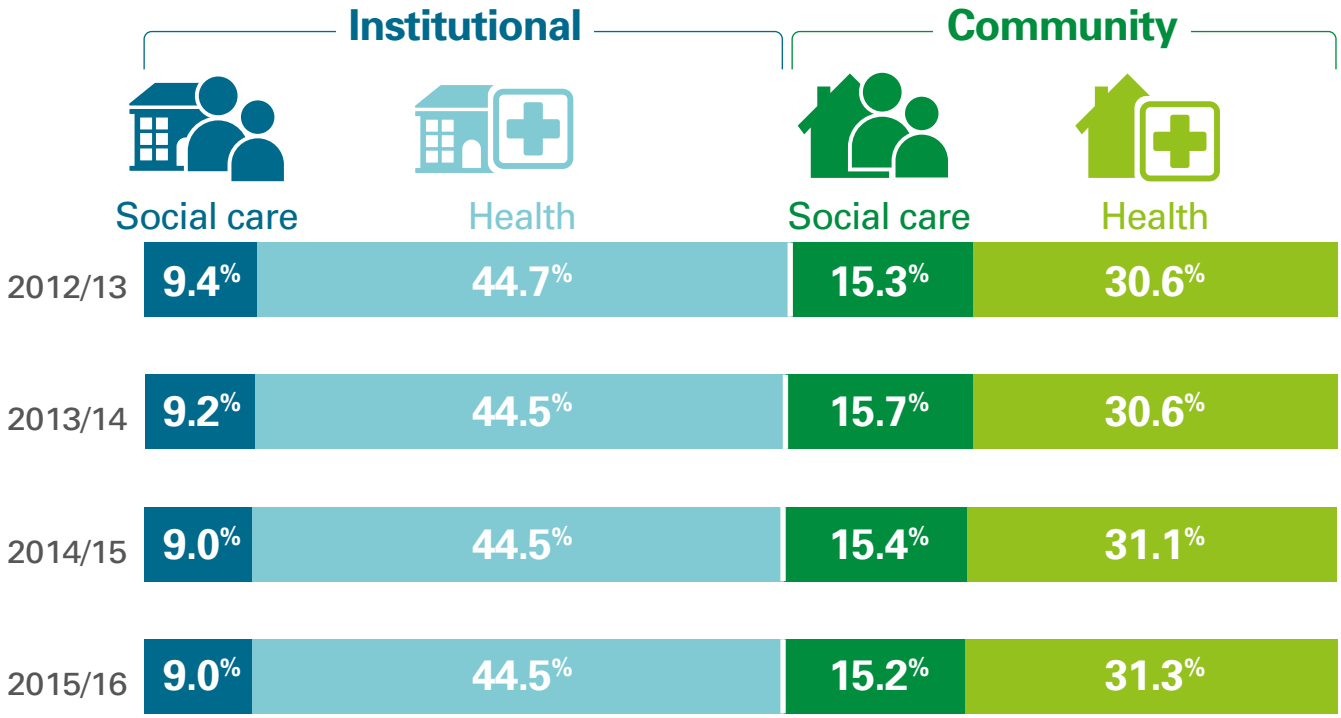
53. Attempts at integrating health and social care go back several years and it is not possible to identify the full cost of the reforms. This, in part, is due to the scale of the reforms and the interconnectedness with the rest of the health and social care system.

54. Due to ongoing financial pressures, most new service initiatives have been funded using additional financial support from the Scottish Government, rather than through the re-distribution of health and social care resources. Therefore, there should be an ongoing commitment from the Scottish Government to provide continued additional funding over coming years. This will provide financial stability to IAs while they implement new ways of working and plan how to redirect funding from current services.

Exhibit 9

The percentage of expenditure on institutional and community-based care

The percentage of expenditure on institutional and community-based care remained static between 2012/13 – 2015/16.



Source: Information Services Division, 2018

55. Major reforms have benefited from a degree of 'pump priming' money to help with change. In 2017/18, IAs total income included national funding which has been directed through NHS budgets, of:

- £100 million from the Integrated Care Fund to help shift the balance of care
- £30 million to help tackle delayed discharges
- £250 million to support payment of the living wage and help establish integration in its first year. This increased by £107 million in 2017/18.

56. The ring-fencing of funding intended to support delegated functions has not helped IAs' efforts to redirect resources, reducing their ability to use their resources flexibly. There are examples of small-scale transfers of resources and we appreciate that more time is needed for IAs to achieve this change (Case study 4, page 33). IAs need to demonstrate how they will sustain any improvements if specific dedicated funding is no longer available.

Case study 4

South Lanarkshire redirecting resources to provide more community-based care

In 2017, South Lanarkshire IJB decided to close 30 care of the elderly beds within Udston Hospital and invest in alternative community-based models of care. An assessment of need found that two-thirds of individuals on the ward could have been better cared for within a community setting. Recurring funding of about £1 million per annum was released as a result. The IJB planned for £702,000 of this to be redirected to community-based services, such as homecare and district nursing to build the area's capacity to support more people at home. To achieve this:

- engagement plans were developed to ensure people using care and their families, staff and elected members of the Udston area were involved in the changes
- financial modelling was undertaken to understand the profile of people on the ward and reallocate resources to more appropriate, alternative health and social services
- the IA worked in partnership with NHS Lanarkshire to ensure good governance.

