AGENDA ITEM NO: 11

Report To:	**Inverclyde Integration Joint Board**	**Date: 29 January 2019**
Report By:	**Louise Long** **Corporate Director, (Chief Officer)** **Inverclyde Health & Social Care Partnership**	**Report No: IJB/03/2019/LA**
Contact Officer	**Helen Watson** **Head of Service Strategy and Support Services** **Inverclyde Health and Care Partnership**	**Contact No: 01475 715381**
Subject:	**AUDIT SCOTLAND REPORTS - NHS IN SCOTLAND AND HEALTH & SOCIAL CARE INTEGRATION: UPDATE ON PROGRESS**	

1.0 PURPOSE

1.1 The purpose of this report is to share the recent Audit Scotland reports on "NHS in Scotland" and "Health & Social Care Integration: Update on Progress" with the Inverclyde Integration Joint Board (IJB) and advise of the key areas relevant to the IJB.

2.0 SUMMARY

2.1 Audit Scotland published their report "NHS in Scotland" in October 2018 and their report "Health & Social Care Integration: Update on Progress" in November 2018. These reports highlighted a number of key findings and recommendations for the Scottish Government, Health Boards and Integration Authorities. The full reports are enclosed as appendices to this report.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Integration Joint Board

1. Notes the Audit Scotland reports and the Inverclyde position in relation to the reports key messages.
2. Agrees that the Action Plan is monitored through the IJB Audit Committee.

Louise Long
Corporate Director (Chief Officer)

4.0 BACKGROUND

4.1 The Scottish Government set out how it wants healthcare and the health of the Scottish population to change in its 2020 Vision. The aim is that everyone should live longer, healthier lives at home or in a homely setting. The "NHS in Scotland" report sets out immediate actions required to deliver this vision, identifies the financial and performance position of the NHS in Scotland and sets out what needs to change to ensure the NHS continues to meet the needs of the Scottish people. The full report is enclosed in Appendix A.

4.2 The "Health & Social Care Integration: Update on Progress" report was published in November 2018. The report examines the effectiveness of governance arrangements in integration authorities. The full report is enclosed in Appendix B.

5.0 KEY MESSAGES AND RECOMMENDATIONS

5.1 Key messages from the NHS in Scotland report:

1. The NHS needs to move away from short term fire-fighting to long term fundamental change.
2. The NHS in Scotland is not in a financially sustainable position.
3. Pressure on the NHS is increasing while performance against the eight key national performance targets continues to decline.
4. Decisive action is required to ensure the NHS is fit to meet the people's needs in the future.
5. Effective leadership is critical. More information is needed about how new forms of care will work, what they will cost and the difference they will make to people's lives.

5.2 Recommendations from the NHS in Scotland report:

The Scottish Government should:

- develop a robust and transparent financial management system for managing and monitoring NHS boards' new year-end flexibility and three-year break-even arrangement.
- ensure NHS governance arrangements are clear and robust with explicit roles and responsibilities and clear lines of accountability at each planning level.
- report publicly on the progress of the Health and Social Care Delivery Plan.

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

- strengthen board-level governance arrangements, including developing an improved national approach to induction, training, and assessment for non-executive directors.
- identify why NHS leadership posts are difficult to fill and develop ways to address this.

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

- develop a national capital investment strategy to ensure capital funding is strategically prioritised.
- continue to develop a comprehensive approach to workforce planning.
- provide a clear breakdown of transitional and future costs to meet projected demand through additional recruitment and training.

The Scottish Government, NHS boards and integration authorities should:

- work together to develop a clearer understanding of demand for services, and capacity and activity trends within primary and secondary care and use this to inform medium to long-term service and workforce planning.
- publish clear and easy to understand information on how the health funding system works, including how much funding was provided, what it was spent on, and the

impact it has on people's lives.

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

5.3 Key messages from the Health and Social Care Integration: Update on Progress report:

1. Integration Authorities (IAs) are operating in an extremely challenging environment. They 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 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. 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. 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.

5.4 Recommendations from the Health and Social Care Integration: Update on Progress report:

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.
- 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:

- 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.
- urgently resolve difficulties with the 'set-aside' aspect of the Act.
- support councillors and NHS board members who are also Integration Joint Board members to understand, manage and reduce potential conflicts with other roles.
- monitor how effectively resources provided are being used and share data and performance information widely to promote new ways of working across Scotland.

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.
- view their finances as a collective resource for health and social care to provide the

best possible outcomes for people who need support.
- 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.

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.
- 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.
- 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.

6.0 INVERCLYDE INTEGRATION JOINT BOARD POSITION AND PROPOSED ACTIONS

6.1 Of the 27 recommendations made within the two reports:

- 5 relate to the Scottish Government.
- 2 relate to the Scottish Government, in partnership with NHS boards.
- 5 relate to the Scottish Government and COSLA.
- 4 relate to Integration Authorities (IAs), councils and NHS boards.
- 5 relate to the Scottish Government, COSLA, councils, NHS boards and IAs.
- 6 relate to the Scottish Government, NHS boards and IAs.

Appendix C contains a summary of the recommendations requiring IJB action together with a note of the Inverclyde position and proposed timelines and responsible officers for any required local actions.

7.0 IMPLICATIONS

7.1 FINANCE

There are no direct financial implications arising from this report.

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

Annually Recurring Costs / (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From	Other Comments
N/A					

LEGAL

7.2 There are no specific legal implications arising from this report.

HUMAN RESOURCES

7.3 There are no specific human resources implications arising from this report.

EQUALITIES

7.4 There are no equality issues within this report.

Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
√	NO – This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

7.5 How does this report address our Equality Outcomes?

There are no Equalities Outcomes implications within this report.

Equalities Outcome	**Implications**
People, including individuals from the above protected characteristic groups, can access HSCP services.	None
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	None
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	None
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	None

7.6 **CLINICAL OR CARE GOVERNANCE IMPLICATIONS**

There are no clinical or care governance issues within this report.

7.7 **NATIONAL WELLBEING OUTCOMES**

How does this report support delivery of the National Wellbeing Outcomes

There are no National Wellbeing Outcomes implications within this report.

National Wellbeing Outcome	Implications
People are able to look after and improve their own health and wellbeing and live in good health for longer.	None
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	None
People who use health and social care services have positive experiences of those services, and have their dignity respected.	None
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	None
Health and social care services contribute to reducing health inequalities.	None
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	None
People using health and social care services are safe from harm.	None
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.	None
Resources are used effectively in the provision of health and social care services.	None

8.0 CONSULTATION

8.1 This report has been prepared by the IJB Chief Financial Officer in consultation with the Chief Officer and the Health Board's Director of Finance and Council's Chief Financial Officer.

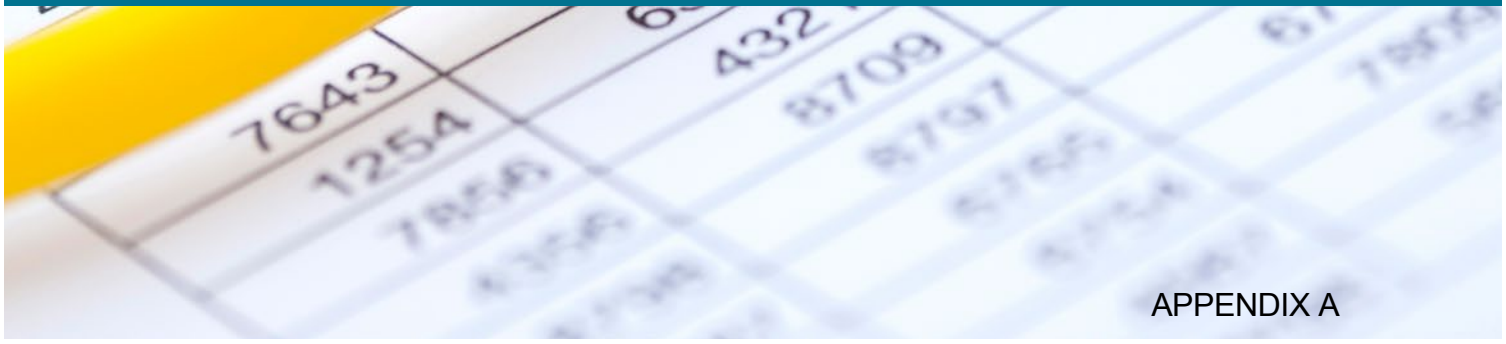
9.0 BACKGROUND PAPERS

9.1 None.

NHS in Scotland 2018

AUDITOR GENERAL

Prepared by Audit Scotland
October 2018



APPENDIX A

Auditor General for Scotland

The Auditor General's role is to:

- appoint auditors to Scotland's central government and NHS bodies
- examine how public bodies spend public money
- help them to manage their finances to the highest standards
- check whether they achieve value for money.

The Auditor General is independent and reports to the Scottish Parliament on the performance of:

- directorates of the Scottish Government
- government agencies, eg the Scottish Prison Service, Historic Environment Scotland
- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Police Authority, Scottish Fire and Rescue Service.

You can find out more about the work of the Auditor General on our website: www.audit-scotland.gov.uk/about-us/auditor-general

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

Contents

Links

PDF download

Web link

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

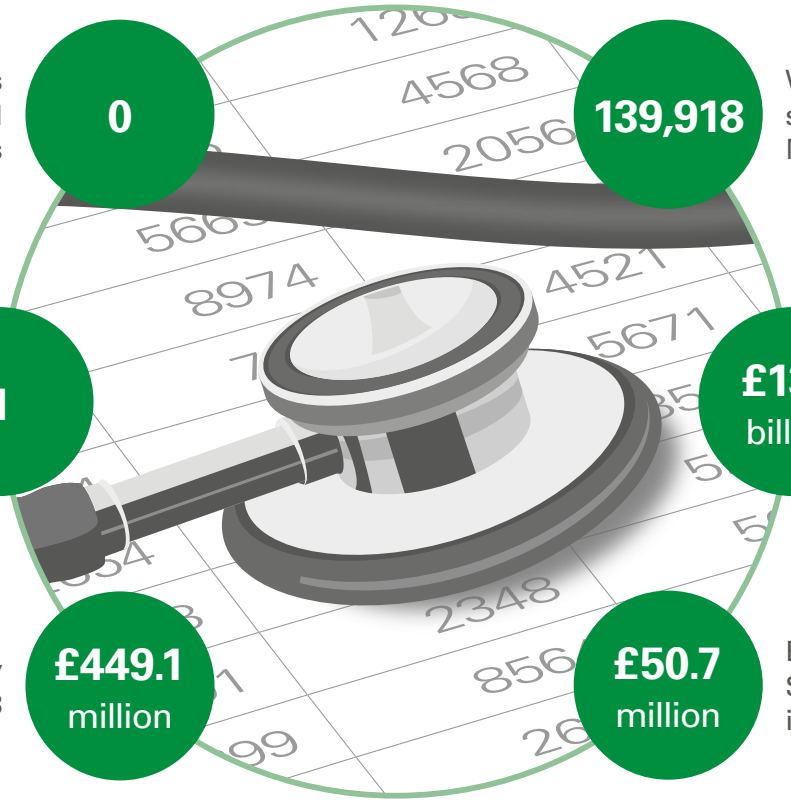
Exhibit data

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

Audit team

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

Key facts



0
Number of boards meeting all key national performance targets

139,918
Whole time equivalent staff employed by the NHS

1
Key national performance target met

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

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

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

Summary

Key messages

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

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

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

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

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

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

Recommendations

The Scottish Government should:

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

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

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

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

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

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

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

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

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

The Scottish Government, NHS boards and integration authorities should:

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

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

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

Introduction

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

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

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

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

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

Part 1

Why is immediate action needed?