The £702,000 provided a degree of financial flexibility to further develop intermediate care services and increase community-based rehabilitation services. The IJB plans to redesignate the Udston beds for use by step-down intermediate care patients to support a reduced reliance on the hospital and residential care.

Source: Bed Modelling in South Lanarkshire, IJB board paper, 30 October 2017

Agreeing budgets is still problematic

57. Fifteen IAs failed to agree a budget for the start of the 2017/18 financial year with their partners. This is partly down to differences in the timing of budget settlements between councils and NHS boards. It can also be due to a lack of understanding between councils and NHS boards of each other's financial reporting, accounting arrangements and the financial pressures faced by each. This lack of understanding can cause a lack of trust and reluctance to commit funds to an integrated health and social care budget.

58. There are difficulties with short-term and late budget settlements, but this should not preclude longer-term financial planning. IAs will only be able to plan and implement sustainable services if they are able to identify longer-term costs and funding shortfalls. This will also help to plan effective exit strategies from current services and larger-scale transfers of resources to community-based and preventative services.

It is critical that governance and accountability arrangements are made to work locally

59. Integrating services is a significant challenge, particularly when partners are dealing with current demand and constrained resources, while trying to better understand how services need to change. The Act should be a basis for all local partners to come together to implement changes. A perceived lack of clarity in the Act is adding to local disagreements and is delaying integration. This lack of clarity and misunderstanding is evident even among people working at senior levels and can impede good relationships.

60. Having a clear governance structure where all partners agree responsibility and accountability is vital. Disagreements can be particularly apparent when it is perceived that accountability for a decision rests with individuals who no longer have responsibility for taking them. Chief executives of councils and NHS boards are concerned that they will be held accountable for failures in how services are delivered when they are no longer responsible for directing those services. In practice, partners need to set out how local accountability arrangements will work. Integration was introduced to shift from a focus on what worked for organisations to what works for the person who needs a health and social care service. Applying this approach should help partners to implement the Act. In some areas partners are working through governance challenges as they implement the Act, and more should be done to share this experience.

61. Our first report on the integration of health and social care recommended that integration partners 'need to set out clearly how governance arrangements will work in practice…This is because there are potentially confusing lines of accountability...People may also be unclear who is ultimately responsible for the quality of care.' Clarity is still needed for local areas over who is ultimately responsible for service performance and the quality of care. In some instances, this uncertainty is hampering decision-making and redesign of services provision. Not enough has been done locally to address this.

62. IJBs have a commissioning role but most IJB COs also have delegated operational responsibility for those functions and services that are delegated to the IJB, with the exception of acute care. There are difficulties in understanding how the 'operational responsibility' aspect works in practice. Auditors report that members of IA leadership teams have differing views about governance, especially clinical governance, and roles and responsibilities. In some areas, councils and NHS boards are putting in place additional layers of reporting as if each were accountable for the actions of the IJB. The IJB approach was introduced in part to simplify arrangements, not to add complexity. There are also significant concerns about the impact of integration on the rest of the acute hospital system.

63. It is the IJB's role, through the CO, to issue directions to its partner council and NHS board about service delivery and allocation of resources. This can be made more difficult by disagreements about governance arrangements. It is complicated further by the reporting lines of the CO, who directly reports to both chief executives of the council and NHS board. COs have reported that it can be difficult to direct those who are effectively their line managers. This reinforces the need for strong relationship building and the establishment of a collective agreement over policy direction, funding arrangements and vision for integration.

Decision-making is not localised or transparent in some areas

64. The Act envisaged that decision-making would be devolved as locally as possible. In some areas, IAs, councils and NHS boards have not yet devolved decision-making in the spirit of the Act and locality plans and management structures are still in development. Officers, staff and local service providers have reported that this is because of a risk-averse response to integration that sees NHS boards and councils retain central control over decision-making. Decision-making by IAs is often influenced by statutory partners' priorities. Often, IJB members rely on their statutory partners for information, advice and policy formulation rather than taking the lead on planning and implementing new ways of providing services.

65. There are examples of IAs working hard to establish decision-making arrangements in their partnership. Aberdeen City has put in place governance systems to encourage and enable innovation, community engagement and participation, and joint working. This should leave it well placed for progressing integration and implementing new services in its community (Case study 5). We have also seen how IAs such as South Lanarkshire and Dundee City are beginning to develop locality-based approaches to service delivery (Case study 6, page 36).

Case study 5

Governance arrangements in Aberdeen City IA

Aberdeen City IJB worked with the Good Governance Institute to develop its risk appetite statement and risk appetite approach. The IJB wanted to consider which decisions and risks should, and importantly those which should not, be considered by the IJB. The idea was to ensure there was capacity for decisions to be made locally, so that staff could influence the outcomes of individuals by ensuring that care was tailored to individual needs. Staff and managers say they now feel trusted to make decisions and implement new ideas to benefit individuals in their communities.

The IJB considers that it has demonstrated an aspiration to develop and encourage innovation in local service provision, and local managers and staff understand that decision-making within localities and input of ideas is welcomed and encouraged within agreed risk parameters. Aberdeen City has worked hard to build relationships and trust throughout the partnership. It accepts that achieving its priorities will involve balancing different types of risk and that there will be a need to balance the relationship between different risks and opportunities. There is also an acceptance and tolerance that new ideas will not always be successful.

Source: Aberdeen City IJB, 2018

Case study 6

Locality approach in South Lanarkshire

In 2017, South Lanarkshire IJB realigned its management structure around its four localities. Each locality has a manager responsible for a range of multidisciplinary teams and a health and social care budget. Moving the management of services to a locality level has empowered local teams to review the models of care in their area to see what fits best for the local community. A public forum in each locality gives the local community a voice in shaping local services. Each locality has produced a local strategic needs assessment setting out local needs and priorities and directing attention towards more locally specific outcomes. A 'community first' model of care places the emphasis on developing more community capacity and support.

Staff report that multidisciplinary working and, where possible, co-location, has improved communication and learning across disciplines. They have better knowledge of skills within the wider integrated team, allowing the most appropriate professional to see people at the right time. Working with separate IT systems is a source of frustration and requires less efficient work arounds. Another challenge is balancing trying to change at pace with a need to maintain day-to-day workload. Teams have taken an incremental approach to change, starting with a small number of staff and people using the health and social care services, and, if the new model goes well, gradually increasing this until the change becomes normal practice.

Source: North Lanarkshire IJB, 2018

Best value arrangements are not well developed

66. As IJBs are local authority bodies, the statutory duty of Best Value applies to them. This means that IJBs, from the outset, must clearly demonstrate their approaches to delivering continuous improvement. In July 2017, IJBs submitted their first annual performance reports in accordance with statutory requirements. One of the reporting requirements is that they demonstrate Best Value in the delivery of services.

67. We found that some aspects of Best Value are widely covered within IJBs' annual performance reports and annual accounts, including financial planning, governance and use of resources. About half of all IJBs had a section in their annual performance reports setting out how they intended to demonstrate the delivery of Best Value. Overall the coverage varies between IJBs and is often not in enough detail to allow the public to judge the IJB's activity on continuous improvement.

IAs are using data to varying degrees to help plan and implement changes to services but there are still gaps in key areas

68. Information Services Division (ISD) is part of NHS National Services Scotland, a special NHS board. ISD provides Local Intelligence Support Team (LIST) analysts to each IA area, along with social care information known as SOURCE. Using a LIST analyst to tailor and interpret local data helps IAs to better understand local need and demand and to plan and target services. LIST also works with Community Planning Partnerships in several areas including care for prison leavers presenting to the Homeless Service and children affected by parental imprisonment.

69. Part of the work IAs are doing, supported by the LIST, is to better understand how to support the top two per cent of people using services who account for 50 per cent of hospital and GP prescribing expenditure. By doing this, they can better direct resources and take preventative steps to ensure these users receive more targeted care. This prevents unnecessary hospital admissions and improves personal outcomes through providing more appropriate care in a homely setting.

An inability or unwillingness to share information is slowing the pace of integration

70. There are several areas which need to further improve to help IAs and their council and NHS board partners make better use of data. These include:

- GP practices agreeing data-sharing arrangements with their IA
- IAs being proactive about sharing performance information, ideas and new practice with other IAs
- IAs and ISD agreeing data-sharing protocols for using data in national databases
- IAs identifying gaps in data about community, primary care and social care services and establishing how this information will be collected. This is something we have highlighted in several of our previous reports
- improving consistency in IAs' data, making comparisons easier.

71. Sharing of information, including both health and performance information, is a vital part of providing effective care that is integrated from the point of view of the people who use services. It is also vital in helping to anticipate or prevent need. Throughout our work we were told of examples where this was not happening in practice, because of local systems or behaviours. Examples include: GP practices being unwilling to share information from new service pilots with other IAs; IAs themselves being unwilling to share performance and good practice information with others; and difficulties in setting up data-sharing agreements between IAs and ISD. Different interpretations of data protection legislation are not helping with the ease with which information is being shared.

72. NHS and social care services are made up of many different specialties and localities, often with different IT systems, for example, systems to record X-ray results or record GP data. Many of these systems have been built up over years and commissioned separately for different purposes. Some services still rely on paper records.

73. This disjointedness has an impact on people who need care and on the ability of health and care professionals to provide the best support that they can. For example, people with multiple and complex health and care conditions can have to explain their circumstances to many different professionals within a short space of time. This can delay people getting the help they need, waste resources and gets in the way of care provision being more responsive to people's needs. Local data-sharing arrangements need to be in place so that professionals can appropriately share and protect the data they hold.

74. Time and money are being spent on fixing local IT problems when national solutions should be found. Local fixes are being put in place to help overcome data-sharing barriers. This includes bringing teams of staff together under one roof, so

they can discuss individual cases, rather than relying on electronic systems such as internal emails to communicate. Local areas are spending time and money implementing solutions which may continue to be incompatible in the future. There is a need for a coordinated approach to the solution, which includes the need to consider a national, single solution for Scotland.

75. New IT systems and technology are crucial to implementing new ways of working. For example, many areas are beginning to introduce virtual means of contacting people using care services, such as video links to people's homes so they do not have to visit a health or care centre. To do this successfully, a reliable communication infrastructure is needed, particularly in rural areas.

76. In April 2018, the Scottish Government published *Scotland's Digital Health & Care Strategy: Enabling, Connecting & Empowering*. As part of this, a new national digital platform is to be developed to enable the sharing of real-time data and information from health and care records as required, across the whole care system. We will monitor developments as part of our work programme.