Key messages

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

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

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

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

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

The NHS is not in a financially sustainable position

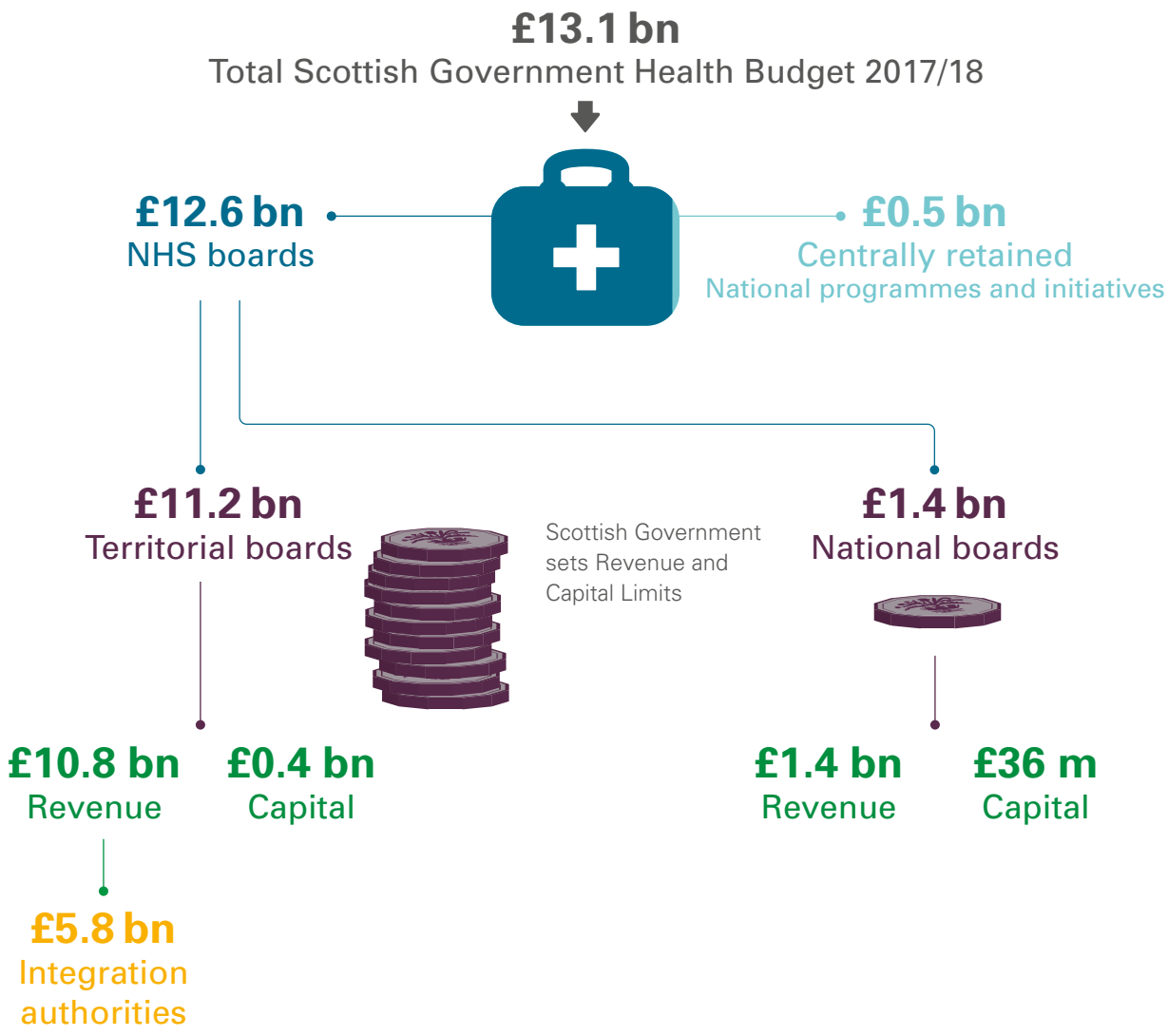
5. Financial sustainability considers whether a body is likely to be able to continue delivering services effectively or change how services are delivered in the medium to longer term with the available resources. We have looked at a number of measures which indicate risks to the sustainability of the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

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

Exhibit 1

Health funding breakdown 2017/18

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



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

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

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

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

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

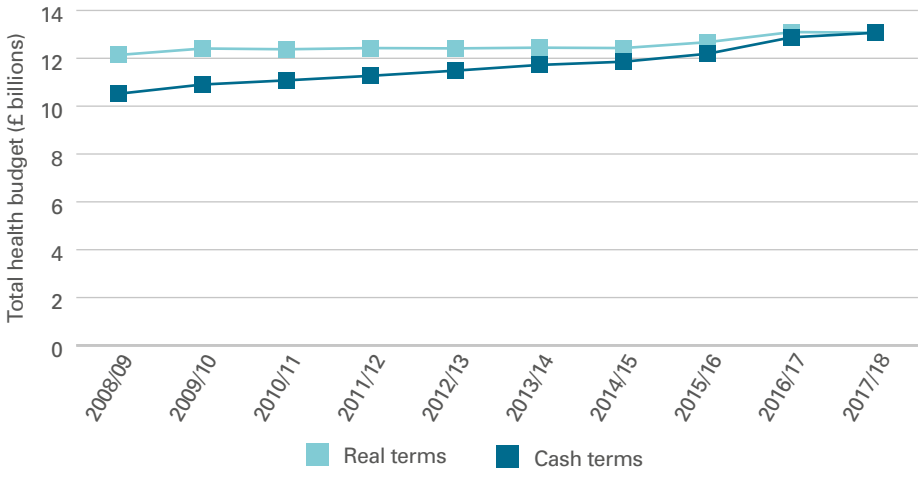
9. In 2017/18, NHS boards' budgets included £107 million ring-fenced funding for health and social care integration. NHS boards were required to pass this funding directly to integration authorities.

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

Exhibit 2

Trends in the health budget in Scotland, 2008/09 to 2017/18

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



Source: Audit Scotland

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

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

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

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

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

More boards are predicting year-end deficits

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

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

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

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

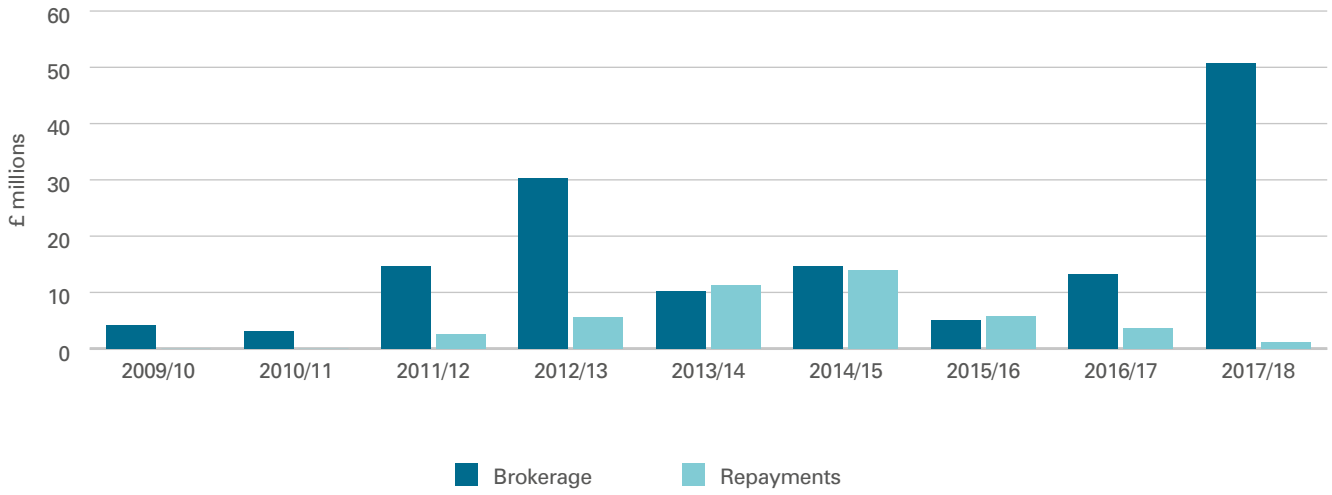
17. In 2017/18, the Scottish Government provided loans totalling £50.7 million to NHS Ayrshire and Arran, Highland, and Tayside. This allowed them to break even. This is significantly more than in 2016/17 and in previous years (Exhibit 3, page 12). The total amount of outstanding loans across all NHS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

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

Exhibit 3

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

Loans paid out are greater than the amount repaid.



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

Source: Audit Scotland

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

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

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

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

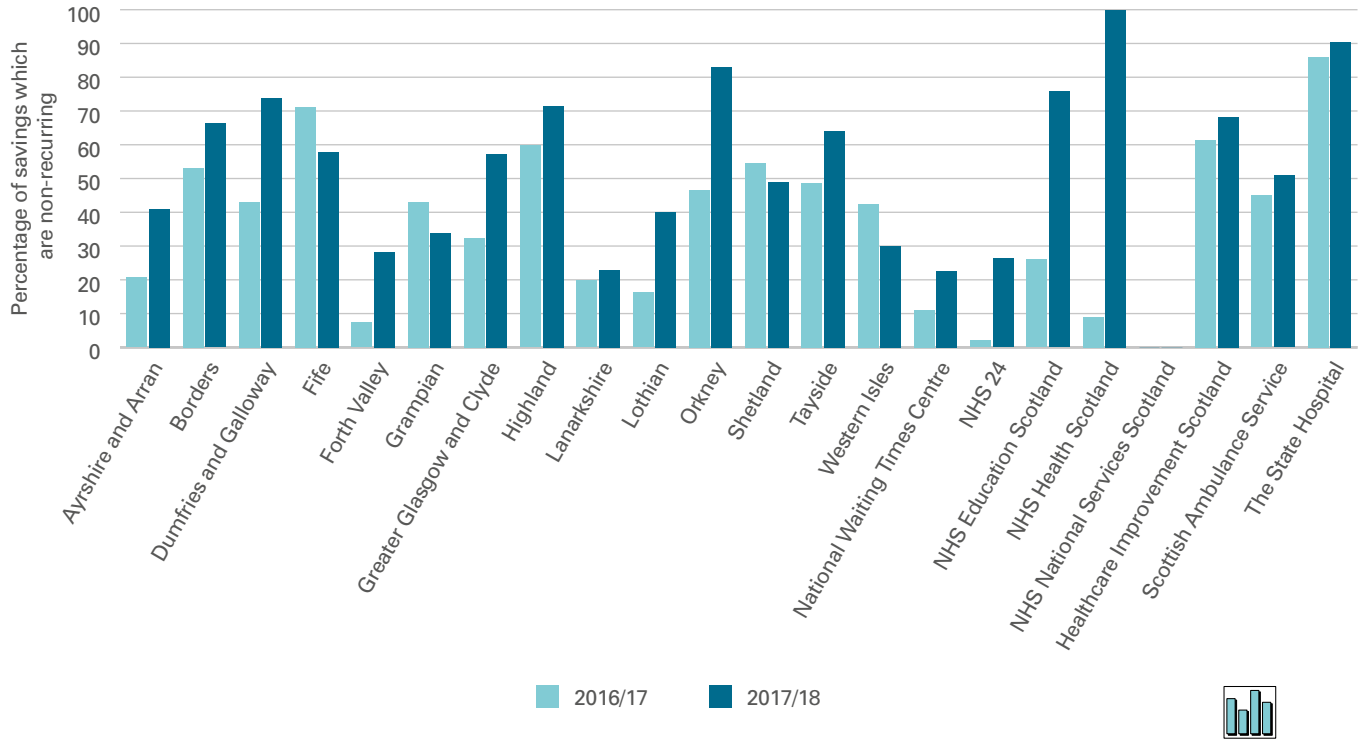
21. In 2017/18, 50 per cent of all savings were one-off (non-recurring), up from 35 per cent in 2016/17, and 20 per cent in 2013/14.[15] Savings reduce expenditure and contribute to achieving financial targets, but they do not necessarily mean increased efficiency or effectiveness.

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

Exhibit 4

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

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



Source: NHS board annual audit reports 2017 and 2018

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

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

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

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

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

Cost pressures continue to intensify

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

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

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

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

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

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

Increases in health costs are likely to outstrip funding increases

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

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

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

Exhibit 5
Cost pressures in 2017/18

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

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

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

5% decrease in real terms on the previous year.

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

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

10% decrease in real terms on the previous year.

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

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

5% increase in real terms on the previous year.

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

Backlog maintenance has increased

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

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

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

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

£899m
Total maintenance backlog in 2017/18.

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

Spending on drugs continues to rise

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

1.5% increase in real terms from 2015/16.

19.4% increase over the past five years.

£1.3bn
spend in community.

£0.4bn
spend in hospitals.

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

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

Cont.

Exhibit 5 (continued)

Spending on drugs continues to rise (continued)

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

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

Clinical negligence costs continued to increase

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

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

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

Source: Audit Scotland

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

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

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

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

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

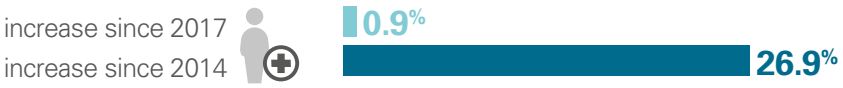
34. The number of people waiting for first outpatient and inpatient appointments continued to increase in the past year while elective and emergency admissions declined. Exhibit 6 (page 17) shows trends across indicators of demand and activity for acute services.