Meaningful and sustained engagement will inform service planning and ensure impact can be measured

77. IAs were set up to have active public involvement, for example through the make-up of their boards and requirements that they publish and engage with communities about their plans. We found some good local examples of engagement. From our analysis of IA strategic plans, we saw evidence of community engagement that influenced the IA's priorities (Case study 7, page 39). Levels of ongoing engagement, and how much it shapes service redesign, are more difficult to judge, but several IAs explicitly mention the importance of engagement and see it as a priority.

78. Several third and independent sector organisations reported that they do not feel that IAs seek or value their input, although they have innovative ways to improve local services that will positively affect the lives of local people. Providers believe that service decisions are based on the funding available over the short term, rather than the needs of the community. Third-sector providers also report that there is often not time to attend engagement meetings, gather information for consultations or research lengthy committee papers. Therefore, IAs have a responsibility to help them become involved and to work with them earlier. IAs must discuss potential changes to services and funding with providers as early as possible.

79. Early engagement with staff, as with the public, has reduced since IAs published strategic plans. Staff want to know how they are contributing to the progress of integration. More communication and involvement will both help increase knowledge of the services available across partnerships and help overcome cultural differences and reluctance to accept change in ways of working.

80. Throughout this report we have recognised the challenging context IAs are operating in. This is inevitably having an impact on the extent to which they can meaningfully engage communities in discussions about improvements to services. IAs need to have in place wide-ranging and comprehensive arrangements for participation and engagement, including with local communities. Where local arrangements for engagement have been shown to work, these should continue. Engagement does not have to be managed and directed solely by the IA. If a local department or service has established relationships and means of engaging with third and independent sector providers which have proved successful, these should continue as before.

Case study 7

Edinburgh IJB: public engagement

The enhanced and proactive engagement approach adopted by Edinburgh IJB facilitated the involvement of the voluntary sector organisations in the co-production of strategic planning. Via the Edinburgh Voluntary Organisation Council, which sits on the IJB board as a non-voting member, the IJB invited the Lothian Community Health Initiatives' Forum (LCHIF) onto its Strategic Planning Groups (SPG). This allowed the LCHIF to get involved in developing the IJB's five strategic Commissioning Plans: Older People, Mental Health, Physical Disabilities, Learning Disabilities, and Primary Care.

LCHIF was subsequently invited to be part of the Older People's and Primary Care Reference Groups. Through involvement on the two reference groups, LCHIF and its members were able to contribute to the work that most reflected the services being delivered by them. The initial involvement of LCHIF on the SPG led to further engagement with other key influencing groups and networks which they felt ultimately benefited the sector, the forum and its members.

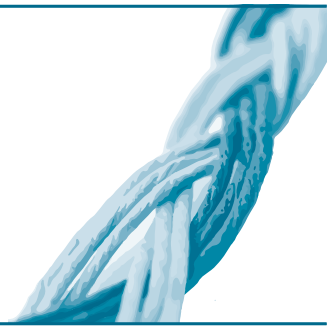
In addition to this involvement, the IJB has also embarked upon a review of its grants to the third-sector. This has been done in full collaboration and partnership with the third-sector. Through the SPG, a steering group was appointed, again with the involvement of LCHIF. This involvement contributed to a commitment being made to establish a grants forum in recognition of the ongoing dialogue that is required to ensure that prevention, early intervention and inequalities remains a priority for the IJB.

Source: Edinburgh IJB, 2018.

81. In September 2017, the Scottish Parliament's Health and Sport Committee published *Are they involving us? Integration Authorities' engagement with stakeholders*, an inquiry report on IAs' engagement with stakeholders.[13] The Committee also found a lack of consistency in stakeholder engagement across IAs. While some areas of good practice were cited, the Committee heard concerns over engagement being 'tokenistic', 'overly top down' and 'just communicating decisions that had already been made'. The Committee argued that a piecemeal approach to engagement with stakeholders cannot continue and that meaningful engagement is fundamental to the successful integration of health and social care services.

82. There is also a role for the Scottish Government in continuing to develop how learning from successful approaches to integration is shared across Scotland. IAs are not being proactive about sharing success stories and the principles behind the planning and implementation of new ways of working which have worked well. Much could be learnt from the work done to date in local areas and IAs should be encouraged to engage with each other and share knowledge and performance information.

Endnotes



1 More details about the joint inspections are available at the Care Inspectorate website.

2 *Health and social care integration*, Auditor General and Accounts Commission, December 2015.

3 *English local authority reserves,* Chartered Institute of Public Finance and Accountancy, June 2015.

4 This takes account of North Ayrshire IJB, which was the only IJB to have an accumulated negative reserve balance. This amounted to £5.8 million and was because of overspends in social care services that were not funded by additional allocations from the NHS board or council.

5 *NHS in Scotland 2018*, Auditor General, October 2018.

6 *Local government in Scotland: Challenges and performance 2018*, Accounts Commission, April 2018.

7 National Performance Framework, Scottish Government, June 2018.

8 *Systems thinking and systems leadership*, NHS Education for Scotland, 2016.

9 *National Health and Social Care Workforce Plan Part 3 – improving workforce planning for primary care in Scotland*, Scottish Government, April 2018.

10 *NHS workforce planning*, Auditor General, July 2017.

11 *Local government in Scotland: Challenges and performance 2018*, Accounts Commission, April 2018.

12 *Medium Term Health and Social Care Financial Framework*, Scottish Government, October 2018.

13 *Are they involving us? Integration Authorities' engagement with stakeholders*, Health and Sport Committee, Scottish Parliament, September 2017.