Exhibit 6

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

Demand for secondary care services

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

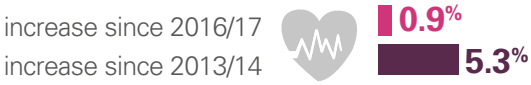


72,837 patients waiting for first **inpatient** appointment in March 2018

Activity

149,424 elective admissions in 2017/18

593,531 emergency admissions in 2017/18



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

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

1,434,118 procedures in 2017/18

453,731 daycase patients in 2017/18

6.2 days average length of hospital stay in 2017/18

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

Trends in demand and activity need to be better understood

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

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

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

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

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

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

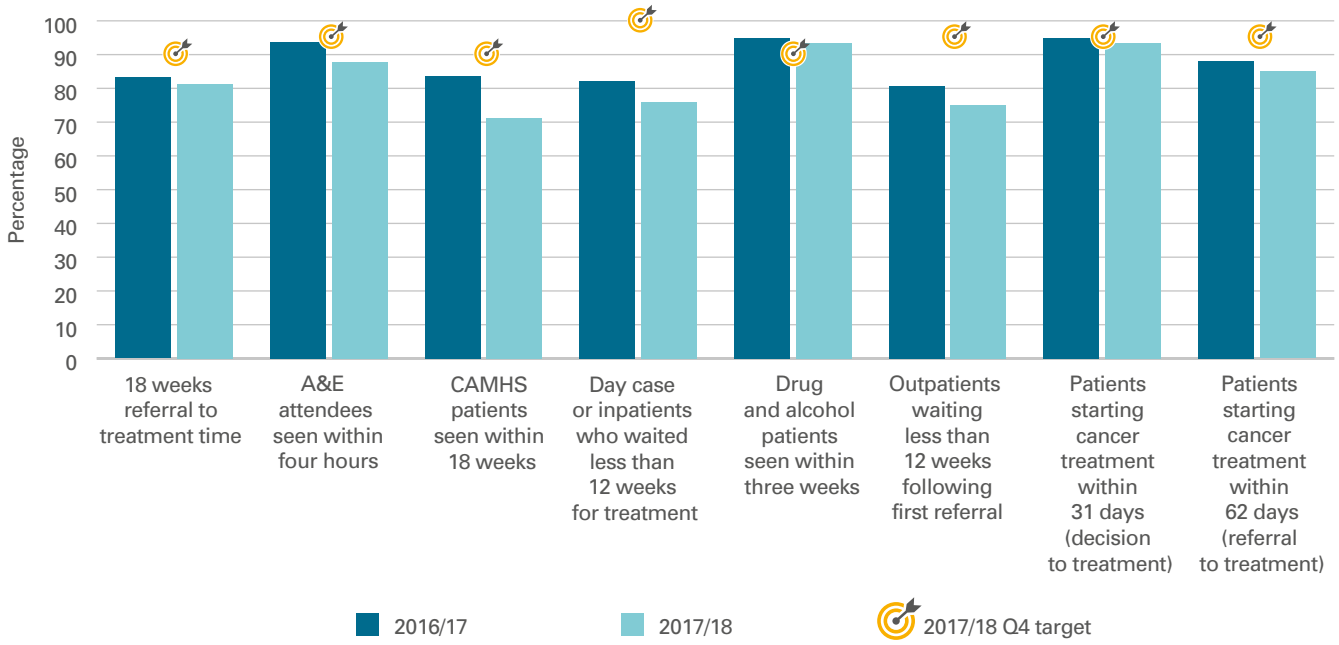
38. The NHS met only one of eight key national performance targets in 2017/18, for 90 per cent of patients referred for drug and alcohol treatment to receive treatment within 21 days (Exhibit 7, page 19). Nationally, the target of 95 per cent of patients starting cancer treatment within 31 days was missed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

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

Exhibit 7

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

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



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

Source: See Appendix 3 for sources

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

- In the final quarter of 2017/18, 93,107 people waited more than 12 weeks for their first outpatient appointment, an increase of six per cent on the previous year. The number of people who waited more than 12 weeks has increased by 215 per cent in the last five years. People waiting more than 16 weeks increased by 13 per cent between 2016/17 and 2017/18, and by 558 per cent over the last five years.

- People waiting more than 12 weeks for an inpatient or day case procedure increased by 26 per cent between 2016/17 and 2017/18 to 16,772 people, and by 544 per cent over the last five years.[26]

41. NHS boards are working with the Scottish Government to implement a range of initiatives aimed at improving access and waiting times, such as the Scottish Access Collaborative. This was set up by the Scottish Government in October 2017 to improve waiting times for patients waiting for non-emergency procedures. However, 2017/18 annual audit reports of NHS boards indicated that financial pressures will continue to have a detrimental impact on performance. NHS boards need to balance quality of care, performance targets, and financial targets. A continuing focus on meeting targets in the acute sector makes it harder to achieve the longer-term aim of moving more funding and services into the community.

The NHS is managing to maintain the overall quality of care, but it is coming under increasing pressure

42. The Scottish Government has three Quality Ambitions for the NHS in Scotland–that the NHS is safe, person-centred, and effective. It does not comprehensively assess and report on these ambitions. Healthcare Improvement Scotland (HIS) is currently rolling out a new Quality of Care approach which involves a more comprehensive assessment of quality.[27]

43. Analysis of a range of measures indicates there are positive examples, including:

- Ninety per cent of patients responding to the 2018 inpatient survey rated their care and treatment as good or excellent, similar to the 2016 survey. Ninety-one per cent of people were positive about their experience of hospital staff, a slight increase since 2016.[28]

- some patient safety indicators improved: the hospital standardised mortality rate decreased by 9.2 per cent between 2013/14 and 2017/18, and C-Diff Infection rate decreased by 0.1 to 0.27 infections per 1,000 occupied bed days between 2016/17 and 2017/18.[29,30]

44. We reported last year that the wide range of pressures facing the NHS may be beginning to affect the quality of care staff are able to provide. This concern remains in 2017/18. For example:

- the percentage of patients rating the quality of care provided by their GP practice as positive has declined from 90 per cent in 2009/10 to 83 per cent in 2017/18. Only 58 per cent of respondents who received treatment in the last 12 months felt they were given the opportunity to involve the people that mattered to them.[31]

- SAB infections, including MRSA, remained relatively static between 2017 and 2018 but remain above the national standard.[32]

- there have been specific concerns about some services. For example, a 2017 HIS inspection of adult health and social care services in Edinburgh rated a majority of quality indicators as weak or unsatisfactory; and an independent inquiry into mental health services in NHS Tayside is under way.[33,34]

45. A key indicator of the quality of care is the extent of serious adverse events happening in hospitals and other healthcare settings. As part of its review of NHS governance in 2017/18, the Scottish Parliament's Health and Sport Committee identified that there was no common definition of a serious adverse event and that there is no national reporting of the frequency of, and learning from, these events. The Committee recommended that a standard definition and national reporting be developed.[35] HIS published a revised national framework in July 2018 to improve consistency in this area.[36]

The NHS workforce is crucial to the future of the NHS but faces significant challenges

46. The NHS depends on having the appropriate number of staff, in the right place, with the appropriate skills. Overall staff levels in the NHS in Scotland are at their highest level ever, with 139,918 whole-time equivalent (WTE) staff employed as at March 2018. This is a 0.3 per cent increase on the previous year. But NHS boards continue to face major workforce challenges (Exhibit 8, page 22).

Withdrawing from the European Union will create additional challenges

47. EU withdrawal has the potential to significantly affect the NHS. It has been difficult to assess the scale of the risk, particularly in terms of workforce as data on the nationality of employees is not routinely collected, and there is still significant uncertainty about what form EU withdrawal will take. Some figures are available:

- General Medical Council data shows that 5.9 per cent (1,177 people) of doctors working in Scotland obtained their primary medical qualification in a non-UK European Economic Area (EEA) country.[37]

- The Scottish Government has estimated that there are 17,000 non-UK EU nationals working in health and social care in Scotland (4.4 per cent of the total health and social care workforce).[38]

NHS boards are working with the Scottish Government to identify how many of their current workforce are non-UK EU citizens.

48. The NHS is already experiencing an impact on recruitment:

- A 2018 British Medical Association (BMA) survey of members across the UK found that 57 per cent of respondents reported a decline in applications for positions in their departments from non-UK nationals since the 2016 vote to leave the European Union.[39]

- The Nursing and Midwifery Council reported that during 2017/18, there was an 87 per cent decrease in the number of nurses and midwives from non-UK EEA registering to work in the UK compared to the previous year.[40]

- In addition, if there is a loss of mutual recognition of professional qualifications between the EU and the UK, it will be more difficult for qualified staff from the EU to work in Scotland.

49. Changes to rules and regulations may also have a significant effect on the NHS. For example, medicine and medical equipment may be more expensive and it may take longer to access essential medical supplies. This includes imported products with limited lifespans, such as radioisotopes that are used to treat cancer. Increases in the price of food due to trade tariffs or additional custom checks will also have an impact on the NHS. Our briefing *Withdrawal from the European Union: Key audit issues for the Scottish public sector* sets out key questions that all public bodies should be asking themselves in the five months to EU withdrawal.

Exhibit 8
Workforce pressures in the NHS

Vacancy rates

Consultants
2013/14 6.5% → 2017/18 7.5%

Allied health professionals
2013/14 3.9% → 2017/18 4.4%

Nursing and midwifery
2013/14 2.7% → 2017/18 4.5%

GPs
2015 22% → 2017 24% (number of practices reporting a vacancy)

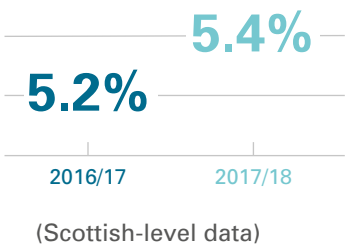
Percentage of vacancies open long term

60% of consultant vacancies open at least six months

30% of nursing and midwifery and AHP vacancies open three months or more

27% of filled GP vacancies took more than six months to fill

Sickness absence

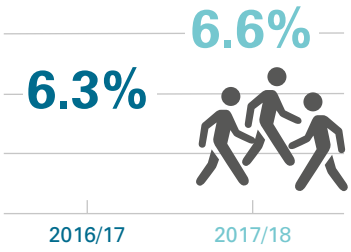


(Scottish-level data)

4% NHS Shetland was the only territorial board to meet the national target

5.8% NHS Fife had the highest sickness absence rate among the territorial boards

Staff turnover



2017 staff survey

46% responded that they could meet all conflicting demands on their time at work

34% responded that there are enough staff to do their job properly

65% believed it is safe to speak up and challenge the way things are done if they have concerns about the quality, negligence or wrongdoing by staff

29% have experienced emotional or verbal abuse from a patient or the public

Note: The 2017 staff survey included some social care staff, who made up a small proportion of the overall total.

Sources: Audit Scotland using ISD Scotland workforce data, June 2018 and *Health and social care staff report 2017*, Scottish Government, March 2018. *Primary Care Workforce Survey Scotland 2017*, Scottish Government, March 2018

Part 2

What needs to change?

Key messages

1 Changing how healthcare services are accessed and delivered is a long-term, complex undertaking. Successfully achieving it will bring real benefits to patients, NHS staff, and the wider public. A number of key elements are critical to success, including clarity about the scale of the challenge, effective leadership, involving stakeholders in planning and decisions, and clear governance.

2 Leaders play a crucial role in developing and delivering change. There is evidence that the NHS is struggling to recruit and retain the right people, and ensure they have the time and support they need.

3 The healthcare system needs to become more open. People need to be able to take part in an honest debate about the future of the NHS. There is a lack of information on:

- how the NHS is performing and the difference it is making to people's lives
- how health funding is used and the impact it has on people
- how much health funding is likely to be required, and available, over the medium to longer term
- the progress being made towards achieving the Scottish Government's 2020 Vision.

4 The overall governance of the NHS needs to be clarified for NHS staff as well as the public. Roles and responsibilities for each planning level need to be explicit and lines of accountability well defined. NHS boards need better support to govern and challenge effectively.

an urgent focus on the elements critical to success is needed

50. There are many reasons why the way in which health services are accessed and delivered in Scotland needs to change. The significant financial, workforce, and demographic pressures facing the NHS, as set out in Part 1, are undoubtedly key drivers, but there are also many positive reasons for change. The Scottish Government's vision for healthcare sets out multiple benefits:

- the Scottish public will benefit from services that are more joined up, tailored, and delivered closer to home. For more complex care needed at hospitals, there will be quicker access and shorter stays

- healthcare staff will have more time to provide high-quality, personalised care
- the wider public sector will benefit from a population that is healthier and takes more responsibility for their own health
- as a result of all of the above, the healthcare system should also become more efficient by reducing the costs of delivering services and improving processes.

51. Achieving these benefits, however, is incredibly challenging. These changes need to happen at the same time, while also continuing to deliver high-quality services on a day-to-day basis. It involves:

- significant organisational and cultural change
- developing and then introducing new ways of working
- designing, delivering, and using new digital technology.

52. It is therefore essential that all the elements needed for successful change are in place. This chapter focuses on the key elements that need addressed if the Scottish Government is to achieve its 2020 Vision.

A clear understanding is needed of the scale of the challenges facing the NHS and the options for addressing them

53. Transforming how health services are delivered and achieving the Scottish Government's vision of delivering more care in the community are long-term projects. They require planning over the short, medium and longer term. An essential part of this is to understand:

- how much funding is likely to be required in the medium to long term
- what funding is likely to be available over the same period.