Appendix 1

Audit methodology

Our objective: To examine the impact public bodies are having as they work together to integrate health and social care services in line with the Public Bodies (Joint Working) (Scotland) Act 2014.

Our audit questions:

- What impact is integration having and what are the barriers and enablers to this change?
- How effectively are IAs planning sustainable, preventative and community-based services to improve outcomes for local people?
- How effectively are IAs, NHS boards and councils implementing the reform of health and social care integration?
- How effectively is the Scottish Government supporting the integration of health and social care and evaluating its impact?

Our methodology:

- Reviewed documents, such as integration schemes, IAs' strategic plans, IJBs' annual audit reports, annual performance reports, national performance data and other key documents including the Scottish Government's National Health and Social Care Financial Framework.
- Interviews, meetings and focus groups with a range of stakeholders including third-sector and independent sector providers. Our engagement involved hearing about experiences of engaging with IAs and how services had changed through integration.
- Interviews at four case study sites – Aberdeen City IJB, Dundee City IJB, Shetland Islands IJB and South Lanarkshire IJB. We met with:
  - Chief Officers and Chief Finance Officers
  - Chairs and vice-chairs of IJBs
  - NHS and council IJB members
  - Chief social work officers
  - IJB clinical representatives (GP, public health, acute, nursing)
  - IJB public representatives (public, carer and voluntary sector)
  - Heads of health and social care, nursing, housing and locality managers and staff
  - NHS and council chief executives and finance officers
  - IT, communications and organisational development officers.

Appendix 2

Advisory group members

Audit Scotland would like to thank members of the advisory group for their input and advice throughout the audit.

Member	Organisation
Alison Taylor	Scottish Government
Alistair Delaney	Healthcare Improvement Scotland
Allison Duncan	IJB Vice Chair
Eddie Fraser	IJB Chief Officer
Fidelma Eggo	Care Inspectorate
Gerry Power	Health and Social Care Alliance
Jeff Ace	NHS Chief Executive
John Wood	Convention of Scottish Local Authorities (COSLA)
Julie Murray	Society of Local Authority Chief Executives
Robin Creelman	IJB Vice Chair
Tracey Abdy	IJB Chief Finance Officer

Note: Members sat in an advisory capacity only. The content and conclusions of this report are the sole responsibility of Audit Scotland.

Appendix 3

Progress against previous recommendations

Recommendations	Progress
Scottish Government should:	
• work with IAs to help them develop performance monitoring to ensure that they can clearly demonstrate the impact they make as they develop integrated services. As part of this: – work with IAs to resolve tensions between the need for national and local reporting on outcomes so that it is clear what impact the new integration arrangements are having on outcomes and on the wider health and social care system.	IAs are reporting locally on outcomes but this is not being drawn together to give a national picture of outcomes for health and social care.
• monitor and publicly report on national progress on the impact of integration. This includes: – measuring progress in moving care from institutional to community settings, reducing local variation in costs and using anticipatory care plans – reporting on how resources are being used to improve outcomes and how this has changed over time – reporting on expected costs and savings resulting from integration.	We found there are a significant number of indicators and measures being used nationally and locally to understand whether integration is making a difference and to monitor changes. But, for the public to understand how the changes are working at a Scotland-wide level, these indicators need to be presented in a clear and transparent way. The Scottish Government has introduced a series of national outcomes for health and social care. The outcomes are not being routinely reported at a national level. The savings estimated to be made from integration were expected to derive from a reduction in unplanned bed days, fewer delayed discharges, improved anticipatory care and less variation in bed day rates across partnerships. The savings from these have not been specifically monitored by the Scottish Government, although actual and projected performance across these measures is reported to the Scottish Government's Ministerial Steering Group.
• continue to provide support to IAs as they become fully operational, including leadership development and sharing good practice, including sharing the lessons learned from the pilots of GP clusters.	Some leadership development has been commissioned from the Kings Fund by the Integration Division at Scottish Government but there is a lack of joint leadership development across the health and social care system to help to embed and prioritise collaborative leadership approaches. There is an appetite for examples of good practice from local partnerships but still a lack of good learning resources.

Cont.

Recommendations	Progress
Integration Authorities should:	
• provide clear and strategic leadership to take forward the integration agenda; this includes: – developing and communicating the purpose and vision of the IJB and its intended impact on local people – having high standards of conduct and effective governance, and establishing a culture of openness, support and respect.	We found that a lack of collaborative leadership and cultural differences are proving to be significant barriers to change in some areas.
• set out clearly how governance arrangements will work in practice, particularly when disagreements arise, to minimise the risk of confusing lines of accountability, potential conflicts of interests and any lack of clarity about who is ultimately responsible for the quality of care and scrutiny. This includes: – setting out a clear statement of the respective roles and responsibilities of the IJB (including individual members), NHS board and council, and the IJB's approach towards putting this into practice – ensuring that IJB members receive training and development to prepare them for their role, including managing conflicts of interest, understanding the organisational cultures of the NHS and councils and the roles of non-voting members of the IJB.	There is a lack of agreement over governance and a lack of understanding about integration which is acting as a significant barrier to progress in some areas. There are still circumstances where clarity is needed over who is ultimately responsible for service performance and the quality of care. In some instances, this uncertainty is hampering decision-making and redesigning how services are provided. Not enough has been done locally to address this.
• ensure that a constructive working relationship exists between IJB members and the chief officer and finance officer and the public. This includes: – setting out a schedule of matters reserved for collective decision-making by the IJB, taking account of relevant legislation and ensuring that this is monitored and updated when required – ensuring relationships between the IJB, its partners and the public are clear, so each knows what to expect of the other.	IAs have helped to improve engagement with the public and providers in the local area in some instances but there is more to do.
• be rigorous and transparent about how decisions are taken and listening and acting on the outcome of constructive scrutiny, including: – developing and maintaining open and effective mechanisms for documenting evidence for decisions – putting in place arrangements to safeguard members and employees against conflict of interest and put in place processes to ensure that they continue to operate in practice – developing and maintaining an effective audit committee – ensuring that effective, transparent and accessible arrangements are in place for dealing with complaints. – ensuring that an effective risk management system is in place.	We found that decision-making is not localised or transparent in some areas and risk management arrangements are not well developed.