Where there is a mismatch between what is available and what is required, then options can be developed involving NHS staff, the public and politicians.

54. In October 2018, the Scottish Government published its *Medium Term Health and Social Care Financial Framework* ('the framework'). This is an important step in enabling an open debate about the scale of the financial challenges ahead and the potential options for dealing with the impact this will have on delivering services.

55. The framework covers the period 2016/17 to 2023/24 and has four main sections:

- health and social care expenditure–setting out current expenditure and historical expenditure trends in health and social care, and historical activity growth and trends in productivity
- future demand for health and social care–including drivers of demand growth and an estimate of the future increases in health spending required
- future shape of health and social care expenditure–setting out how shares of health funding will be re-distributed across different parts of the system in future years

- reforming health and social care–identifies five specific areas of activity (shifting the balance of care, regional working, public health and prevention, Once for Scotland, and annual savings plans) that will contribute to the reform of health and social care delivery.

56. The financial framework focuses on 'frontline' NHS board expenditure, comprising the 14 territorial NHS boards and four of the national boards (NHS 24, Golden Jubilee Hospital, State Hospital and the Scottish Ambulance Service), and local government net expenditure on social care. The framework sets out a 'do nothing' position. This takes into account estimated expenditure growth caused by factors such as demand and pay and prices and sets out that health and social care resource expenditure in 2023/24 would need to be £20.6 billion. This is more than the projected resource funding availability of £18.8 billion over the same time period. The framework sets out the three main ways in which the Scottish Government plans to bridge the gap:

- efficiency savings–a one per cent efficiency requirement across health and social care
- savings arising from shifting the balance of care–this includes A&E, inpatients and outpatients
- additional savings–from regional working, public health prevention, and back office efficiencies.

A remaining gap of £159 million is identified which is expected to be addressed over the period to 2023/24.

57. The projected funding figures set out in the framework are based on the Scottish Government receiving additional funding from the UK Government of £3.3 billion due to increased funding for the NHS in England (known as Barnett resource consequentials). It is not yet known how the UK Government plans to fund increases in English health expenditure and the options chosen may affect the amount available to the Scottish Government.

58. Alongside the publication of the health and social care financial framework, the Cabinet Secretary announced recently that NHS territorial boards will no longer be required to break even at the end of each financial year. Instead, they will be required to break even every three years. This should provide NHS boards and integration authorities with greater flexibility in planning and investing over the medium to longer term to achieve the aim of delivering more community-based care. It also makes it even more important that NHS boards plan their finances over a medium to longer-term period. Traditionally, NHS boards have taken a short-term approach to financial planning with most of their financial plans covering three years or less. This continued to be the case in 2017/18. The main reasons given by NHS boards for this are the current uncertainties around the implications of regional planning and the national health financial framework. The Scottish Parliament's Health and Sport Committee reported in 2018 that it 'did not accept an inability to undertake longer-term financial planning exists'.[41]

59. As we showed in Part 1, the NHS estate is likely to require more investment than is likely to be available. This makes it more urgent to identify how the type, location, and size of healthcare facilities need to change as more services are delivered in the community. We recommended in our *NHS in Scotland 2017*

report that the Scottish Government, in partnership with NHS boards and integration authorities, should develop a capital investment strategy to ensure the NHS Scotland estate is appropriate for delivering more regional and community-based services.[42] This will help the Scottish Government and NHS boards engage and involve the public in agreeing how the NHS estate will develop. The Scottish Government is developing a national health capital investment plan, scheduled for completion by the end of the financial year 2018/19.

There is a need to ensure effective leadership is in place with the time and support to deliver change

60. Effective leadership is critical to achieving successful change. Leaders need to drive change and improvement, involve staff and the public in developing a common vision and work with partners to deliver it. But they also require a skilled and cohesive team to support them and strong sponsorship from the top. Health and social care integration has changed the context in which NHS boards operate and has also increased the number of effective leaders required across Scotland.

61. The Scottish Government has recently developed a new approach to leadership and succession planning. This includes developing a talent management scheme to identify future leaders and introducing values-based recruitment to ensure new appointments share the values of the organisation, in addition to skills and experience.

62. There are indications that finding effective leaders and support teams is becoming more difficult:

- The NHS Greater Glasgow and Clyde chief executive position required two recruitment rounds to fill.
- The Scottish Borders Integration Joint Board chief finance officer role was vacant from October 2017 until recently. This has now been filled through a one-year secondment from NHS Lothian.
- The chief executive position in NHS Orkney has been an interim appointment since January 2018 and a recruitment exercise has only recently taken place.
- NHS Highland has experienced significant turnover in non-executive members, with six new members in 2017/18. This has led to challenges in ensuring members have the skills, experience and training required to fulfil their role.
- There is an increasing number of joint posts across NHS boards. For example:
  - The chief executive and director of finance in NHS Grampian are now also the chief executive and director of finance in NHS Tayside
  - The director of finance for the Golden Jubilee National Hospital is also the interim director of finance for the Scottish Ambulance Service.
- Increasing regional planning has created additional responsibilities for senior leadership teams.
- Key support functions such as finance and human resources are also experiencing vacancies in many boards. Twelve boards reported vacancies in their finance team and 11 boards reported vacancies in their HR team.

- The NHS workforce is ageing, and chief executive positions at NHS Grampian, Highland, and Tayside will become vacant due to retirement. The chief executive at NHS Borders is also due to retire at the end of April 2019.

- Only 62 per cent of respondents to the 2017 national health and social care staff survey felt that the senior managers responsible for the wider organisation were sufficiently visible. 64 per cent of respondents had confidence and trust in the senior managers responsible for their wider organisation.[43]

63. NHS board chief executives and senior teams are responsible for the delivery of critical day-to-day services as well as leading the changes to how services are accessed and delivered in their boards. This places significant demands on senior leadership teams. To successfully plan and deliver the whole-scale changes that are required takes time and capacity.

NHS governance arrangements are confusing and non-executive directors need more support

The overall governance of the NHS needs to be clarified

64. The arrangements for NHS planning are complex. There are now multiple planning levels from small localities through to national planning (Exhibit 2 in our report *NHS in Scotland 2017* describes these). Last year we said that it was not yet clear how planning at each of the different levels would work together in practice. This remains the case:

- Lines of accountability for health and social care integration are still not universally clear. Auditors highlighted issues in some areas in 2017/18 relating to the need for greater clarity to avoid duplicating governance arrangements, managing overspends in integration authorities, and ownership of performance management.

- Regional plans have not yet been published so it is not clear how roles and responsibilities between NHS boards will work within the regions or where accountability and decision making will lie for service planning, delivery, and performance.

- There is no public information on the progress of national planning initiatives, such as Once for Scotland (delivering services and functions more efficiently at a national level).

- It is not clear to what extent the public, staff, and NHS boards have been involved in some decisions to change how services are accessed and delivered. For example, the Scottish Government has decided to develop regional elective centres across Scotland to carry out procedures such as knee and hip replacements. This will change how people access services, but the decision was taken before regional plans were developed.

65. As new planning layers have been created, none have been removed. This multiplicity of levels and lack of clarity over their roles means NHS governance is confusing. If the different planning levels are to work together effectively and the public is to easily understand what each part of the system is intended to do, governance arrangements must be clear and robust. This means that roles and responsibilities are explicit, and lines of accountability are well defined. For example, the roles and responsibilities of NHS boards have changed with the

introduction of Integration Authorities and will continue to change as regional and national planning develops further. It is important to ensure that the roles and responsibilities of NHS boards in this new context are clear.

66. The Scottish Government, working with NHS boards and integration authorities, should clearly set out the key decisions that need to be made in planning how to deliver services and why. This would help ensure:

- decisions are made at the right level, are coherent and fit with existing policies and plans
- there is clear accountability for delivering outcomes
- NHS staff and the public have the opportunity to make their voice heard.

67. To ensure the multiple planning levels can operate effectively, it is also essential that lines of accountability and levels of scrutiny within the Scottish Government's Health and Social Care Directorate are clear and robust. There is scope to improve these. The directorate is led by the Director General of Health and Social Care, who is also the Chief Executive of NHS Scotland. The Chief Executive is responsible for the day-to-day performance of the NHS and for implementing Scottish Government health policies. The Director General is responsible for holding the NHS to account for its performance and how well it has implemented Scottish Government policies. The Director General is also the chair of the directorate's Assurance Board which holds the directorate to account for its performance. The challenges facing the health and care system make this dual role ever harder.

68. There is also scope to increase independent scrutiny of the directorate. In the Auditor General for Scotland's report *The 2017/18 audit of the Scottish Government Consolidated Accounts*, the Auditor General highlighted the important role of non-executive directors in ensuring effective scrutiny and challenge within the Scottish Government.[44] The report found that, across the Scottish Government, scrutiny and challenge was not as effective as it needed to be. Within the Health and Social Care Directorate, only one non-executive director provided independent challenge in 2017/18 as a member of the directorate's Assurance Board.

Boards need better support to challenge and govern effectively

69. Each NHS board is responsible for ensuring that health services are delivered safely, efficiently and effectively, and to give the public confidence in the NHS. There is evidence that not all boards are operating effectively. Our forthcoming report, *Health and Social Care Integration: Update on progress,* will examine the effectiveness of governance arrangements in integration authorities.

70. Boards are made up of executive members, including the chief executive and other senior managers, and non-executive members. These include staff representatives and members of the public appointed through a competitive recruitment process. The board is responsible for:

- ensuring the organisation delivers its functions in accordance with the Scottish ministers' policies
- the strategic and financial leadership of the organisation

- holding the chief executive and senior management to account.

71. Board members need to have an appropriate level of knowledge, skills, and expertise to do their role effectively. But there is no consistent approach across the NHS to ensuring this. For example:

- Skills gap analysis–not all NHS boards have identified the range of skills and expertise among board members and areas where training or additional expertise may be needed.

- New member induction–in a 2018 survey of board members by the Scottish Parliament's Health and Sport Committee, only 61 per cent of respondents agreed there is adequate induction for board members.[45]

- Training and development–most NHS boards have training and development programmes for board members, but these are often ad-hoc. Less than half (48 per cent) of board members surveyed by the Scottish Parliament's Health and Sport Committee agreed there was adequate training.[46]

- Performance assessment–not all NHS boards do one-to-one annual appraisals. If these do take place, it is not always clear how formal these are, for example, if it is an informal discussion or a structured appraisal. There is no standard approach across the NHS to assessing the performance of board members.

72. The majority (63 per cent) of board members surveyed by the Scottish Parliament's Health and Sport Committee in 2018 thought their board had the right skills, knowledge and expertise. However, a third thought their board only partly had the right skills, knowledge and expertise.[47] NHS boards are complex organisations in a continually changing environment and without appropriate support, boards cannot fulfil their role effectively.

Scrutiny arrangements need to be improved across the NHS

73. Through our audit work we have identified areas for improvement:

- Financial and performance reporting–there are examples of financial reporting to boards that was too lengthy or not easily understandable, or too high-level and did not provide enough information for board members to be able to scrutinise. Performance reporting did not always provide appropriate detail on the reasons for performance or planned actions to improve targets.

- Accessibility and transparency–the language used in reports can often contain acronyms and technical information that is not explained and can be difficult for lay people to fully understand. Agenda items are often for noting with no discussion required and board minutes do not always provide a clear picture of the level of scrutiny that took place in meetings. Board papers are not always easy to find on board websites.

74. The majority of board members who responded to the 2018 survey (87 per cent), felt that members of their board always or mostly challenged advice, opinions and information presented. However, 13 per cent disagreed. Almost one in five (17 per cent), reported that their board only sometimes or hardly ever sufficiently holds the chief executive and senior management team to account for the operational management of the organisation and the delivery of agreed plans to time and budget.[48]

75. The Scottish Government is carrying out a range of work aimed at strengthening governance arrangements in NHS boards. This includes piloting a standardised review of corporate governance. Case study 1 sets out the scope and key findings from the pilot in NHS Highland.

Case study 1

Scottish Government corporate governance review of NHS Highland

A review team was set up which included the chair of NHS Greater Glasgow and Clyde and a non-executive director from Healthcare Improvement Scotland. The team developed a framework for assessing governance based on sources of evidence that included codes of conduct from other bodies, academic literature, and lessons learned from successes and failures from across the UK public sector. The review included desk research, face to face interviews with current and previous, board members and other stakeholders, and observation of board meetings.

The review made a number of recommendations to the board, including the need to:

- develop a clear strategic plan for the board, and a planning cycle
- make sure appropriate reporting methods are in place
- agree shared expectations of the roles and responsibilities of board members and clarify the relationship between the board and the Executive Team. Develop an induction programme and map existing board member skills against the future requirements
- develop a governance map, setting out remits of committees and how they relate to one another. Develop guidance on writing board papers, including protocol for ensuring confidentiality and making sure papers are circulated five days ahead of meetings. Minutes should include an action plan
- make sure there is a shared understanding of best practice in assessing and managing risk, and the operation of the finance and audit committees. The chair and chief executive should attend the Audit Committee and there should be an external review of the existing internal audit services
- develop an engagement strategy, including clearly defining the roles and responsibilities of board members in supporting this
- consider external support to help resolve recent issues. Develop protocols for board members to raise concerns. Reconsider having board members sitting on operational groups.