Cont.

Recommendations	Progress
• develop strategic plans that do more than set out the local context for the reforms; this includes: – how the IA will contribute to delivering high-quality care in different ways that better meets people's needs and improves outcomes – setting out clearly what resources are required, what impact the IA wants to achieve, and how the IA will monitor and publicly report their progress – developing strategies covering the workforce, risk management, engagement with service users and data sharing, based on overall strategic priorities to allow the IA to operate successfully in line with the principles set out in the Act and ensure these strategies fit with those in the NHS and councils – making clear links between the work of the IA and the Community Empowerment (Scotland) Act and Children and Young People (Scotland) Act.	IAs are beginning to link their resources to strategic priorities but more needs to be done to show when their planned outcomes will be achieved. They also need to show how the shift from the current ways of working to new models of care will happen.
• develop financial plans that clearly show how IAs will use resources such as money and staff to provide more community-based and preventative services. This includes: – developing financial plans for each locality, showing how resources will be matched to local priorities – ensuring that the IJB makes the best use of resources, agreeing how Best Value will be measured and making sure that the IJB has the information needed to review value for money and performance effectively.	There is some evidence of small-scale transfers of resources, but most IAs have funded changes to services using ring-fenced funding, such as specific additional integrated care funding provided by the Scottish Government. This is instead of shifting resources from an acute setting, such as hospitals, to community settings such as local clinics and GP surgeries. While this may have achieved performance improvement in things such as delayed discharges, ring-fenced funding may not be available long term. Therefore, IAs need to ensure the financial sustainability of ongoing support for changes made. Financial planning is not integrated, or long term and financial pressures make meaningful change hard to achieve. Arrangements for understanding and measuring Best Value arrangements are not well developed.
• shift resources, including the workforce, towards a more preventative and community-based approach; it is important that the IA also has plans that set out how, in practical terms, they will achieve this shift over time.	We found there has been limited change in how resources are being used across the system at this stage – see above.

Cont.

Recommendations	Progress
Integration Authorities should work with councils and NHS boards to:	
• recognise and address the practical risks associated with the complex accountability arrangements by developing protocols to ensure that the chair of the IJB, the chief officer and the chief executives of the NHS board and council negotiate their roles in relation to the IJB early in the relationship and that a shared understanding of the roles and objectives is maintained.	We found a lack of agreement over governance and a lack of understanding about integration remain significant barriers in some areas. There are still circumstances where clarity is needed over who is ultimately responsible for service performance and the quality of care. In some instances, this uncertainty was hampering decision-making and redesigning how services are provided. In our opinion, not enough has been done locally to address this.
• review clinical and care governance arrangements to ensure a consistent approach for each integrated service and that they are aligned to existing clinical and care governance arrangements in the NHS and councils.	Auditors report that members of IA leadership have differing views about governance, especially clinical governance, and roles and responsibilities.
• urgently agree budgets for the IA; this is important both for their first year and for the next few years to provide IAs with the continuity and certainty they need to develop strategic plans; this includes aligning budget-setting arrangements between partners.	We found that at present, not all councils and NHS boards view their finances as a collective resource for health and social care. Some councils and NHS boards are still planning budgets around their own organisations rather than taking account of their IJBs local strategic priorities. The ambition for integration is that the health and social care resources in the local area would be brought together and used to deliver integrated services with improved outcomes for people. While this is happening in some areas, councils and NHS boards in other areas can be unwilling to give up financial control of budgets and IJBs can struggle to exert influence over their budgets. Some IAs have little or no involvement in the budget-setting process. At a very basic level IJBs struggle in some areas to agree budgets. Fourteen IJBs failed to agree a budget for the start of the 2017/18 financial year.
• establish effective scrutiny arrangements to ensure that councillors and NHS non-executives, who are not members of the IJB board, are kept fully informed of the impact of integration for people who use local health and social care services.	We have seen that IJB board papers are shared with council and NHS board partner organisations. In some areas though, rather than streamlining governance and scrutiny arrangements, councils and NHS boards are putting in place additional layers of reporting as if each were accountable for the actions of the IJB.
• put in place data-sharing agreements to allow them to access the new data provided by ISD Scotland.	IAs and ISD are have difficulties in agreeing data-sharing protocols for using national databases.

Appendix 4

Financial performance 2017/18

IJB	Position (pre-additional allocations) Overspend/ (underspend)	Additional allocation/ (reduction) Council	Additional allocation/ (reduction) NHS board	Use of reserves	Year-end position Deficit/ (Surplus)
	(£million)	(£million)	(£million)	(£million)	(£million)
Aberdeen City	2.1	0	0	2.1	0
Aberdeenshire	3.5	1.5	2.0	0	0
Angus	(0.4)	0	0	0	(0.4)
Argyll and Bute	2.5	1.2	1.4	0	0
Clackmannanshire and Stirling	1.1	0	0	1.1	0
Dumfries and Galloway	(2.5)	0	0	0	(2.5)
Dundee City	2.5	0	2.1	0.4	0
East Ayrshire	3	2.2	1.3	0	(0.5)
East Dunbartonshire	1.1	0	0	1.1	0
East Lothian	0.7	0.6	0.1	0	0
East Renfrewshire	(0.4)	0	0	0	(0.4)
Edinburgh	7.4	7.2	4.9	0	(4.7)
Eilean Siar	(3.0)	0	0	0	(3.0)
Falkirk	1.3	0	1.4	0.2	(0.3)
Fife	8.8	2.5	6.4	0	0
Glasgow City	(12.0)	0	0	0	(12.0)
Inverclyde	(1.8)	0	0	0	(1.8)
Midlothian	(0.7)	0.2	0	0	(0.9)
Moray	1.9	0	0	1.9	0
North Ayrshire	3.5	0	1.0	0	2.6
North Lanarkshire	(11.7)	0	0.6	0	(12.3)
Orkney	0.7	0.2	0.5	0	0
Perth and Kinross	(1.4)	(2.6)	1.3	0	0
Renfrewshire	4.8	2.7	0	2.1	0
Scottish Borders	4.5	0.3	4.2	0	0
Shetland	2.4	(0.3)	2.9	0	(0.2)
South Ayrshire	0.3	0	0	0.3	0
South Lanarkshire	(1.2)	0	1.0	0	(2.2)
West Dunbartonshire	(0.6)	0	0	0	(0.6)
West Lothian	1.8	0	1.8	0	0

Note: Arithmetic differences arising from roundings.
Source: Audited Integration Authority annual accounts, 2017/18

Health and social care integration

Update on progress

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REPORT TO: **MORAY INTEGRATION JOINT BOARD AUDIT, PERFORMANCE AND RISK COMMITTEE ON 13 DECEMBER 2018**

SUBJECT: **PAYMENT VERIFICATION ASSURANCE UPDATE**

BY: **CHIEF OFFICER**

1. REASON FOR REPORT

1.1 The purpose of this report is to update the Audit Performance &Risk Committee (APR) on the activity of the Payment Verification (PV) Assurance Group during 2017/18 and the Revised Payment Verification Protocols for all contractor groups as detailed in the Document List (DL) (2018)19. This report allows the Committee to be sighted on the key issues highlighted during the course of the year.

2. RECOMMENDATION

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

i) consider the arrangements in place in Grampian for the management of the payment verification process;

ii) note the outcomes from the Payment Verification process during 2018/19; and

iii) note the review of the PV Service provided by National Services Scotland (NSS) Practitioner Services Divisions (PSD) on behalf of NHS Grampian.

3. BACKGROUND

3.1. NHS Grampian has statutory responsibility for monitoring contracts with Family Health Service providers covering General Medical services (GMS) Dental Pharmacy and Optometry.

3.2. Contracts with independent practitioners for the delivery of Family Health Services (FHS) i.e. General Medical, General Pharmaceutical, General Dental and Ophthalmic services are, mainly, subject to nationally agreed terms and

conditions, with some exceptions that allow for local agreement on enhanced services.

3.3. NHS Boards are the accountable bodies for the delivery of FHS and are required to ensure that payments made to independent practitioners are valid and in line with agreed contractual arrangements, timely and accurate. The responsibility for the planning and delivery of FHS was delegated to the three Grampian Integration Joint Boards (IJB's) with effect from 1 April 2016 and the operational management of these services is hosted by the Moray IJB on behalf of all three.

3.4. As part of the NHS Grampian Audit process, the PV Assurance Group implements and oversees management arrangements covering pre and post verification of payments across all independent medical, dental, pharmaceutical and ophthalmic primary care practitioners. PV is regulated through the protocols set out in the (NHS) Chief Executive's Letter (CEL) DL (2018) 19 issued in October 2018.

3.5. NHS Grampian's PV Assurance Group is chaired by the Service Manager for Primary Care Contracts (PCC). Membership includes Health & Social Care Partnership (HSCP), Primary Care Leads, Finance Manager, Clinical and Planning Leads, representatives from the PCC Team and Practitioners Services Department (PSD) Links are maintained with NHS Counter Fraud Services and the Assistant Director of Finance who is also NHS Grampian's Fraud Liaison Officer via the Chair of the PV Assurance Group.

4. KEY MATTERS RELEVANT TO RECOMMENDATION

4.1 The Payment Verification process is embedded in local management performance and governance processes, within the H&SC Partnerships, for primary care. Information from the formal PV reports prepared by Practitioner Services Division in line with regulatory requirements as outlined in the CEL is used alongside local knowledge to identify areas of interest or concern. Where relevant, these are then followed up either across the whole contractor group, or with individual contractors as appropriate.

4.2 In the year 2017/18, there have been some significant challenges identified in relation to the PV service provided by PSD and as such, the Service Manager Primary Care Contracts has begun a review of this service.