Source: Audit Scotland using Corporate Governance in NHS Highland report, Scottish Government, May 2018

The Scottish Government and the NHS need to become more open

76. If efforts to transform the NHS are to be successful there must be a shared understanding of why change is needed. There must also be broad agreement between the public, politicians, NHS staff, NHS boards, integration authorities, and the Scottish Government about:

- the scale of the challenge
- the options for what needs to happen
- how changes will be implemented.

There is currently no common agreement on these areas. If health and care services are to change to meet the needs of Scotland's people, then the NHS and the Scottish Government must become more open. People need access to information if they are to have an honest debate about the future of the NHS and get involved in designing services to meet their needs.

77. In our report, *NHS in Scotland 2017*, we stated that 'open and regular involvement with local communities about the NHS is needed to develop options for delivering services differently.'[49] People are closely invested in their local health services, and there continue to be many examples of public and political opposition to attempts by NHS boards to change how services are delivered. This suggests that local communities are still not being involved appropriately in planning changes to services.

There is still no overall picture of how the NHS is performing and the difference the NHS is making to people's lives

78. In previous years we have commented that existing national NHS performance measures do not measure the quality of care across the whole healthcare system, focusing mainly on access to the acute sector. It is important that wider performance measures are developed to provide a clear picture of how the system as a whole is working.

79. The Scottish Government commissioned an independent review of targets and indicators in health and social care in Scotland. This reported in November 2017 and recommended that the Scottish Government move to a system of indicators and targets which allow improvements across a whole system of care to be tracked.[50] The Scottish Government has not yet made progress on the recommendations.

80. The availability of public information on performance has improved with the introduction of the NHS Performs website, which shows information on indicators such as A&E performance and hospital deaths, at hospital, NHS board, and national-level.[51] However, the range of data is limited and focuses on the acute sector. Another positive development is the uptake in the use of Care Opinion, an independent website which allows patients and the public to publicly share their stories and experiences of health services across Scotland. All NHS boards in Scotland are now using Care Opinion and NHS staff are able to view stories and respond.

Better information is needed on how the NHS uses funding to support change

81. Health funding in Scotland is the single largest area of Scottish Government expenditure. The Scottish public need to know what this funding is being used for and what it is achieving.

82. There is no easy-to-understand, summarised public information available on health funding and what it is spent on. There is information on parts of the system, but they do not provide a comprehensive picture or provide information that is easy to access.

83. There is also no public information on how the health funding system works, for example:

- How much funding, and the type of funding, the Scottish Government allocates to NHS boards throughout the year, and how NHS boards then allocate this to integration authorities.
- What the Scottish Government expects NHS boards to spend funding on and how NHS boards prioritise expenditure.
- How the Scottish Government monitors how NHS boards use funding and whether they are achieving the outcomes the Scottish Government wants.

84. Since June 2018, the Scottish Parliament has received a monthly update on boards' financial position. This includes their year-to-date position against budget and the expected outturn at year-end.[52] The reports also indicate which NHS boards may require brokerage to break even at the financial year-end. This is a helpful step forward in providing information that the public and MSPs can use to scrutinise financial performance. There is, however, room for improvement to make the information more helpful. For example, in the June 2018 report, eight NHS boards were projecting that they would not break even at year-end, but only four boards indicated that they might require brokerage.[53] It is not clear from the information presented why the remaining four boards do not expect to require brokerage or why the boards indicating they may need brokerage do not expect to identify additional savings.

The Scottish Government is making progress with the Health and Social Care Delivery Plan but public reporting is needed

85. The Health and Social Care Delivery Plan sets out an ambitious set of actions to achieve the 2020 Vision. A number of key actions have been achieved, including putting in place a new national GP contract in April 2018 and publishing national public health priorities in June 2018. Work is also under way across a range of other areas, including increasing paramedic and health visitor numbers, developing new elective centres, and establishing a new national public health body.

86. Significant progress still needs to be made, however, to achieve the 2020 Vision. In a number of areas, including those where actions have been achieved, implementation and embedding is likely to take a number of years and progress is often dependent on other actions being achieved. For example, the success of the new GP contract is dependent on resolving issues such as premises costs and increasing the number of GPs and others, such as pharmacists and paramedics, to develop multidisciplinary teams. Progress has also been slower than planned in some areas; for example the publication of the national public health priorities were over a year later than the target date. This is partly due to

the complexity and scale of the changes. Successfully achieving the actions in the Delivery Plan will require staff, public, and political buy-in and involvement.

Detailed workforce planning is overdue

87. All three parts of the Health and Social Care National Workforce plan have now been published, with the final part on the primary care workforce published in April 2018.[54] As with part one, parts two and three largely focus on what needs to be done to plan for the future, rather than on setting out what the medium to longer-term workforce will look like. In our 2017 report, *NHS workforce planning*, we recommended that there is a need to better understand future demand and to provide a breakdown of the cost of meeting this demand.[55] The National Workforce Plan does not provide this information. We will be undertaking an audit of primary care workforce planning in 2018/19.

Reporting on progress towards the Scottish Government's 2020 Vision needs to be made public

88. Progress towards achieving the Delivery Plan is reported to the Scottish Government's Health and Social Care Delivery Plan Programme Board every six weeks. This board is responsible for the strategic oversight and operational assurance of the delivery of the Delivery Plan. There is scope to improve the monitoring and reporting of progress:

- There is no public reporting of progress. Programme Board minutes are made public but agendas and papers, including progress updates, are not published.
- An integrated performance framework covering all elements of the Delivery Plan has not yet been developed. The Delivery Plan states that this would be produced by early 2017. As we reported in our *NHS in Scotland 2017* report, the Delivery Plan does not set out in detail how the changes described in it will be achieved and many of the actions in it are statements of intent rather than actions.[56] It remains important that the performance framework sets out clearly what work is being done and how progress will be measured.
- In the overall progress reports provided to the Programme Board it is not always clear whether current progress is as expected, or why expected progress has not been made. Where completion dates have been delayed, these are not always clearly labelled as delayed, despite some activities slipping by more than a year from the planned target date.
- The public and politicians cannot fully hold the Scottish Government to account or get involved in changing how health care services are accessed and delivered if they do not know what:
  - activities are being undertaken
  - progress is being made towards achieving these
  - challenges are being faced in achieving the Delivery Plan actions.

Endnotes

1 *NHS Scotland Workforce Information - Overall trend*, ISD Scotland, June 2018.

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

3 *Acute Hospital Activity and NHS Beds Data Release*, ISD Scotland, June 2018.

4 *Annual Report and Accounts for year ended March 2018,* Scottish Ambulance Service.

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7 *Draft budget 2018/19*, Scottish Government, December 2017.

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9 *NHS Consolidated Accounts for financial year 2017/1*8, Scottish Government, 2018.

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11 *NHS Consolidated Accounts for financial year 2017/18*, Scottish Government, 2018.

12 *NHS board Local Delivery Plans 2015/16-2017/18* and *NHS Scotland 2018-19 Consolidated Summary Financial Report*, June 2018.

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15 *NHS board annual audit reports 2017/18.*

16 *NHS board Local Delivery Plans 2013/14-2017/18.*

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

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33 *Services for older people in Edinburgh - joint inspection of adult health and social care services,* Healthcare Improvement Scotland, May 2017.

34 *Carseview Centre: Tayside leadership team commissions independent assurance on mental health services*, NHS Tayside press release, May 2018.

35 *The Governance of the NHS in Scotland - ensuring delivery of the best healthcare for Scotland,* Health and Sport Committee, July 2018.

36 *Learning from adverse events through reporting and review,* Healthcare Improvement Scotland, July 2018.

37 General Medical Council submission to Health and Sport Committee inquiry into the impact of leaving the EU on health and social care in Scotland, General Medical Council, January 2018.

38 *Non-UK nationals in Scotland's workforce*, Statistics from the Annual Population Survey 2017, 13 June 2018.

39 *Quarterly survey*, Q2, British Medical Association, 2018.

40 *The Nursing and Midwifery Council register*, Nursing and Midwifery Council, March 2018.

41 *The Governance of the NHS in Scotland - ensuring delivery of the best healthcare for Scotland,* Health and Sport Committee, July 2018.

42 *NHS in Scotland 2017*, Audit Scotland, October 2017.

43 *Health and Social Care Staff Experience Report 2017,* Scottish Government, March 2018.

44 *The 2017/18 audit of the Scottish Government Consolidated Accounts*, Auditor General for Scotland, September 2018.

45 *NHS Corporate Governance - Survey Analysis Report,* Scottish Parliament Information Centre, February 2018.

46 Ibid.

47 Ibid.

48 Ibid.

49 *NHS in Scotland 2017*, Audit Scotland, October 2017.

50 *Review of Targets and Indicators for Health and Social Care in Scotland,* Scottish Government, November 2017.

51 https://www.nhsperforms.scot/.

52 *NHS Scotland 2018-19 Consolidated Financial Reporting.*

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

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Appendix 1

Audit methodology

This is our annual report on how the NHS in Scotland is performing. Our audit assessed how well the NHS managed its finances and performance against targets in 2017/18 and why immediate action is needed.

Our findings are based on evidence from sources that include:

- the audited annual accounts and auditors' reports on the 2017/18 audits of the 22 NHS boards
- Audit Scotland's national performance audits
- NHS boards' Local Delivery Plans (LDPs), which set out how boards intend to deliver services to meet performance indicators and targets, as well as indicative spending plans for the next three years
- activity and performance data published by ISD Scotland, part of NHS National Services Scotland
- publicly available data and information on the NHS in Scotland including results from staff and user surveys
- interviews with senior officials in the Scottish Government and a range of other key stakeholders.

We reviewed service performance information at a national and board level. Our aim was to present the national picture and highlight any significant variances between boards. We focused on a sample of key targets and standards, covering some of the main activities of the NHS. Where we have used trend information, we have selected a time period where information is most comparable. Information about the financial performance of the NHS is included in Appendix 2 (page 37).

Appendix 2

Financial performance 2017/18 by NHS board

Board	Core revenue outturn (£m)	Total savings made Annual Audit Report (£m)	Non-recurring savings in Annual Audit Report	NRAC: distance from parity
Ayrshire and Arran	779.5	24.8	41%	-1.0%
Borders	223.9	8.3	66%	1.3%
Dumfries and Galloway	327.5	22.6	74%	2.8%
Fife	683.6	22.5	58%	-1.0%
Forth Valley	547.1	24	28%	-1.0%
Grampian	1,003.6	27.7	34%	-0.9%
Greater Glasgow and Clyde	2,349.2	122.4	57%	1.8%
Highland	693.2	35	71%	-0.7%
Lanarkshire	1,239.4	36.1	23%	-1.0%
Lothian	1,512.2	23.5	40%	-0.9%
Orkney	55.6	1.3	83%	5.1%
Shetland	56.8	4.7	49%	3.0%
Tayside	820.6	46.8	64%	-1.0%
Western Isles	82.1	3.5	30%	15.1%
Healthcare Improvement Scotland	28.2	2	68%	
National Services Scotland	416.6	18.2	0%[1]	
National Waiting Times Centre	66.2	4.5	23%	
NHS 24	71.7	2.4	26%	
NHS Education for Scotland	444.4	8	76%[1]	
NHS Health Scotland	19.4	0.3	100%	
Scottish Ambulance Service	235.4	8.7	51%	
State Hospital	32	1.8	90%	

Notes: 1. These figures are from Month 13 Financial Reporting Return to the Scottish Government. 2. NRAC is the NHS Scotland Resource Allocation Committee.

Appendix 3

NHS performance against key LDP standards in 2017/18

Measure	18 weeks referral to treatment time	A&E attendees seen within four hours	CAMHs patients seen within 18 weeks	Day case or inpatients who waited less than 12 weeks for treatment
	standard = 90%	standard = 95%	standard = 90%	standard = 100%
Ayrshire and Arran	78.6	90.8	98.2	85.2
Borders	86.7	89.5	48.2	84.5
Dumfries and Galloway	84.0	90.3	89.9	77.7
Fife	79.1	94.6	67.7	87.6
Forth Valley	83.4	83.4	48.0	56.1
Grampian	65.5	94.1	48.7	64.0
Greater Glasgow and Clyde	89.3	86.7	88.7	78.7
Highland	81.7	96.0	82.9	65.0
Lanarkshire	82.1	90.0	71.4	62.6
Lothian	74.6	75.4	65.1	79.3
Orkney	98.9	95.9	94.7	95.9
Shetland	81.8	94.4	94.7	94.2
Tayside	71.9	98.0	40.7	73.6
Western Isles	91.7	97.7	94.7	100.0
National total	**81.2**	**87.9**	**71.2**	**75.9**

Key Green = Standard met
Red = Standard missed

Measure	Drug and alcohol patients seen within three weeks	Outpatients waiting less than 12 weeks following first referral	Patients starting cancer treatment within 62 days (referral to treatment)	Patients starting cancer treatment within 31 days (decision to treatment)
	standard = 90%	standard = 95%	standard = 95%	standard = 95%
Ayrshire and Arran	98.6	85.0	87.3	97.4
Borders	89.3	91.7	95.7	100.0
Dumfries and Galloway	95.6	90.4	94.9	96.6
Fife	95.9	93.6	86.2	97.4
Forth Valley	98.4	84.6	79.7	97.0
Grampian	91.0	63.4	76.7	87.2
Greater Glasgow and Clyde	94.5	74.5	81.3	92.7
Highland	86.8	80.7	81.4	93.2
Lanarkshire	99.4	84.8	96.5	99.2
Lothian	79.9	66.2	87.2	91.1
Orkney	100.0	62.5	91.7	100.0
Shetland	100.0	80.7	100.0	100.0
Tayside	87.3	70.7	86.5	92.5
Western Isles	91.7	88.9	88.9	100.0
National total	**93.5**	**75.1**	**85.0**	**93.5**

Sources:

Child and Adolescent Mental Health Services: Waiting Times, Workforce and Service Demand: Quarter ending 31 March 2018, ISD Scotland, June 2018

National Drug and Alcohol Treatment Waiting Times Report - January-March 2018, ISD Scotland, June 2018

18 weeks referral to treatment (RTT), Month ending March 2018; ISD Scotland, May 2018

New Outpatient Appointment: Waiting Times for Patients waiting at Month end, Census date at 31 March 2018, June 2018

Inpatient or day case admission: waiting times for patients seen, Quarter ending March 2018; ISD Scotland, June 2018

Accident and Emergency: attendances and time in department by NHS board and month, Month ending March 2018; ISD Scotland, June 2018

Performance against the 62 day standard from receipt of an urgent referral with suspicion of cancer to first treatment by NHS board, Quarter to March 2018; ISD Scotland, June 2018

Performance against the 31 day standard from date decision to treat to first cancer treatment by NHS board, Quarter to March 2018, ISD Scotland, June 2018.

NHS in Scotland 2018

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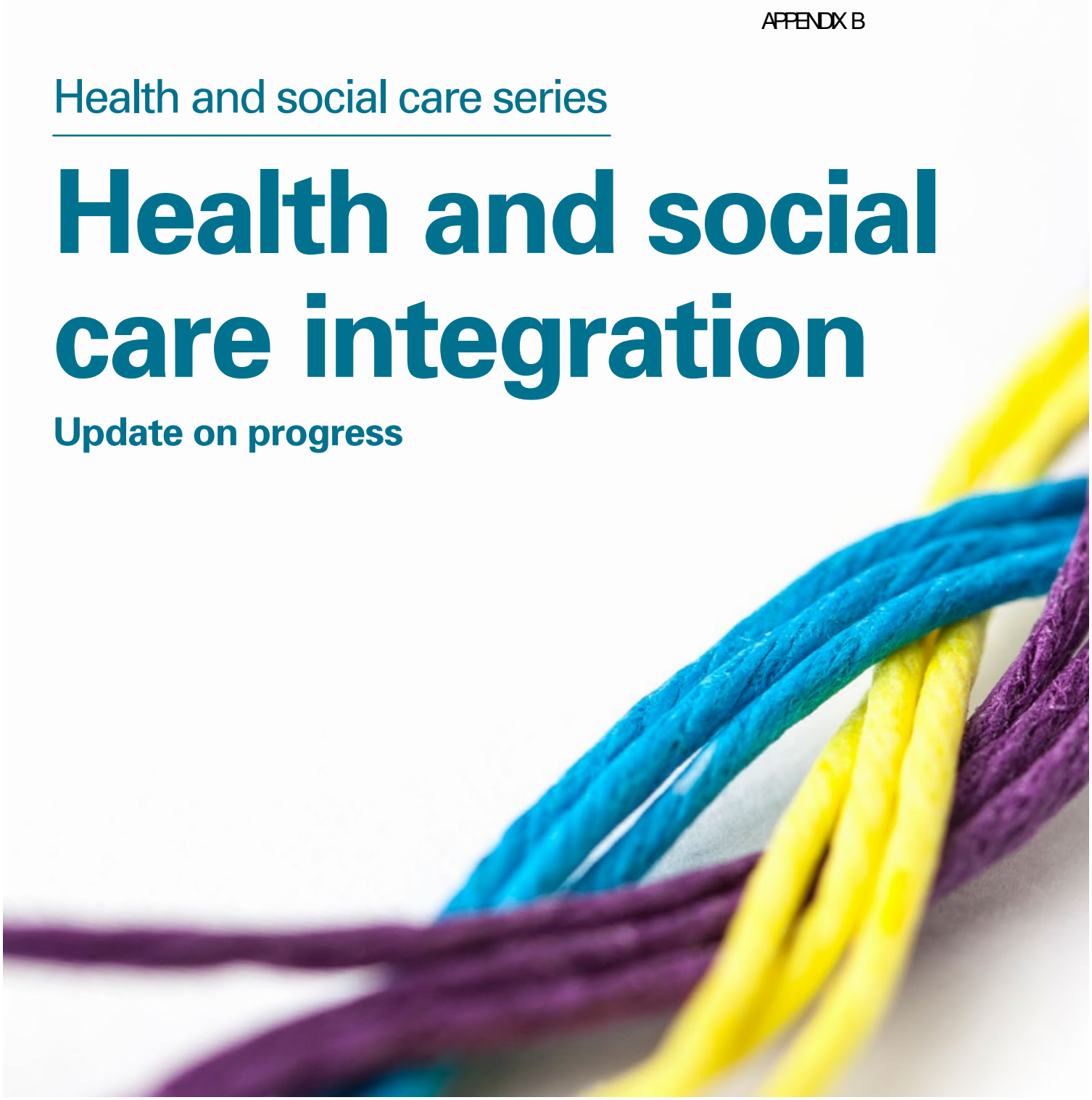
APPENDIX B

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.

We expect councils to achieve the highest standards of governance and financial stewardship, and value for money in how they use their resources and provide their services.

Our work includes:

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

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

Auditor General for Scotland

The Auditor General's role is to:

- appoint auditors to Scotland's central government and NHS bodies
- examine how public bodies spend public money
- help them to manage their finances to the highest standards
- check whether they achieve value for money.

The Auditor General is independent and reports to the Scottish Parliament on the performance of:

- directorates of the Scottish Government
- government agencies, eg the Scottish Prison Service, Historic Environment Scotland
- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Police Authority, Scottish Fire and Rescue Service.

You can find out more about the work of the Auditor General on our website: www.audit-scotland.gov.uk/about-us/auditor-general

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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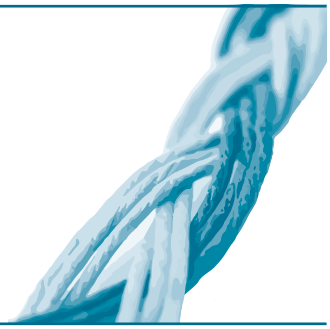


Links

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

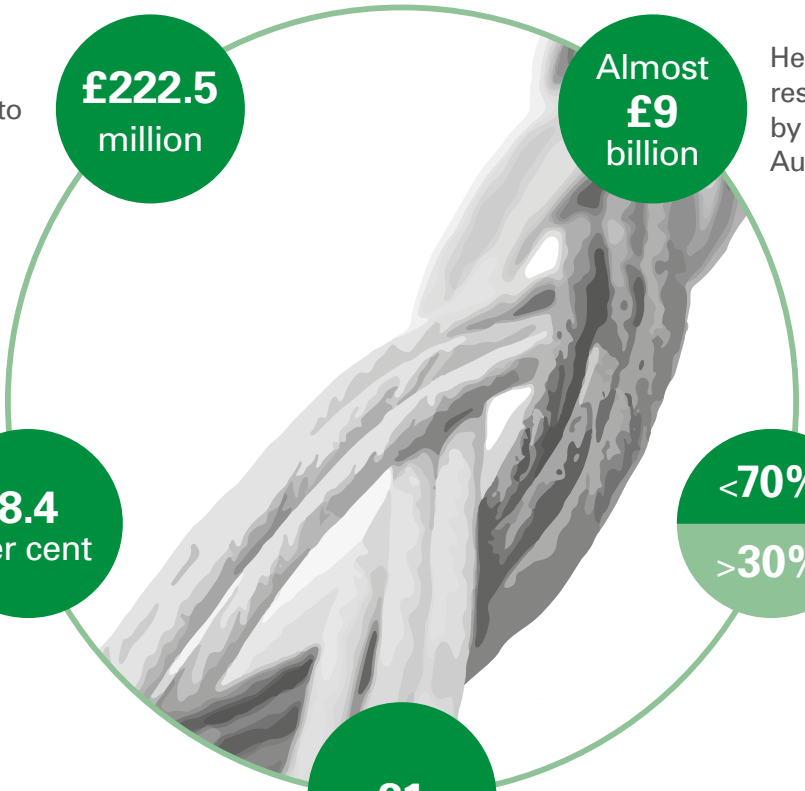
£222.5 million

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%

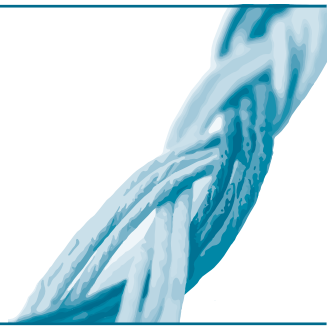
Integration Authority funding comes from the NHS

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:

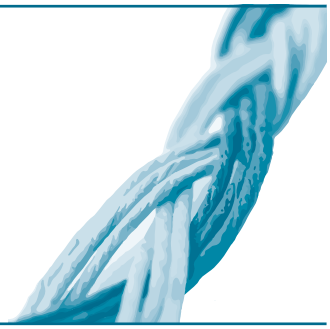
- share learning from successful integration approaches across Scotland
- address data and information sharing issues, recognising that in some cases national solutions may be needed
- review and improve the data and intelligence needed to inform integration and to demonstrate improved outcomes in the 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.

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.

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.

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

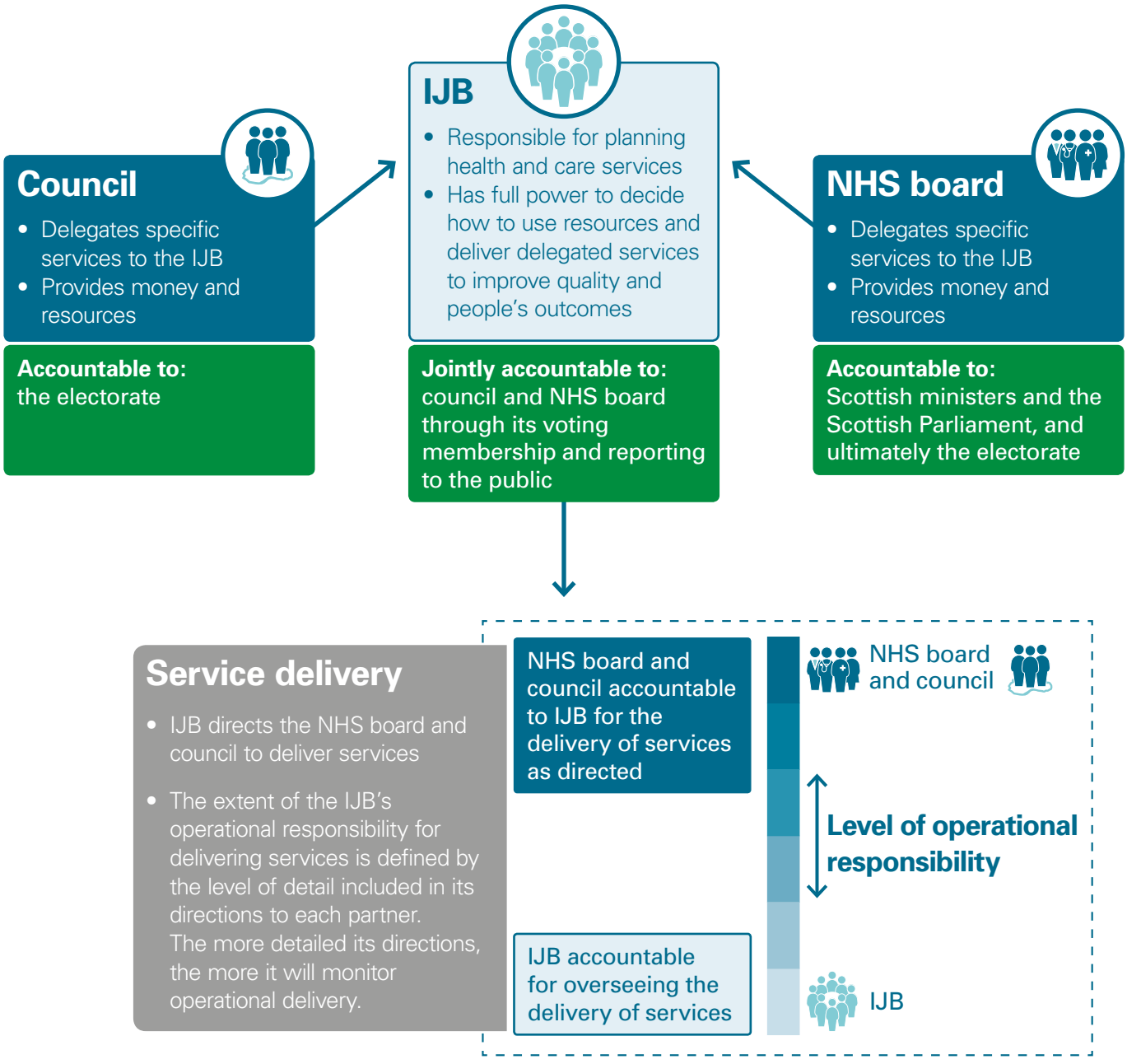
the reforms affect everyone who receives, delivers and plans health and social care services in Scotland

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

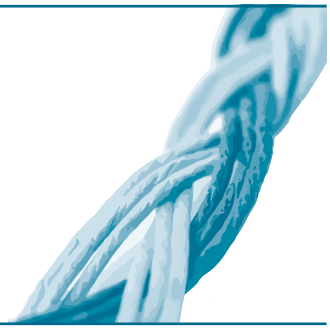
There are 30 Integration Joint Boards across Scotland.



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.

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:

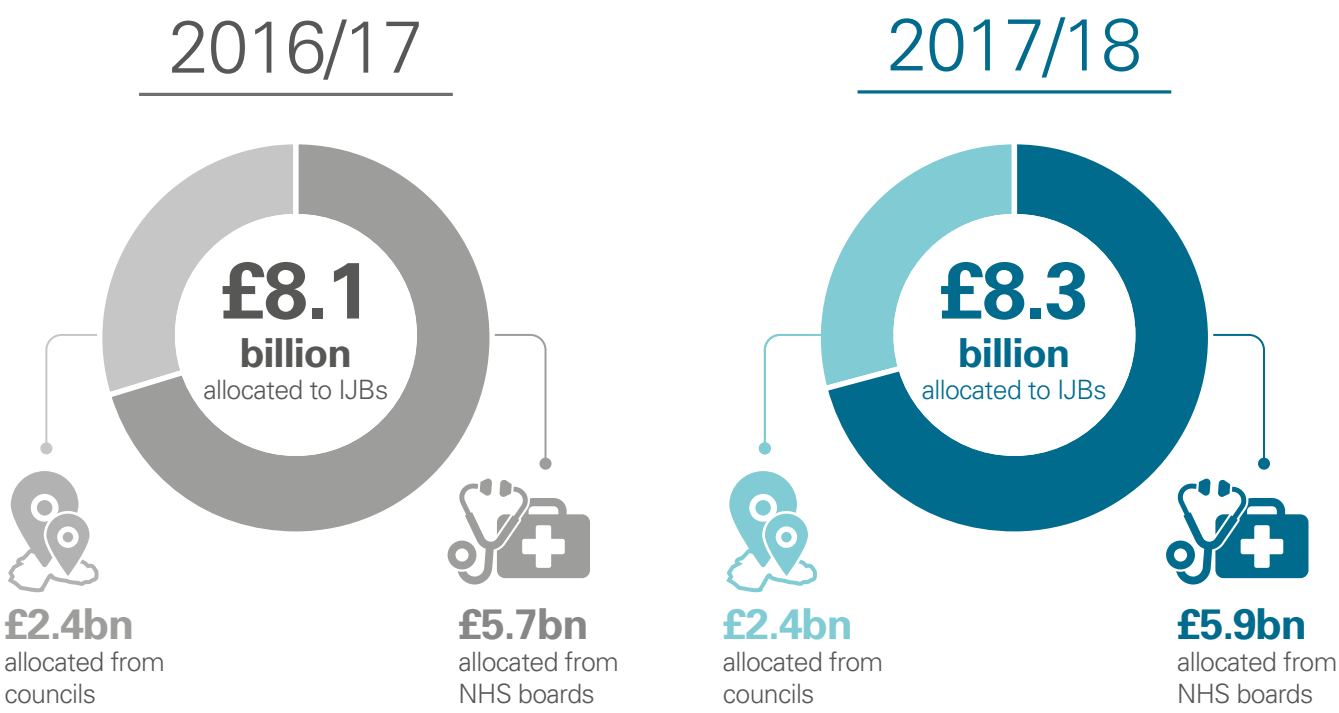
- as a working balance to help prevent the impact of uneven cash flows
- as a contingency to cushion the impact of unexpected events or emergencies
- held to fund known or predicted future requirements – often referred to as 'earmarked reserves'.[3]

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

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:

- 17 needed additional money from NHS boards amounting to £33.3 million
- 11 needed additional money from councils amounting to £19.1 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.

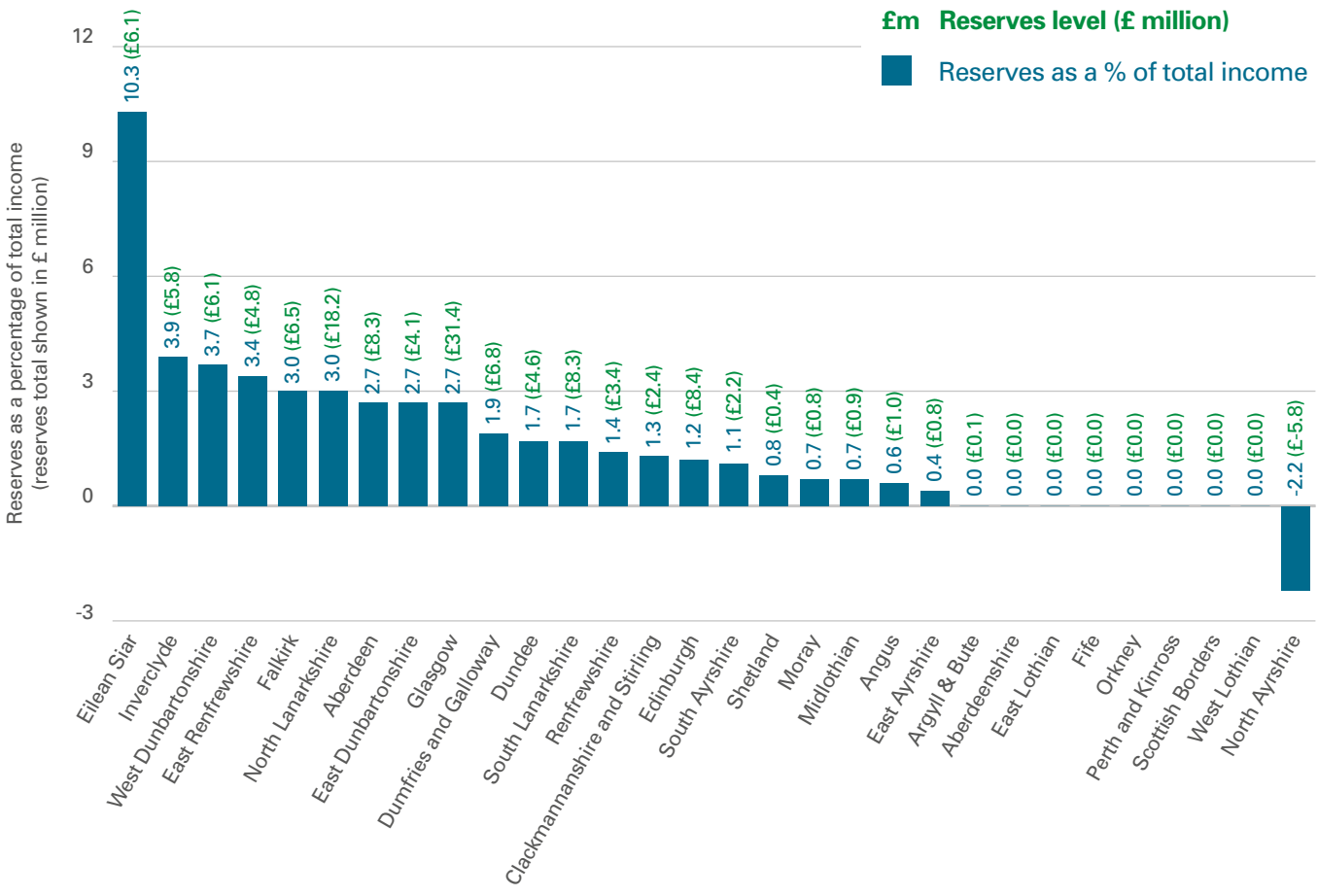
Reserves

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:

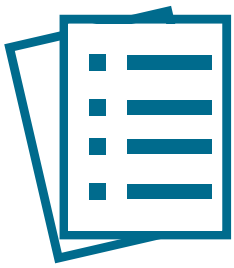
- **Outcome:** We are healthy and active
- **Indicators:** Healthy life expectancy, mental wellbeing, healthy weight, health risk behaviours, physical activity, journeys by active travel, quality of care experience, work-related ill health, premature mortality
- **Sustainable development goals:** gender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

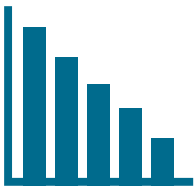
Cont.

Exhibit 4 (continued)



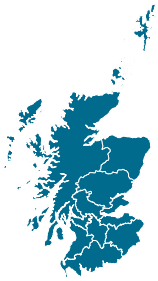
12 principles within the Act

- 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

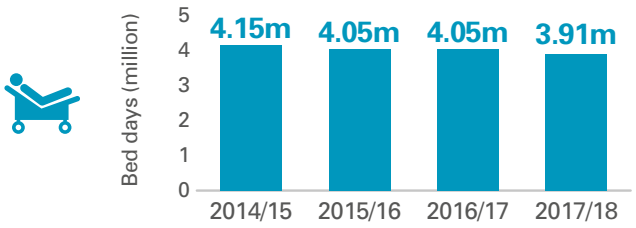
Source: Audit Scotland

Exhibit 5

National performance against six priority areas

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

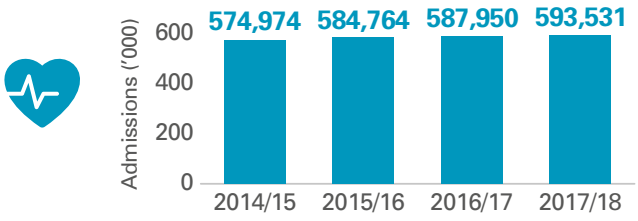
1. Acute unplanned bed days



Integration aims to reduce unplanned hospital activity

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

2. Emergency admissions

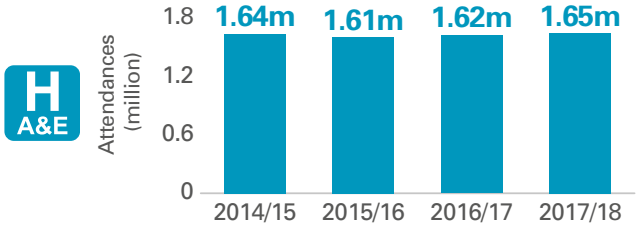


Integration aims to ensure that people's health and care needs are anticipated and planned appropriately, reducing unplanned hospital activity

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

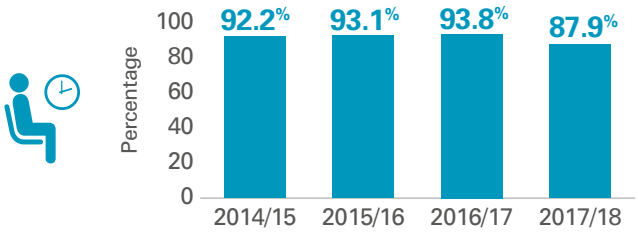


A&E attendances can be an indication of the degree to which community services are helping people receive care in the right place at the right time.

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

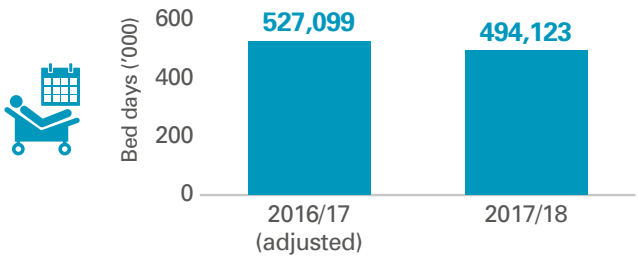
3b. Achievement of the four-hour A&E waiting time target



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+)

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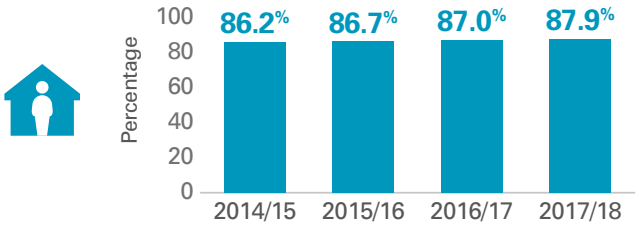
Exhibit 5 (continued)

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

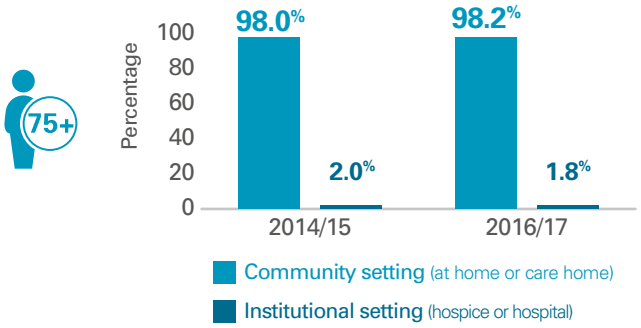


Integration aims to support people with health and care needs in their own home or in a community setting, especially at the end of life.

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).

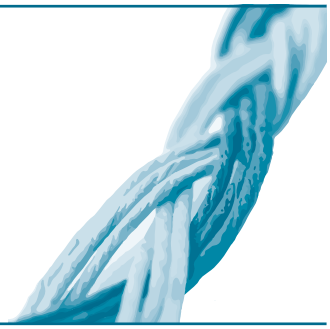
Angus

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

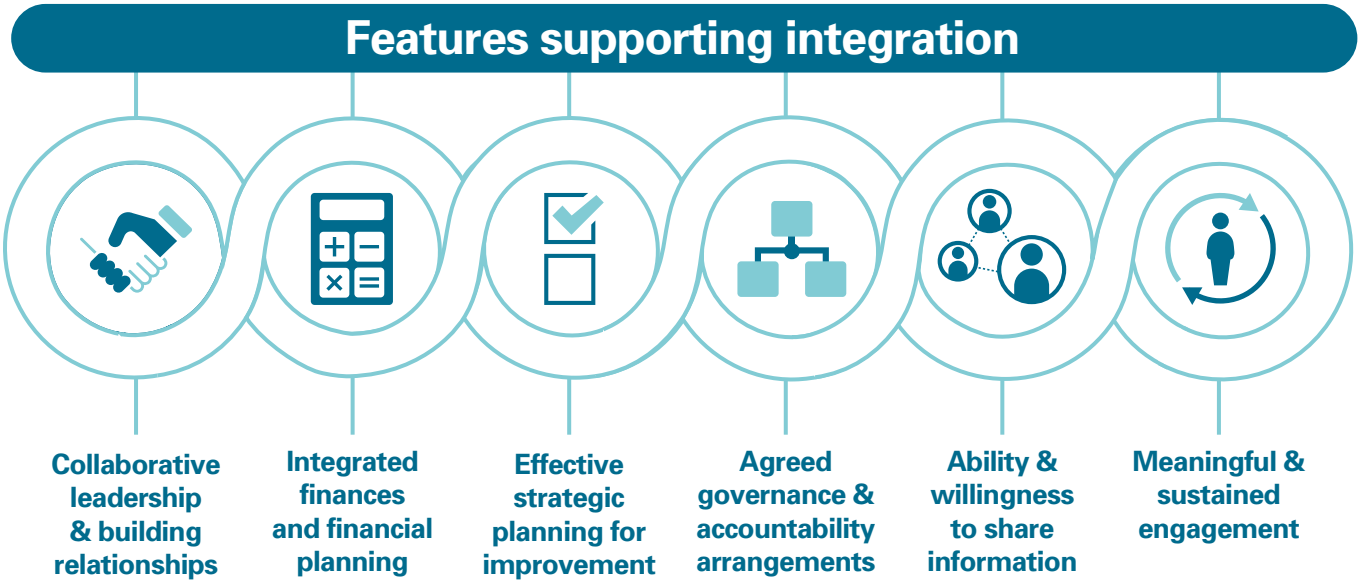


29. IAs are addressing some significant, long-standing, complex and inter-connected issues in health and social care. Our work has identified six key areas that, if addressed, should lead to broader improvements and help IAs to take positive steps toward making a systematic impact on health and care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

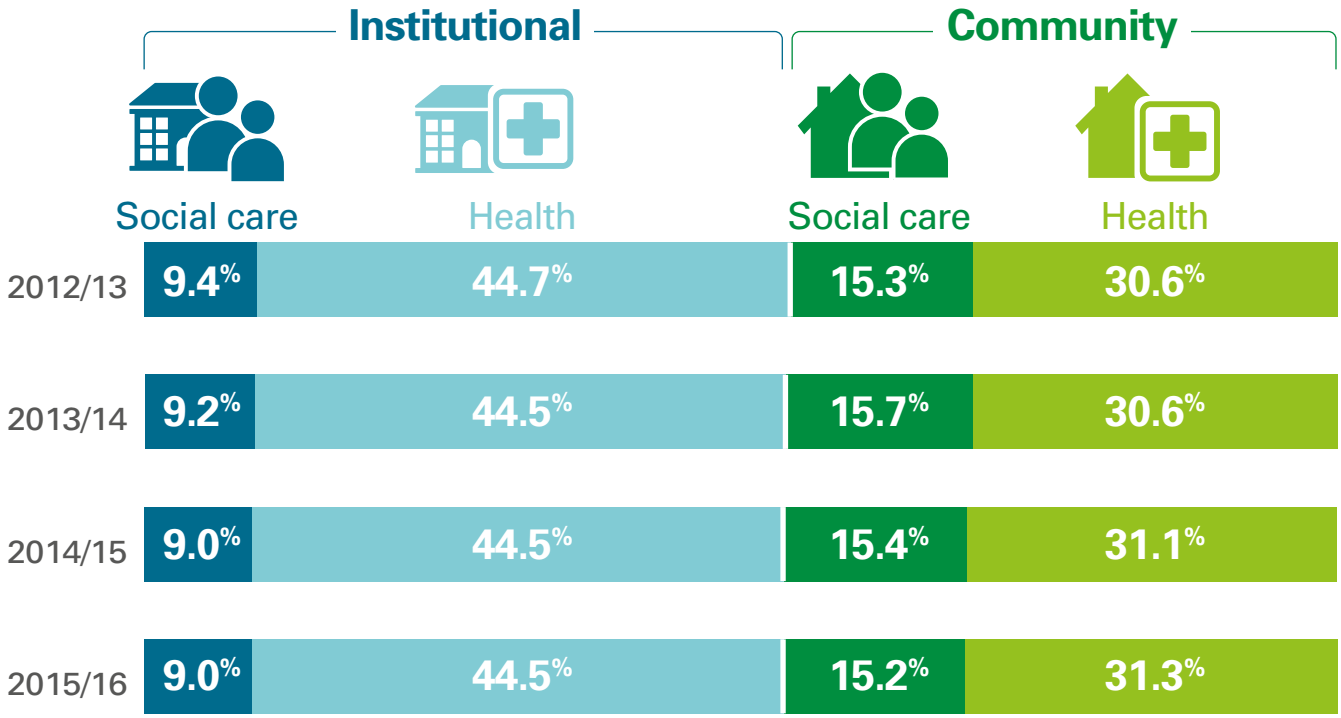
53. Attempts at integrating health and social care go back several years and it is not possible to identify the full cost of the reforms. This, in part, is due to the scale of the reforms and the interconnectedness with the rest of the health and social care system.

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.

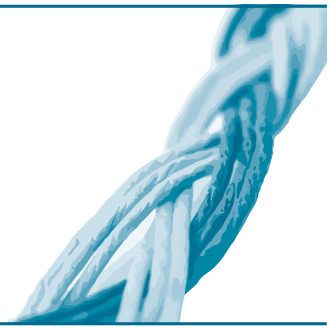
In addition to this involvement, the IJB has also embarked upon a review of its grants to the third-sector. This has been done in full collaboration and partnership with the third-sector. Through the SPG, a steering group was appointed, again with the involvement of LCHIF. This involvement contributed 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**	**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	2.2	0.6	0.6	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

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The table below shows the 15 recommendations that require IJB input together with a note on the Inverclyde position/recommended action against each

Audit Scotland Recommendation		Inverclyde Position/Proposed Action	Responsible Officer	Timeframe
Actions for Scottish Government in partnership with NHS Boards and integration authorities				
1.	Develop a national capital investment strategy to ensure capital funding is strategically prioritised	The IJBs are keen for this to happen as soon as possible to ensure that capital investment within the NHS is spread across services appropriately to encourage the required shifts in the balance of care. Additional workgroups have been set up to achieve this within GG&C but additional focus is needed	Chief Officer to discuss with NHSGG&C and GG&C Capital Planning Group and Scottish Government colleagues	October 2019
2.	Develop a comprehensive approach to workforce planning	Inverclyde has an agreed workforce plan which it is in the process of implementing	Head of Strategy & Support Services	Already in place
3.	Provide a clear breakdown of transitional and future costs to meet projected demand through additional recruitment and training	This already happens within Inverclyde through a number of local and GG&C work-streams	Chief Officer to discuss with NHSGG&C and Scottish Government colleagues	October 2019
Actions for Scottish Government, NHS Boards and integration authorities				
4.	Work together to develop a clearer understanding of demand for services, and capacity and activity trends within primary and secondary care and use this to inform medium to long-term service and workforce planning	The New Ways project in Inverclyde allowed Inverclyde to move forward significantly in impacting on the activity within primary and secondary care. This process will inform future service and workforce plans. Succession plan and people plan are in place and monitored.	Senior Manager HSCP	Already in place

5.	Publish clear and easy to understand information on how the health funding system works, including how much funding was provided, what it was spent on, and the impact it has on people's lives	The ambition with the new Strategic Plan is to provide much clearer links to the funding linked to specific outcomes so it is easier to see what was spent and what the outcomes of that spend are.	Senior Management Team Strategic Planning Group	June 2019
6.	Put staff, local communities, and the public at the heart of change and involve them in planning and implementing changes to how services are accessed and delivered	Consultation is something that Inverclyde already does well for all planned service changes.	Head of Strategy & Support Services	Already in place
Actions for Integration Authorities, Councils and NHS Boards working together				
7.	Ensure operational plans, including workforce, IT and organisational change plans across the system, are clearly aligned to the strategic priorities of the IA	Inverclyde is currently updating its Strategic Plan for 2019-23. The new plan will ensure alignment of all operational and strategic plans Linkages to system wide planning must also be maintained	Head of Strategy & Support Services	April 2019
8.	Monitor and report on Best Value in line with the Act	Inverclyde is already doing this through its Performance and Finance reports as evidenced by the Audit Scotland review of the 2017/18 IJB Accounts.	Chief Financial Officer/ Head of Strategy & Support Services	Already in place
9.	View finances as a collective resource for health and social care to provide the best possible outcomes for people who need support	Inverclyde already does this with integrated teams in place. Longer term we aim to do more of this to create optimum conditions for integration.	Chief Officer/ Chief Financial Officer to take forward with GG&C colleagues	December 2019

10.	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	Further work being done on locality planning to deliver this work with Community Planning Board to support engagement and participation.	Head of Strategy & Support Services	June 2019
Actions for Scottish Government, COSLA, councils, NHS boards and Integration Authorities working together				
11.	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	Inverclyde already has a medium term financial plan in place for the IJB. We work closely with the Council and Health Board on financial planning to support future investment decisions. Longer term finance plans for the IJB are being developed in line with the Strategic Plan	Chief Financial Officer	Already in place
12.	Agree local responsibility and accountability arrangements	This is already in place and working well within Inverclyde. No significant issues or disputes locally about accountability arrangements.	Chief Officer	Already in place
13.	Share learning from successful integration approaches across Scotland	This is already happening. Officers from Inverclyde are involved in local and national networks which involved shared learning and best practice.	Senior Management Team	Already in place
14.	Address data and information sharing issues, recognising that in some cases national solutions may be needed	This is an ongoing issue for all parties and does cause excessive operational difficulties at times. A long term resolution of this would be welcomed but requires a national solution and funding to be identified.	Chief Officer and Head of Strategy & Support Services to continue discussions with NHSGG&C and	April 2020

			Inverclyde Council	
15.	Review and improve the data and intelligence needed to inform integration and to demonstrate improved outcomes in the future.	More work on producing meaningful data around Set Aside and localities is being developed.	NHSGG&C to provide agreed Set Aside datasets	September 2019