Medical

4.3 The revision for 2018 -19 PV reflects the changes to the GP Contract and the introduction of the Scottish Workload Formula (SWF). As a result the following areas have been removed from the PV Protocol;

- Organisational Core Standard Payment
- Temporary Patients Adjustment (TPA)
- Additional Services
- Quality and Outcome Framework (QOF)

4.4 The following areas are now determined within the PV requirements for Primary Medical Services; these are detailed in full in the PV Protocol:

- Retention of evidence
- Data Protection
- Premises and IT Costs
- PV of Global Sum
- Random Checking
- Targeted checking
- PV Practice Visit
- Trend Analyses
- PV of Board Admin Funds
- PV for Enhanced Services
- GP Practice System Security

4.5. PSD carried out seven PV practice Visits in the year 2017/18 (Quarter 3- October - December). As a consequence of these visits, several recoveries were made in relation to; High Risk Medicines Monitoring; Minor Surgery and Extended Hours.

4.6. NHS Grampian Enhanced Service Group requested PSD to support the review of the Local Enhanced Service (LES) Contract for Homeopathy Service and because of data received, this LES was withdrawn in October 2018. The withdrawal of the LES was ratified by NHS Grampian Local Medical Contract negotiation Committee. On review of the Service it became apparent that the significant reduction in numbers being referred meant the Service was not fulfilling the terms of the contract. The annual cost of the LES to NHS Grampian was, £36,696 per annum (£3,058 per month).

Dental

4.7. One of the methods of verifying payments made under the General Dental Services arrangement is to examine patients. This is carried out by the Scottish Dental Reference Service (SDRS).

4.8 In the Report to the Audit and Risk Committee on 28 September 2017 (para 8 of the minute refers), The Service Manager Primary Care Contracts expressed concern about the access to the Dental Reference Officers (DRO) and the considerable length of time for outputs to be shared with NHSG PV Assurance Group.

4.9 Members of the PV assurance Group met with the Dental Director, National Services Scotland in 2017, where these concerns were noted. This resulted in more assurance that random DROs were being actioned. However, in the recent months there is again a concern about this service. This has been raised with PSD and will be discussed in full with Senior Management.

4.10. NHS Grampian closely monitors the performance of Scottish Dental Access Initiative (SDAI) practices through the PV group and the Dental Performance Advisory Group and as a result can report that 3 such practices are undergoing recovery of grant aided money as a result of non-compliance. This amounts to £235,071.43 across all three practices.

Ophthalmic

4.11. There are no significant concerns regarding care and treatment or recovery of claims within the Ophthalmic PV reports

4.12. There is however concern about the timescales for reporting on PV requirements.

Pharmacy

4.13 There are no significant concerns regarding care and treatment or recovery of claims within the Ophthalmic PV reports

4.14. There is however concern about the timescales for reporting on PV requirements

5. SUMMARY OF IMPLICATIONS

(a) Corporate Plan and 10 Year Plan (Local Outcomes Improvement Plan (LOIP)) and Moray Integration Joint Board Strategic Commissioning Plan 2016 – 2019

The MIJB requires effective governance arrangements for those services and functions delegated to it. Such governance arrangements include systems for managing risks.

(b) Policy and Legal

There are no legal implications arising from this report.

(c) Financial implications

There are no direct financial implications arising from this report but the Committee should note the failure to manage risks effectively could have a financial impact on the MIJB.

(d) Risk Implications and Mitigation

There is a risk that NHS Grampian does not have full assurance that PV is being carried out appropriately and as a result, they may not fulfil its statutory responsibility for monitoring contracts with Family Health Service providers covering General Medical services (GMS) Dental Pharmacy and Optometry.

The Service Manager Primary Care Contracts has, as identified earlier begun a significant review of the PV service across all contractors.

PSD visit NHS Board to jointly review performance under the partnership agreement and consider together service developments.

The current Partnership Agreement expires in March 2019 and therefore there will be an opportunity to discuss proposed changes, which will be effective for the three years April 2019 to March 2022. These changes are likely to modify some services and performance standards, notably in payment verification, and also updated arrangements for data processing and information sharing following the implementation of the General Data Protection Regulation in May 2018.

The NHS Grampian PSD Partnership Agreement meeting will also present the opportunity for NHS Grampian to fully address the challenges and concerns regarding timescales in particular detailed in this report and receive assurances that these will be remedied.

(e) Staffing Implications

There are no staffing implications directly arising from this report.

(f) Property

There are no implications in terms of Council or NHS property directly arising from this report.

(g) Equalities/Socio Economic Impact

An Equality Impact Assessment has not been completed because there are no service, policy or organisational changes being proposed

(h) Consultations

Consultation has taken place with key stakeholders from NHS Grampian; including Primary Care Clinical Leads, Management Leads, Finance colleagues and Directors of Contractor areas; Chief Financial Officer, Legal Services Manager (Litigation and Licencing) and Caroline Howie, Committee Services Officers and comments have been incorporated in this report.

6. CONCLUSION

6.1. The Audit Performance& Risk Committee is asked to note the content of this report and the continued work and arrangements around the payment verification process within NHS Grampian.

6.2. It is also asked to support the review of the PV process being carried out and the proposed discussion and any necessary amendments to the Partnership agreement between NHS Grampian and PSD.

6.3. Finally, it may be that the Audit Performance & Risk Committee request an update further to discussions with PSD regarding the Partnership Agreement.

Author of Report: Patricia Morgan; Service Manager Primary Care Contracts

Background Papers: DL (2018)19. Revised Payment Verification Protocols – General Dental Services, Primary Care Services, General Ophthalmic Services, Pharmaceutical Services.

Ref: