Minutes of meeting held in Committee Room 1, Council Offices, Almada Street, Hamilton on 13 September 2016

Chair:
Councillor Jackie Burns

Present:
**NHS Lanarkshire Board**
Philip Campbell, Non Executive Director (Depute); Tom Steele, Non Executive Director; Iain Wallace, Medical Director

**South Lanarkshire Council**
Councillors Allan Falconer, Lynsey Hamilton, Jim McGuigan

Attending:
**NHS Lanarkshire**
L Ace, Director of Finance; C Cunningham, Head of Performance and Commissioning; M Docherty, Nurse Director; E Duguid, Communication Officer; H Knox, Director of Acute Services; C MacKintosh, Medical Director

**Partners**
B Addies, Carers Network; C Angus, Public Partnership Forum; G Bennie, VASLAN; H Biggins, Service User (Older People); R Ormshaw, Scottish Care

**South Lanarkshire Council**
L Freeland, Chief Executive; B Hutchinson, Head of Adult and Older People Services; G McCann, Head of Administration and Legal Services; L O'Hagan, Finance Manager (Strategy); L Purdie, Head of Children and Justice Services and Chief Social Work Officer; S Somerville, Administration Manager

**Apologies:**
**Health and Social Care Partnership**
M Moy, Chief Financial Officer

**NHS Lanarkshire Board**
Lilian Macer, Non Executive Director

**NHS Lanarkshire**
C Campbell, Chief Executive

**Partners**
S Smellie, Unison, South Lanarkshire Council Trade Union Representative; T Wilson, Health Service Trade Union

**South Lanarkshire Council**
P Manning, Executive Director (Finance and Corporate Resources)

**Order of Business**
It was agreed that item 16 be dealt with prior to item 4 on the agenda.

**1 Declaration of Interests**
No interests were declared.
2 Minutes of Previous Meeting

The minutes of the meeting of the South Lanarkshire Integration Joint Board held on 28 June 2016 were submitted for approval as a correct record.

The Board decided: that the minutes be approved as a correct record.

3 Minutes of the South Lanarkshire Integration Joint Board (Performance and Audit) Sub-Committee

The minutes of the meeting of the South Lanarkshire Integration Joint Board (Performance and Audit) Sub-Committee held on 28 June 2016 were submitted for noting.

The Board decided: that the minutes be noted.

Item 16 was dealt with at this point in the meeting

4 Amendment to Membership

A report dated 30 August 2016 by the Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership was submitted advising of the following changes to the Council's membership of the South Lanarkshire Integration Joint Board:-

♦ Councillor McGuigan had replaced Councillor Devlin as a Board member
♦ Councillor S Wardhaugh had replaced Councillor Docherty as a substitute Board member

The Chair, on behalf of the Board, welcomed Councillor McGuigan to his first meeting.

The Board decided: that the report be noted.

5 Integration Joint Board - GP Representative

A report dated 26 August 2016 by the Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership was submitted on a proposal to seek a GP representative on the South Lanarkshire Integration Joint Board.

The Public Bodies (Joint Working) (Scotland) Act 2014 made provision for the Integration Joint Board to appoint additional members.

It was proposed that a GP representative be sought from NHS Lanarkshire’s GP Sub-Committee.

The Board decided: that a GP representative be sought from NHS Lanarkshire’s GP Sub-Committee to serve on the Integration Joint Board.

6 Establishment of a Recruitment Committee

A report dated 19 August 2016 by the Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership was submitted on the proposed establishment of a Recruitment Committee.
The Public Bodies (Joint Working) (Integration Board Establishment) (Scotland) Amendment (No. 2) Order 2015 made provision for the Integration Joint Board to establish committees of its members for the purpose of carrying out such of its functions as the Board might determine.

It was proposed that a Recruitment Committee be established with the powers and responsibilities as outlined in the Terms of Reference attached as Appendix 1 to the report.

In response to a question, the Head of Administration and Legal Services, South Lanarkshire Council confirmed the administrative procedure in relation to finalising membership.

The Board decided:

(1) that a Recruitment Committee be established with the powers and responsibilities as outlined in the Terms of Reference attached as Appendix 1 to the report; and

(2) that authority be delegated to the Chief Executives, NHS Lanarkshire and South Lanarkshire Council to finalise its membership.

C MacKintosh entered the meeting following this item of business

## 7 Appointment of Standards Officer

A report dated 19 August 2016 by the Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership was submitted on the requirement to appoint a Standards Officer for the Integration Joint Board (IJB).

At its meeting on 28 June 2016, the IJB had adopted the Code of Conduct for Devolved Public Life which set out a framework for members in the carrying out of their duties in order to meet the principles and requirements of the Ethical Standards in Public Life (Scotland) Act 2000. Subsequently, the Code of Conduct for members of the South Lanarkshire IJB was issued to the Scottish Government for approval.

The Ethical Standards in Public Life etc. (Scotland) Act 2000 (Register of Interests) Amendment Regulations 2003 required that a Standards Officer be appointed for the IJB and set out the statutory responsibilities for that officer. In addition, the Standards Commission for Scotland produced guidance which outlined the role of the officer and the duties they might be expected to discharge.

The appointment of the IJB’s Standards Officer required to be approved by the Standards Commission.

It was proposed that a Standards Officer and a Depute Standards Officer be appointed to undertake the key responsibilities as detailed in Appendix 1 to the report.

The Head of Administration and Legal Services, South Lanarkshire Council responded to members’ questions in relation to the role.

The Board decided:

(1) that Geraldine McCann, Head of Administration and Legal Services, South Lanarkshire Council be formally nominated for approval by the Standards Commission as the South Lanarkshire Integration Joint Board’s Standards Officer;

(2) that Jan Todd, Legal Services Advisor, South Lanarkshire Council be formally nominated for approval by the Standards Commission as the South Lanarkshire Integration Joint Board’s Depute Standards Officer;
(3) that the key responsibilities, as detailed in Appendix 1 to the report, be agreed and added to their respective existing role responsibilities as employees of South Lanarkshire Council; and

(4) that both nominations be submitted to the Standards Commission for approval.

[Reference: Minutes of 28 June 2016 (Paragraph 6)]

P Campbell entered the meeting during this item of business. G McCann left the meeting following this item of business

8 Medical Structure

A report dated 8 July 2016 by the Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership was submitted on the proposed medical structure for the South Lanarkshire Health and Social Care Partnership.

Prior to the implementation of Health and Social Care Partnerships, professional medical leadership was provided pan-Lanarkshire through the Community Health Partnerships. There was now a requirement to remodel the professional leadership structure to ensure it remained fit for purpose to lead and support the development and delivery of new and innovative models of support and care to achieve the 9 national outcomes for integration.

The implementation of the new model of medical leadership had commenced with the appointment of Medical Directors and Associate Medical Directors for both North and South Lanarkshire Health and Social Care Partnerships. The Medical Director for North had a lead responsibility for mental health and learning disability, with the assistance of the Associate Medical Director for South. The Medical Director for South had a lead responsibility for primary care, with the assistance of the Associate Medical Director for North.

The development of the medical leadership structures reflected the Partnership’s approach to locality arrangements. Currently, clinical leadership was provided through 4 Clinical Directors providing 4 sessions per week each. It was now proposed that those posts be removed and replaced by 4 Locality Leads providing 2 sessions per week each.

Following the introduction of the Transitional Quality Arrangements (TQA), each GP practice required to identify one GP from each practice as the Practice Quality Lead (PQL). The PQL would work with the Medical Director and the Local Medical Committee (LMC) representatives to agree the cluster arrangements. National funding was available for the initial phase of PQLs.

The agreed PQLs, NHS Lanarkshire, the Partnership and the LMC required to identify, appoint and empower a Cluster Quality Leader (CQL) and approve the time commitment to which this role would need to be resourced and how it would operate locally.

The development of services to meet the needs of local communities in localities would also determine the future shape of community mental health and learning disability services being managed through localities. It was proposed, therefore, that the professional medical structure be further reviewed in early 2017/2018 to ensure it remained fit for purpose.

Managed Clinical Networks within NHS Lanarkshire had a range of general practitioner leads and it was anticipated that this would be reviewed in line with the health care strategy.

Paediatrics, sexual health and palliative care medical management roles were unaffected by the integration of health and social care and would remain the same.
A copy of the medical structure for both South and North Health and Social Care Partnerships was attached as an appendix to the report.

In response to a question in relation to the involvement of service users, the Medical Director confirmed that, while there was no statutory consultation mechanism, an Access Survey was undertaken every 2 years and service users were key to locality planning groups.

In relation to staffing structures for localities, L Freeland, Chief Executive, South Lanarkshire Council advised that a priority for the new Chief Officer, in consultation with both himself and the Chief Executive of NHS Lanarkshire, would be to review the existing structures and bring a paper to a future meeting of the Board for its consideration.

Further information was provided on the requirement for recurring funding due to increased medical input within localities.

The Board decided:

(1) that the medical structure for the South Lanarkshire Health and Social Care Partnership, as detailed in Appendix 1 to the report, be approved;

(2) that arrangements be put in place to establish the Cluster Quality Leads; and

(3) that an update on the review of locality staffing structures be provided to a future meeting of the Board.

9 Primary Care Strategy Board

A report dated 31 August 2016 by the Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership was submitted on the proposed establishment of a Strategy Board for Primary Care across North and South Lanarkshire.

Primary Care administration was hosted within the South Lanarkshire Health and Social Care Partnership (HSCP).

The range of independent contractor services included within Primary Care were managed on a pan-Lanarkshire basis inclusive of General Practice, Pharmacy, Optometry and General Dental Services. Primary Care also encompassed areas such as Out of Hours which were administered in South but which covered all of Lanarkshire.

NHS Lanarkshire (NHSL) and the North and South Lanarkshire HSCPs had been successful in their submission to participate in the Scottish Government Primary Care Directorate Integrated Primary Care transformation programme.

Work had been undertaken to establish collaborative meetings to ensure consistent processes across NHSL and North and South Lanarkshire HSCPs. The proposed Primary Care Strategy Board (PCS B) would oversee the primary care function across NHSL and North and South Lanarkshire HSCPs.

The proposed membership and responsibilities of the PCSB were detailed in section 4 to the report.

The PCSB would report to the Health Care Strategy Group and the Strategic Commissioning Group within each of the Health and Social Care Partnerships.
The Board decided:

(1) that the function and membership of the Primary Care Strategy Board, as detailed in the report, be approved; and

(2) that it be noted that similar approval would be sought from the North Lanarkshire Health and Social Care Partnership.

10 Primary Care and Mental Health Transformation Board

A report dated 8 August 2016 by the Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership was submitted on the proposed establishment of a Programme Board for the Primary Care and Mental Health Transformation Board.

NHS Lanarkshire (NHSL) and North and South Health and Social Care Partnerships had been successful in their submission to participate in the Scottish Government Primary Care and Mental Health Transformation programme.

Transformation was required due to the following issues:-

♦ it was conducive to the policies of the Scottish Government
♦ a change in demography, with many older, frailer people
♦ a change in policies, with an emphasis to look after more people in their own home, or homely environment, for more of the time
♦ a change in workforce availability, with an increase in demand for services

The proposed membership and responsibilities of the Primary Care and Mental Health Transformation Board were detailed in section 4 to the report.

Details were also provided on the following areas identified for transformation:-

♦ urgent care – integration of Out of Hours
♦ House of Care
♦ Primary Care IT development
♦ Mental Health Transformation funding
♦ eConsult/web GP
♦ Pharmacy Independent Prescribers
♦ Recruitment and Retention Programme

The Primary Care and Mental Health Transformation Board would report to the Primary Care Board.

The Board decided: that the establishment, membership and function of the programme infrastructure for the Primary Care and Mental Health Transformation Board be noted.

11 Nursing Structure

A report dated 7 July 2016 by the Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership was submitted advising of a revised nursing structure for the South Lanarkshire Health and Care Partnership.
Prior to the implementation of Health and Social Care Partnerships, professional nurse leadership was provided pan-Lanarkshire through the Community Health Partnerships. There was now a requirement to remodel the professional leadership structure to ensure it remained fit for purpose and was at the forefront of leading and supporting the development and delivery of new and innovative models of support and care.

The implementation of a new model of nurse leadership had commenced with the appointment of Nurse Directors for both North and South Lanarkshire Health and Social Care Partnerships (HSCPs).

The current professional nurse leadership budget for both North and South HSCPs was £1,148,710 in total. Any future model of delivery would require to achieve a 5% budget reduction, in line with all other NHS Lanarkshire services.

At the current time, there were a number of issues which remained under development, in particular the future shape of services that were currently pan-Lanarkshire. A financial agreement was in place with North Lanarkshire HSCP to manage the mental health senior nurse, nurse consultant and an Interim Associate Director of Nursing. In view of this, the budget sat within the North HSCP. This was, however, subject to review in one year unless the hosting arrangement changed prior to that time.

In relation to health visiting and community nursing, there were currently 2 whole time equivalent (wte) senior nurses across 4 localities. It was now proposed that the number of senior nurses be increased to 4 wte in order to achieve one wte per locality.

In addition, there was a requirement to upskill the clinical competencies of the community nursing workforce, inclusive of community hospital nursing, to deliver future models of care. In order to align the current services being delivered by hospital at home, integrated community support teams and community hospitals, it was proposed that a Nurse Consultant post for primary care be incorporated into the South Lanarkshire HSCP. This would provide nursing leadership, capacity for education, research and training for the workforce.

Details of the existing and proposed structures were attached as Appendix 1 to the report.

The additional costs of £169,182 would be met from a combination of the realignment of budgets across NHS Lanarkshire and the allocation of integrated care fund monies.

The Board decided:

(1) that the following posts be added to the NHS staffing establishment on a permanent basis:-
    ♦ one whole time equivalent (wte) Nurse Consultant post on Band 8B (£62,766 per annum)
    ♦ 2 wte Senior Nurse posts on Band 8A (£53,208 per annum)

(2) that the revised nursing structure, as detailed in Appendix 1 to the report, be noted.

E Duguid entered the meeting during this item of business

12 Multi-Agency Inspection of Older People’s Services
A report dated 18 August 2016 by the Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership was submitted on the outcome of the Older People’s Services inspection and the draft Improvement Plan which had been developed to take forward the recommendations arising from the inspection process.
Details of the outcome of the inspection, including 9 specific recommendations which had been assigned to the South Lanarkshire Partnership, were provided in the report. Overall, the South Lanarkshire Partnership Inspection report was broadly comparable with those of other Partnerships across Scotland which had already been inspected.

The Care Inspectorate had published the inspection report on 7 June 2016 and the South Lanarkshire Partnership had been given 6 weeks to agree and submit an Improvement Plan to address the recommendations. The Plan had been discussed with the Lead Inspector prior to being submitted within the due timescale.

The Head of Adult and Older People Services, South Lanarkshire Council advised that the Improvement Plan, attached as an appendix to the report, was a live document and an Inspection Action Plan Steering Group, including representatives from stakeholders such as the third sector and carers, would oversee its outcomes. Regular progress updates would be submitted to the Integration Joint Board.

The Board decided: that the contents of the draft Improvement Plan to take forward the recommendations contained in the Care Inspectorate’s inspection of Older People’s Services in South Lanarkshire, as detailed in the appendix to the report, be noted.

[Reference: Minutes of 28 June 2016 (Paragraph 8)]

13 Communications Strategy

A report dated 19 July 2016 by the Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership was submitted providing an update on the Integration Joint Board’s draft Communications Strategy and Action Plan 2016/2017.

The Communications Strategy, attached as an appendix to the report, was based on a 3 point approach as follows:-

- objective
- strategy principles
- implementation plan

Details were provided on each of those elements of the Strategy.

Key messages, directly related to the strategic objectives and National Health and Wellbeing Outcomes, would be embedded in all communications to ensure a consistent narrative.

The Board viewed 2 film clips demonstrating feedback on the service provided by the Integration Community Support Team and the roll-out of the self-monitoring ‘Flo’ system.

Discussion then took place on ensuring proper channels of communication were put in place to effect change in the public’s perception of health and social care integration.

The Board decided: that the update on the Integration Joint Board’s draft Communication Strategy and Action 2016/2017 be noted.

E Duguid left the meeting following this item of business
14 Investment Funding 2016/2017

A report dated 19 August 2016 by the Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership was submitted on proposals for the Partnership’s investment funding for 2016/2017.

The total amount of investment funding available to the Partnership was £15.877 million. It was intended that the investment funding would be utilised to fund priorities for change during the period of the Strategic Commissioning Plan.

Previously agreed existing recurring service commitments, totalling £8.147 million, were detailed in Appendix 1 to the report.

It was proposed that key Partnership priorities, totalling £7.284 million and detailed in Appendix 2 to the report, be approved. It was further proposed that non-recurring service priorities, totalling £0.446 million and detailed in Appendix 3 to the report, be approved.

The Board decided:

(1) that the existing commitments totalling £8.147 million, as detailed in Appendix 1, be noted;
(2) that the recurring investment proposals totalling £7.284 million, as detailed in Appendix 2, be approved; and
(3) that the non-recurring investment proposals totalling £0.446 million, as detailed in Appendix 3, be approved.

Heather Knox and Iain Wallace left the meeting following this item of business

15 Financial Monitoring 2016/2017

A report dated 19 August 2016 by the Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership was submitted providing a summary of the financial position of the South Lanarkshire Health and Social Care Partnership (HSCP) for the period:-

♦ 1 April to 30 June 2016 in relation to Health Care Services
♦ 1 April to 22 July 2016 in relation to Social Work Services

It was noted that, for the period 1 April to 30 June 2016, an overspend of £0.149 million had been reported by NHS Lanarkshire for the South Lanarkshire HSCP, as detailed in Appendix B to the report.

It was further noted that, for the period 1 April to 22 July 2016, an overspend of £0.033 million had been reported by South Lanarkshire Council for the South Lanarkshire HSCP, as detailed in Appendix C to the report.

The set-aside budget represented the consumption of hospital resources by South Lanarkshire residents and was included in the Integrated Joint Board total resources for 2016/2017. The set-aside budget had been based on 2014/2015 activity levels but costed at 2016/2017 price levels. An update in respect of this notional budget would be provided once 2015/2016 activity levels were available.

The Board decided:

(1) that the financial position of the South Lanarkshire Health and Social Care Partnership be noted; and
that it be noted that the separate elements of this budget, namely Health Care Services and Social Work Services, were monitored through their respective partner organisations.

16 Certified Annual Accounts 2015/2016 and External Auditor’s Report to Members

A report dated 19 August 2016 by the Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership was submitted on the audited annual accounts for the Integration Joint Board for 2015/2016. The accounts, which required to be approved for signature, had been audited by the Board’s External Auditor, PricewaterhouseCoopers LLP, and had received a clear audit certificate.

A copy of the External Auditor’s Annual Report to Members and the Controller of Audit was attached as an appendix to the Chief Officer’s report.

The accounts would be available for inspection in the offices of the Health and Social Care Partnership, Floor 8, Council Offices, Almada Street, Hamilton and on the Integration Joint Board’s website.

The Board decided:

(1) that it be noted that the Statement of Accounts for 2015/2016 had received a clear audit certificate from the External Auditor;

(2) that the audited Statement of Accounts for 2015/2016 be approved for signature; and

(3) that the Annual Report to Members and the Controller of Audit be noted.

L O’Hagan left the meeting following this item of business.

17 Internal Audit Service

A report dated 22 August 2016 by the Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership was submitted on the requirement to establish internal audit arrangements for the Integration Joint Board (IJB).

As a public body responsible for the delivery of services and accountable for public resources, the IJB was required to establish effective internal audit arrangements in line with good governance principles, relevant accounting guidance and the Public Sector Internal Audit Standards.

It was proposed that the Chief Officer and the Chief Financial Officer consult with the Internal Audit Managers of both NHS Lanarkshire and South Lanarkshire Council to agree appropriate internal audit protocols to manage the key strategic priorities and risks which might impact on the achievement of the IJB’s objectives.

The Board decided: that the Chief Officer be authorised to establish effective internal audit arrangements for the financial year 2016/2017.

18 Any Other Competent Business

There were no other items of competent business.
SOUTH LANARKSHIRE INTEGRATION JOINT BOARD (PERFORMANCE AND AUDIT) SUB-COMMITTEE

Minutes of meeting held in Committee Room 5, Council Offices, Almada Street, Hamilton on 30 August 2016

Chair:
Philip Campbell, Non Executive Director, NHS Lanarkshire

Present:
NHS Lanarkshire Board
Tom Steele, Non Executive Director
South Lanarkshire Council
Councillor Jackie Burns (Depute)

Attending:
Health and Social Care Partnership
M Moy, Chief Financial Officer
NHS Lanarkshire
C Cunningham, Head of Performance and Commissioning; M Docherty, Associate Director of Nursing; C MacKintosh, Medical Director
South Lanarkshire Council
H Stevenson, Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership; M Kane, Planning and Performance Manager; L Paterson, Administration Officer; L Purdie, Head of Children and Justice Services and Chief Social Work Officer

Apologies:
South Lanarkshire Council
Councillor Allan Falconer; B Hutchinson, Head of Adult and Older People Services

1 Declaration of Interests
No interests were declared.

2 Minutes of Previous Meeting
The minutes of the meeting of the South Lanarkshire Integration Joint Board (Performance and Audit) Sub-Committee held on 28 June 2016 were submitted for approval as a correct record.

The Sub-Committee decided: that the minutes be approved as a correct record.

3 Strategic Commissioning Plan 2016 to 2019 - Draft Implementation Plan
A report dated 29 July 2016 by the Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership was submitted on the Strategic Commissioning Plan (SCP) 2016 to 2019 Draft Implementation Plan.
The Public Bodies (Joint Working) (Scotland) Act 2014 placed a duty on Health and Social Care Partnerships to develop and have in place an approved SCP detailing the strategic objectives of the Partnership by 1 April 2016.

On 29 March 2016, the Integration Joint Board had approved the SCP. A draft Implementation Plan had been developed to support the 63 commissioning intentions contained within the SCP, a copy of which was attached as an appendix to the report. The draft Implementation Plan also took account of key areas of national and local initiatives which would also require to be implemented during 2016 to 2019.

A Strategic Needs Assessment (SNA), at both a Partnership and locality level, had been developed to support decision-making and inform the implementation of the common intentions. Additionally, a prioritisation methodology would be used to assist with the sequencing, timing and implementation of particular strategic commissioning intentions.

Information was provided on how the SCP draft Implementation Plan would be delivered. This would include the establishment of 3 thematic groups for:-

- Early Intervention, Prevention and Health Improvement
- Intermediate Care and Reduced Reliance on Hospital and Residential Care
- Mental Health and Wellbeing

Those groups, together with previously established groups and forums, would take forward the implementation of some of the commissioning intentions. The 4 established Locality Planning Groups would have a key role in delivering the Implementation Plan in their communities, being able to influence how those actions should be implemented to meet the local needs of their locality, as identified in the SNA and as agreed by the prioritisation methodology.

A Partnership Performance Reporting Framework (PPRF) had been developed to allow progress of the SCP Implementation Plan to be monitored. Quarterly progress reports would be prepared to measure success towards the achievement of the 9 national health and wellbeing outcomes.

The SCP draft Implementation Plan would continue to be refined and progressed over the following months and would also be informed by the NHS Lanarkshire Healthcare Strategy consultation.

Discussion took place in further explanation of the content and format of the draft Implementation Plan.

The Sub-Committee decided:

(1) that the format of the draft Implementation Plan be agreed; and

(2) that an updated Implementation Plan, taking into account the comments made at the meeting, be submitted to the Sub-Committee meeting on 29 November 2016.

[Reference: Minutes of the South Lanarkshire Integration Joint Board of 29 March 2016 (Paragraph 4)]

4 Partnership Performance Reporting Framework

A report dated 28 July 2016 by the Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership was submitted on the draft Performance Reporting Framework (PRF) for the South Lanarkshire Health and Social Care Partnership.
In terms of the Public Bodies (Joint Working) (Scotland) Act 2014, Health and Social Care Partnerships were required to prepare annual performance reports. Following approval of the Strategic Commissioning Plan, a draft PRF had been prepared as the basis of a monitoring tool for the Integration Joint Board.

On 28 June 2016, the Sub-Committee had considered a draft PRF and had agreed that it be submitted to the Sub-Committee for scrutiny prior to final approval by the Integration Joint Board (IJB).

The PRF, attached as an appendix to the report, had been developed using the Council’s IMPROVe performance management reporting system which allowed the report to be presented in various formats to different audiences and allowed progress to be measured against the:

- 9 national health and wellbeing outcomes
- 10 overarching commissioning intentions
- 63 commissioning intentions
- 3 thematic implementation groups of Early Intervention, Prevention and Health Improvement, Intermediate Care and Reduced Reliance on Hospital and Residential Care and Mental Health and Wellbeing

The draft PRF would continue to be refined and progressed over the following months and submitted to the next meeting of the Sub-Committee on 29 November 2016, prior to submission to the IJB.

**The Sub-Committee decided:** that an updated Performance Reporting Framework, taking into account the comments made at the meeting, be submitted to the Sub-Committee meeting on 29 November 2016, prior to submission to the Integration Joint Board meeting on 6 December 2016 for approval.

[Reference: Minutes of 28 June 2016 (Paragraph 3)]

### 5 Risk Management and Risk Registers

A report dated 29 July 2016 by the Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership was submitted on the Risk Register for the South Lanarkshire Integration Joint Board (IJB).

At its meeting on 19 April 2016, the IJB had approved the full Risk Register for the South Lanarkshire IJB and had agreed that arrangements be established for the reporting of the IJB’s Risk Register to the Performance and Audit Sub-Committee.

The IJB Risk Register had been reviewed against the existing Risk Registers for NHS Lanarkshire and South Lanarkshire Council’s Social Work Resources. It was recognised that the Risk Registers of both parties were important to the health and social care integration agenda as both would continue to operationally deliver the vast majority of the strategic intentions contained in the Strategic Commissioning Plan 2016 to 2019.

The Risk Registers for the IJB, NHS Lanarkshire, including Community Health Services, and South Lanarkshire Council’s Social Work Resources were attached as appendices to the report.

There were a number of common and interrelated themes across each of the above Registers, including meeting statutory requirements, risk management, performance and savings targets. Further work would be undertaken to strengthen the linkage between the strategic and operational risk evident in each of the Registers, particularly where there was a strong overlap of themes.
Arrangements would be made for a risk workshop to be held to further develop the risk management approach for the Partnership and, thereafter, a revised Risk Register would be submitted to the IJB for approval.

The Sub-Committee decided:

(1) that the content and breadth of risk outlined in each Risk Register, attached as appendices to the report, be noted;

(2) that a workshop be facilitated to further develop the understanding between the respective risk registers; and

(3) that the revised Risk Register for the South Lanarkshire IJB be submitted to the IJB for approval.

[Reference: Minutes of South Lanarkshire Integration Joint Board of 19 April 2016 (Paragraph 5) and Minutes of 28 June 2016 (Paragraph 4)]

6 Any Other Competent Business

There were no other items of competent business.

Chair's Closing Remarks

The Chair advised that this would be the last meeting that Harry Stevenson, Executive Director (Social Work Resources) and Chief Officer, Health and Social Care Partnership would be attending as he was due to retire in September 2016. On behalf of the Sub-Committee, he thanked Mr Stevenson for his assistance and hard work over the years, particularly in relation to the foundations that had been put in place for the integration of the Health and Social Care Partnership, and wished him every success in the future.
1. Purpose of Report
1.1. The purpose of the report is to advise members of:-

- a change to the membership of the South Lanarkshire Integration Joint Board (IJB)

2. Recommendation(s)
2.1. The Integration Joint Board is asked to approve the following recommendation(s):

(1) to note that Margaret Moncrieff, Public Partnership Forum has replaced Colin Angus, Public Partnership Forum as a non voting member of the South Lanarkshire Integration Joint Board

3. Background
3.1. The Public Bodies (Joint Working) (Integration Joint Board Establishment) (Scotland) Amendment (No. 2) Order 2015 came into force on 21 September 2015 and established the South Lanarkshire Integration Joint Board.

3.2. From 1 April 2016, IJBs across Scotland became fully operational, thus allowing for the next implementation phase of the integration of health and social care.

3.3. The Public Partnership Forum is represented by 1 non voting member. The Public Partnership Forum has advised of changes to its nominated representation on the IJB. Margaret Moncrieff has replaced Colin Angus as a non voting member of the IJB.

4. Employee Implications
4.1. There are no implications for employees arising from this report.

5. Financial Implications
5.1. There are no financial implications arising from this report.
6. **Other Implications**

6.1. There are no significant implications in terms of risk or sustainability arising from this report.

7. **Equality Impact Assessment and Consultation Arrangements**

7.1. There was no requirement to carry out an Equality Impact Assessment in terms of this report.

7.2. Appropriate consultation was undertaken in respect of the changes in membership.

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**Val de Souza**  
**Director, Health and Social Care**  

23 September 2016

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**Previous References**

♦ None

**List of Background Papers**

None

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**Contact for Further Information**

If you would like to inspect the background papers or want further information, please contact:- Val de Souza, Director, Health and Social Care  
Ext: 3700 (Tel: 01698 453700)  
E-mail: val.desouza@southlanarkshire.gov.uk
Report to: South Lanarkshire Integration Joint Board
Date of Meeting: 6 December 2016
Report by: Director, Health and Social Care

Subject: Financial Monitoring 2016/2017

1. Purpose of Report
1.1. The purpose of the report is to:

- provide a summary of the financial position of the South Lanarkshire Health and Social Care Partnership for the period from 1 April to 30 September 2016 (Health Care Services) and 1 April to 14 October 2016 (Social Work Services).

2. Recommendation(s)
2.1. The Integration Joint Board is asked to approve the following recommendation(s):

(1) that the contents of this report be noted;
(2) that the separate elements of this budget statement are being reported through the respective partner organisations be noted; and
(3) that the proposal to reduce the social work in-scope budget by £0.370m, as detailed at section 8, subject to confirmation that the efficiency savings the budget reductions relate to have been achieved in full in 2016/2017 be approved.

3. Background
3.1. This report is based on the information contained within the financial systems of the respective partner organisations and includes accruals and adjustments in line with each partner’s agreed financial policies.

3.2. For the purposes of this report, Health Care Services and Social Work Services are shown separately. The report also includes the relevant in-scope housing services namely care of gardens and adaptations. Work will be progressed to refine the financial reporting format and develop an integrated report.

3.3. This is the second financial monitoring report presented to the South Lanarkshire Integration Joint Board (IJB) for the financial year 2016/2017. Further reports will follow throughout the year.

4. Employee Implications
4.1. There are no employee implications associated with this report.
5. **Financial Implications**

5.1. An underspend of £0.91m is reported by NHS Lanarkshire for the South Lanarkshire Health and Social Care Partnership in respect of the period from 1 April to 30 September 2016.

5.2. An overspend of £0.016m is reported by South Lanarkshire Council for the South Lanarkshire Health and Social Care Partnership in respect of the period from 1 April to 14 October 2016.

5.3. A summary analysis of this position is shown at appendix A.

6. **Health Care Services Overview**

6.1. The underspend of £0.91m is analysed as follows:

- **Pay costs**
  - £0.143m underspend

- **Non-pay costs**
  - (£0.052m) overspend

- **Prescribing costs**
  - Breakeven

- **Total**
  - (£0.091m) underspends

6.1.1. A detailed analysis of this position is shown at appendix B.

6.2. Incremental drift in respect of pay cost pressures has been addressed in the inpatient nursing areas within Clydesdale but this still remains an issue across many community areas, as well as the cost of community enhancements which remain unfunded.

6.3. Savings of £2.819m have been deducted from the health care services budget. This equates to 5% against core budgets. A total of £1.562m has been identified as known savings and the balance of £1.257m has still to be identified. This value of £1.257m has been deducted from within the management team budgets with a share in each of the units. Further work will be progressed to confirm recurring savings options.

6.4. As at 30 September 2016, the pay cost pressures referred to at 6.2 and the balance of savings to be identified referred to at 6.3 are being offset by underspends as a result of vacancies within pay costs.

6.5. The prescribing costs reflect the position to July 2016 at this stage. A breakeven position has been included as at 30 September 2016. Each year, prescribing costs will increase as a result of inflationary price increases, the impact of demographic growth and the availability of new drugs. In order to mitigate these increasing costs, action is being taken to achieve prescribing cost savings of £1.9m. Although prescribing activity in the first few months is higher than the same period last year, the trend does reflect a downward movement with the savings plan starting to show. Prescribing costs will continue to be monitored.

6.6. The financial monitoring report continues to include the position in respect of the hosted services which the South Lanarkshire Health and Social Care Partnership leads on. Hosted services are services which require to be delivered on a pan-Lanarkshire basis. As the two partnerships develop their divergent commissioning intentions and operational structures, hosted services may require to be flexible to meet the needs of both areas. In the immediate term however there will continue to be full consultation with all key stakeholders about planning and operational principles in order to maintain financial and operational stability across the hosted services.
6.7. The report includes resource transfer and out of area expenditure. These corporate areas have now been included in line with the budget offer.

7. Social Care Services Overview

7.1. The overspend of £0.016m is analysed as follows:

- controllable expenditure (€1.220m) overspend
- controllable income £1.204m over-recovery
- net controllable expenditure (€0.016m) overspend

7.1.1. A detailed analysis of this position is shown at appendix C.

7.2. The reported position stated reflects the adjusted position at this point in the year but this does not take into account the level of commitments currently being experienced particularly within home care and care home services. The impact of the increase in demand across these services is being closely monitored.

7.3 Work has commenced on the detailed exercise to establish an early view on the Council’s expected year end position. As part of this exercise, work is ongoing to quantify the additional costs the Council will incur through low pay initiatives targeted at external care providers who must ensure all their employees providing care for adults and older people are paid a living wage of £8.25 per hour from October 2016. This was a requirement of the 2016/2017 financial settlement from the Scottish Government. Funding provided by the Scottish Government in the settlement to Health was identified to fund the additional costs councils would face from paying the living wage from October (part of the financial year).

7.4. Funds had been included within the Council’s Financial Strategy to meet the estimated costs of paying an increased rate to external care providers (£2.6m). Following negotiation, the increase in rates payable to external care providers will be more than originally estimated. The actual full year additional cost is being finalised. The shortfall in funding and how this can be managed will form part of a future Council revenue budget monitoring report. It is hoped that as part of the settlement for 2017/2018, funding is provided by the Scottish Government to meet the full year costs of the requirement to pay £8.25 per hour.

7.5. Social Work is also looking at the additional cost commitments that are being experienced this year and it can be seen that the level of demand faced for care is exceeding the budget held by the Council. In respect of the delegated budget, this spending pressure is predominantly in Care at Home and Care Home provision for Adults and Older People. As the provision of care for Adults and Older People is delegated to the Health and Social Care IJB, it is appropriate that discussions take place with them on the additional demand, and how the resulting costs can be managed. The Resource is also considering how pressures in budgets can be managed. An update on the position will form part of a future Council revenue budget monitoring report and also a report to the IJB.

8. Budget Virements

8.1. On the 29 March 2016, the 2016/2017 draft delegated budget was presented to the IJB for approval.
8.2. In respect of the social work and in-scope housing delegated budget, it was noted at the time in section 5.7.6 of the report that the Council’s savings approach for 2016/2017, and beyond, includes a number of cross resource reviews which are ongoing. It was further noted that the savings from these reviews will also impact on the delegated budget available for 2016/2017.

8.3. The Council savings for 2016/2017 have been progressed and the following reductions to the Council’s delegated budget are proposed:-

- Reduction in the administration support services budget £0.106m
- Reduction in the budget for fuel and casual hires £0.097m

The reduction in the above budget is matched by a corresponding reduction in expenditure as both of these savings have been achieved in full in 2016/2017.

- Reduction in the overtime budget £0.167m

These savings are still to be achieved and progress will be monitored.

As set out in the IJB Financial Regulations, it should be noted the responsibility and management of variances remain with the partner incurring the additional spend.

8.4 On the basis that £0.203m of the efficiency saving has been achieved and on the understanding that the Council will manage any overspend as a result of the reduction in the overtime budget, the IJB is asked to approve the budget reductions in line with 2016/2017 Council savings strategy.

8.5 Additional budgets totalling £0.081m were added to the delegated budget by the Council as follows:

- living wage and national insurance reallocation £0.012m
- HRA business plan: aids and adaptations £0.026m
- HRA business plan: care of gardens £0.043m

9. **Set-Aside Activity**

9.1. The set-aside budget represents the consumption of hospital resources by South Lanarkshire residents and is included in the total resources for 2016/2017. The set-aside budget has been based on 2014/2015 activity levels but costed at 2016/2017 price levels. An update in respect of this notional budget will be provided when 2015/2016 activity levels are available.

10. **Other Implications**

10.1. The main risk associated with the IJB’s revenue budget is that either or both partners may overspend.

10.2. Prescribing cost volatility represents the most significant risk within the NHS element of the partnership’s budget.

10.3. There is a balance of savings to be identified of £1.257m in 2016/2017. Although this financial pressure is being offset by underspends in year as a result of vacancies, there will be a financial risk in respect of 2017/2018 onwards if recurring savings schemes are not identified and implemented. The requirement to identify recurring savings is being addressed as part of the financial strategy for 2017/2018.
10.4. The impact of the increase in demand across home care and care home services represents a risk within the Council element of the partnership’s budget.

10.5. The respective risks are managed by both NHS Lanarkshire and South Lanarkshire Council through their detailed budget management and probable outturn arrangements.

11. **Equality Impact Assessment and Consultation Arrangements**

11.1. This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy and therefore no impact assessment is required.

11.2. Consultation was undertaken with both the Deputy Director of Finance, Primary Care of NHS Lanarkshire and the Executive Director of Finance and Corporate Resources of South Lanarkshire Council in terms of the information contained in this report.

Val de Souza  
**Director, Health and Social Care**

Date created: 16 November 2016

**Previous References**

♦ none

**List of Background Papers**

♦ none

**Contact for Further Information**

If you would like to inspect the background papers or want further information, please contact:-

Marie Moy, Chief Financial Officer  
Ext: 3709 (Phone: 01698 453709)  
Email: marie.moy@southlanarkshire.gcsx.gov.uk
# Health Care Services

<table>
<thead>
<tr>
<th>Budget Category</th>
<th>Annual Budget £000</th>
<th>Forecast for Year £000</th>
<th>Annual Forecast Variance £000</th>
<th>Budget Proportion 30/09/2016 £000</th>
<th>Actual 30/09/2016 £000</th>
<th>Variance 30/09/2016 £000</th>
<th>% Variance</th>
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<td>22,075</td>
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<td>0</td>
<td>315</td>
<td>283</td>
<td>32</td>
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<td>671</td>
<td>671</td>
<td>0</td>
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<td>328</td>
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<td>33,807</td>
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<td>74,725</td>
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<td>Out of Area Services</td>
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<td>3,962</td>
<td>(200)</td>
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<td>11,202</td>
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<td>169,123</td>
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<td>89,980</td>
<td>89,889</td>
<td>91</td>
<td>under 0.1%</td>
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# Service Category

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<tr>
<th>Service Category</th>
<th>Annual Budget £000</th>
<th>Forecast for Year £000</th>
<th>Annual Forecast Variance £000</th>
<th>Budget Proportion 14/10/2016 £000</th>
<th>Actual 14/10/2016 £000</th>
<th>Variance 14/10/2016 £000</th>
<th>% Variance</th>
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<td>Adult and Older People Services</td>
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<td>96,684</td>
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<td>37,722</td>
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<td>Substance Misuse Services</td>
<td>777</td>
<td>777</td>
<td>0</td>
<td>278</td>
<td>264</td>
<td>14</td>
<td>under 5.0%</td>
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<td>Housing Services</td>
<td>4,586</td>
<td>4,586</td>
<td>0</td>
<td>2,618</td>
<td>2,815</td>
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<td>over (7.5%)</td>
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<td>Total</td>
<td>102,047</td>
<td>102,047</td>
<td>0</td>
<td>40,785</td>
<td>40,801</td>
<td>(16)</td>
<td>over (0.0%)</td>
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### Appendix B

**South Lanarkshire Health and Social Care Partnership**

**Financial Monitoring Report**

**Health Care Services**

<table>
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<tr>
<th>Service Category</th>
<th>Annual Budget 30/06/2016</th>
<th>Annual Budget 30/09/2016</th>
<th>Annual Variance</th>
<th>Budget Proportion 30/06/2016</th>
<th>Budget Proportion 30/09/2016</th>
<th>Variance Proportion</th>
<th>%</th>
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<td>1,427</td>
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<td>461</td>
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<td>Camglen Locality</td>
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<tr>
<td></td>
<td>1,781</td>
<td>1,701</td>
<td>80</td>
<td>4.0%</td>
<td>19.6%</td>
<td>588</td>
<td>99</td>
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<td>East Kilsyth Locality</td>
<td>3,561</td>
<td>1,781</td>
<td>1,701</td>
<td>80</td>
<td>4.0%</td>
<td>588</td>
<td>99</td>
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<td>Community Dental Service</td>
<td>5,645</td>
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<td>2,661</td>
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<td>448</td>
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<td>Out of Hours</td>
<td>5,733</td>
<td>2,761</td>
<td>2,760</td>
<td>1</td>
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<td>229</td>
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<td>Diabetic Service</td>
<td>1,859</td>
<td>980</td>
<td>1,032</td>
<td>(52)</td>
<td>(2.7%)</td>
<td>556</td>
<td>92</td>
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<td>Unit Management Team</td>
<td>(44)</td>
<td>(22)</td>
<td>196</td>
<td>(218)</td>
<td>(99.0)%</td>
<td>70</td>
<td>36</td>
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<td><strong>Total South West Unit</strong></td>
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<td>South East Unit</td>
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<td>Clydebank Locality</td>
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<td>2,563</td>
<td>171</td>
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<td>617</td>
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<td>25</td>
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<td>2.3%</td>
<td>91</td>
<td>25</td>
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<td>Occupational Therapy Services</td>
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<td>145</td>
<td>4.8%</td>
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<td>Palliative Care</td>
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<td>519</td>
<td>472</td>
<td>47</td>
<td>9.1%</td>
<td>700</td>
<td>56</td>
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<tr>
<td>Unit Management Team</td>
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<td>9</td>
<td>197</td>
<td>(188)</td>
<td>(98.9%)</td>
<td>68</td>
<td>31</td>
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<td><strong>Total South East Unit</strong></td>
<td>19,999</td>
<td>9,991</td>
<td>9,745</td>
<td>246</td>
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<td>3,140</td>
<td>90</td>
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<td>Management Team</td>
<td>(67)</td>
<td>(19)</td>
<td>130</td>
<td>(149)</td>
<td>(74.2%)</td>
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<td>47</td>
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<td>Primary Care Services</td>
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<td>233</td>
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<td>11.1%</td>
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<td>56</td>
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<td>Medical Director</td>
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<td>6.8%</td>
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<td>35</td>
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<td>0</td>
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<td>Organisational Development Fund</td>
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<td>(11.1%)</td>
<td>312</td>
<td>19</td>
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<td>0</td>
<td>0.0%</td>
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<td>21,483</td>
<td>143</td>
<td>0.7%</td>
<td>27,171</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td>43,583</td>
<td>21,626</td>
<td>21,483</td>
<td>143</td>
<td>0.7%</td>
<td>27,171</td>
<td>70</td>
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<td>43,583</td>
<td>21,626</td>
<td>21,483</td>
<td>143</td>
<td>0.7%</td>
<td>27,171</td>
<td>70</td>
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#### Budget Virements

1) Additional funding to cover the pay awards for grade A4C employees has been included as well as funding to cover the additional employer’s costs of the increase in national insurance contributions.

#### Variance Explanations

1) An underspend of £0.143m is reported in respect of pay costs. As at September 2016, there is an average vacancy factor of 6.8% over the year. This takes into account additional hours worked through Bankaide, overtime and excess part time hours and compares to an average vacancy factor during 2015/16 of 6.6%.

2) An overspend of £0.052m across non-pay costs is mainly attributable to out-of-area services and is partly offset by underspends across directly managed budgets.
## Integrated Joint Board

### Appendix C

#### South Lanarkshire Health and Social Care Partnership

**Financial Monitoring Report**

#### Social Care and In-Scope Housing Services

<table>
<thead>
<tr>
<th>Budget Category</th>
<th>Annual Budget</th>
<th>Forecast for Year</th>
<th>Annual Forecast Variance</th>
<th>Budget Proportion</th>
<th>Actual</th>
<th>Variance</th>
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<td>2,699</td>
<td>83</td>
<td>under 3.0%</td>
<td></td>
<td>e</td>
</tr>
<tr>
<td>Supplies &amp; Services</td>
<td>4,992</td>
<td>4,992</td>
<td>0</td>
<td>2,457</td>
<td>2,480</td>
<td>(23)</td>
<td>over (0.9%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport &amp; Plant</td>
<td>2,734</td>
<td>2,734</td>
<td>0</td>
<td>1,358</td>
<td>1,840</td>
<td>(482)</td>
<td>over (35.5%)</td>
<td>c, 2</td>
<td></td>
</tr>
<tr>
<td>Administration Costs</td>
<td>461</td>
<td>461</td>
<td>0</td>
<td>249</td>
<td>264</td>
<td>(15)</td>
<td>over (6.0%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payments to Other Bodies</td>
<td>9,219</td>
<td>9,219</td>
<td>0</td>
<td>4,195</td>
<td>4,421</td>
<td>(226)</td>
<td>over (5.4%)</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Payments to Contractors</td>
<td>70,308</td>
<td>70,308</td>
<td>0</td>
<td>32,905</td>
<td>32,932</td>
<td>(27)</td>
<td>over (0.1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer Payments</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financing Charges</td>
<td>51</td>
<td>51</td>
<td>0</td>
<td>34</td>
<td>35</td>
<td>(1)</td>
<td>over (2.9%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Controllable Expenditure</strong></td>
<td><strong>149,625</strong></td>
<td><strong>149,625</strong></td>
<td><strong>0</strong></td>
<td><strong>74,057</strong></td>
<td><strong>75,277</strong></td>
<td><strong>(1,220)</strong></td>
<td>over (1.4%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Controllable Income</strong></td>
<td><strong>(47,578)</strong></td>
<td><strong>(47,578)</strong></td>
<td><strong>0</strong></td>
<td><strong>(33,272)</strong></td>
<td><strong>(34,476)</strong></td>
<td><strong>1,204</strong></td>
<td>over recovery (3.6%)</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td><strong>Net Controllable Expenditure</strong></td>
<td><strong>102,047</strong></td>
<td><strong>102,047</strong></td>
<td><strong>0</strong></td>
<td><strong>40,785</strong></td>
<td><strong>40,801</strong></td>
<td><strong>(16)</strong></td>
<td>over (0.0%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Budget Virements

- a) Realignment of administration efficiency saving (£0.106m) to the non integrated budget
- b) Corporate review efficiency saving for overtime (£0.167m)
- c) Corporate review efficiency saving for fuel and casual hires (£0.097m)
- d) Living wage and national insurance reallocation £0.012m
- e) HRA business plan : Aids and Adaptations £0.026; Care of Gardens £0.043

### Variance Explanations

1. The overspend is attributable to: Home Care services which is currently being reviewed in line with Service requirements; turnover being less than budgeted and the non achievement of savings
2. This overspend reflects the cost of transport to meet current service delivery
3. The overspend is due to the number of applications for grants for disabled adaptations being greater than anticipated.
4. This over recovery of income relates to income from service users following financial assessments, one-off recoveries of previous year care costs
1. Purpose of Report

1.1. The purpose of the report is to:-

- present the proposed Internal Audit Plan for 2016/2017 that has been prepared by the Chief Internal Auditors of South Lanarkshire Council (SLC) and NHS Lanarkshire Health Board

2. Recommendation(s)

2.1. The Integration Joint Board is asked to approve the following recommendation(s):-

(1) that the proposed Internal Audit Plan for 2016/2017 (Appendix 1) is approved.

3. Background

3.1. The Public Bodies (Joint Working) (Scotland) Act 2014, requires the Integration Joint Board (IJB) to comply with the accounts and audit regulations and legislation under section 106 of the Local Government (Scotland) Act 1973.

3.2. A professional and objective internal audit service requires to be established in accordance with recognised internal audit standards and practices as laid out in the Public Sector Internal Audit Standards, in order to comply with article 7 of the Local Authority Accounts (Scotland) Regulations 2014.

3.3. The Integrated Resources Advisory Group also issued guidance which set out the IJB’s responsibility to establish adequate and proportionate internal audit arrangements for risk management, governance and control of the delegated resources. The guidance further advised that the IJB should make appropriate and proportionate arrangements for the consideration of the audit provision.

3.4. At a meeting of the IJB on 13 September 2016, the IJB agreed to authorise the Chief Officer to establish effective internal audit arrangements for the financial year 2016/2017. This included the agreement of appropriate protocols to provide a framework within which internal audit services would be provided and to manage the key strategic priorities and risks that could impact on the achievement of the IJB’s objectives.
3.5 Audit Scotland have been appointed by the Accounts Commission and the Auditor General as the external auditors of the IJB from 2016/2017 to 2020/2021.

4. **2016/2017 Audit Plan**
4.1. The proposed internal audit plan at Appendix 1 totals 60 days and presents a plan of work covering key aspects of the IJB’s governance arrangements, including performance management, financial management and the production of an Internal Audit Annual Report. This programme of work will be delivered by 30 April 2017 and will ensure compliance with the Local Authority Accounts (Scotland) Regulations 2014 and also the guidance issued by the Integrated Resource Advisory Group in respect of internal audit arrangements.

4.2. Joint working arrangements across SLC and NHS internal audit functions are currently being established to deliver this plan of work. NHS Lanarkshire internal auditors will continue to be responsible for undertaking audit assignments in relation to operational matters across in-scope NHS services. SLC internal auditors will continue to be responsible for undertaking audit assignments in relation to operational matters across social work and in-scope housing services. Joint working arrangements will be implemented in respect of ‘IJB only’ audits and any cross-cutting audits. Hosted Services will be encompassed in this methodology.

4.3. Appendix 2 outlines the current assessment by both Chief Internal Auditors of areas that are likely to form part of discussions around future year’s audit coverage.

5. **Employee Implications**
5.1. The Internal Audit Plan for 2016/2017 will be delivered jointly by the internal audit functions within SLC and NHS Lanarkshire Health Board.

6. **Financial Implications**
6.1. There will be no charge for the provision of this support service as joint working arrangements are being established to deliver this service.

7. **Other Implications**
7.1. This report relates to all national outcomes as effective governance arrangements will ensure that the IJB can fulfil its statutory duties.

7.2. To mitigate against the risk of the non-delivery of the Plan, the progress of every assignment will be monitored using South Lanarkshire Council’s risk management software, Figtree. Audit performance will require co-operation from the IJB and delivery of the Plan is dependent on assignments being completed within four weeks of the completion of fieldwork. To assist in meeting this target, it would be helpful if:
   ◆ designated contacts could attend opening and closing meetings
   ◆ a senior officer could be nominated to liaise with auditors during the field work
   ◆ a closing discussion meeting is accepted within two weeks of completion of the fieldwork
   ◆ draft reports are reviewed for factual accuracy
   ◆ action plans could be signed within two weeks of closing meetings

7.3. There are no sustainable or environmental implications arising directly from this report.
8. **Equality Impact Assessment and Consultation Arrangements**

8.1. This report does not introduce a new policy, function or strategy and therefore, no impact assessment is required.

8.2. There is also no requirement to undertake any further consultation in terms of the information contained in this report.

Val de Souza  
Director, Health and Social Care

Date created: 15 November 2016

**Previous References**

♦ 13 September 2016

**List of Background Papers**

♦ none

**Contact for Further Information**

If you would like to inspect the background papers or want further information, please contact:-
Tony Gaskin, Chief Internal Auditor, NHS Lanarkshire
(Phone: 01334 696028)
Email: tonygaskin@nsh.net

Yvonne Douglas, Audit and Compliance Manager
Ext: 5957 (Phone: 01698 455957)
Email: yvonne.douglas@southlanarkshire.gcsx.gov.uk
<table>
<thead>
<tr>
<th>Audit assignment</th>
<th>Outline Scope</th>
<th>Expected days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Due diligence</td>
<td>Review and validation of the processes used by NHSL, SLC and the IJB to ensure compliance with national guidance on the assurance work undertaken by the parties in respect of identifying and agreeing resources transferred to the IJB.</td>
<td>10</td>
</tr>
<tr>
<td>Governance</td>
<td>On-going support and advice re further development of the IJB’s internal control and corporate governance arrangements including, but not limited to, a review of the extent to which the IJB governance arrangements are consistent with and meeting key requirements and expectations as laid out in relevant legislation and the approved SL Integration Scheme.</td>
<td>15</td>
</tr>
<tr>
<td>Performance</td>
<td>A high-level review of the performance management and reporting arrangements in place to monitor the delivery of the IJB Strategic Plan including compliance with relevant regulations and work to assess the robustness of process used to produce core integration indicators.</td>
<td>15</td>
</tr>
<tr>
<td>Financial Management</td>
<td>A review of the arrangements in place to manage key financial risks including budgetary control arrangements and how the IJB is developing arrangements in respect of financial planning and financial sustainability.</td>
<td>10</td>
</tr>
<tr>
<td>Internal Audit Annual Report</td>
<td>Annual report containing annual internal audit opinion on assurance and review of the IJB’s self-assessment of governance and systems for preparing the 2016/2017 Annual Governance Statement.</td>
<td>5</td>
</tr>
<tr>
<td>Audit Management</td>
<td>Preparation of 2016/2017 audit plan. Development of longer-term strategic audit plan. Liaison with senior management and the external auditor (as appropriate). Attendance at the Finance and Audit Sub-committee (as appropriate).</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Main-Heading</td>
<td>Sub-Heading</td>
<td>Scope</td>
</tr>
<tr>
<td>----------------------------</td>
<td>--------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>AUDIT PROCESS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit Management</td>
<td></td>
<td>Audit Risk Assessment and Planning, Liaison with External Auditors and other review bodies, Audit Management and Liaison with Directors, Attendance at Audit Committee</td>
</tr>
<tr>
<td><strong>CONTINGENCY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contingency</td>
<td>Contingency reserve for investigations and reviews</td>
<td>At request of IJB/Audit Committee</td>
</tr>
<tr>
<td><strong>GOVERNANCE AND ACCOUNTABILITY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assurance</td>
<td>Annual Internal Audit Report and Governance Statement Assurance</td>
<td>CIA's annual assurance statement to Audit Committee</td>
</tr>
<tr>
<td>Control Environment</td>
<td>Code of Corporate Governance</td>
<td>Governance structures including IJB and Committee effectiveness, and Governance documentation to fulfil the requirements of legislation and the Integration Scheme</td>
</tr>
<tr>
<td></td>
<td>Assurance Framework</td>
<td>Assurance structures (including Audit Committee); relevance, reliability, timeliness and quality of evidence</td>
</tr>
<tr>
<td><strong>RISK MANAGEMENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Management</td>
<td>Risk Management Strategy, Standards and Operations</td>
<td>Review of RM strategy and supporting structures in order to conclude on risk maturity</td>
</tr>
<tr>
<td></td>
<td>Resilience; Business Continuity and Emergency Planning</td>
<td>Compliance with Emergencies and business continuity guidance</td>
</tr>
<tr>
<td><strong>INFORMATION GOVERNANCE</strong></td>
<td>Information Governance Standards</td>
<td></td>
</tr>
<tr>
<td>Information Assurance</td>
<td>Information Assurance Standards</td>
<td>Information Governance and Information Assurance Strategy</td>
</tr>
<tr>
<td></td>
<td>Data quality</td>
<td>Processes to ensure data is collated appropriately and reported accurately and timeously to the right people</td>
</tr>
<tr>
<td><strong>HEALTH AND SOCIAL CARE PLANNING</strong></td>
<td>Planning and Commissioning</td>
<td></td>
</tr>
<tr>
<td>Planning and Commissioning</td>
<td>Strategic planning</td>
<td>Review of process for production of Strategic Commissioning Plan including compliance with regulations</td>
</tr>
<tr>
<td></td>
<td>Commissioning - Parties</td>
<td>Directions to the Parties (NHS Board and Local Authority) to deliver the Strategic Plan including monitoring of delivery and remedial action</td>
</tr>
<tr>
<td></td>
<td>Commissioning and Management-Private and 3rd sector</td>
<td>Commissioning services from private and 3rd sector including monitoring of delivery and remedial action</td>
</tr>
<tr>
<td>Main-Heading</td>
<td>Sub-Heading</td>
<td>Scope</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Performance Management</td>
<td>Performance Reporting</td>
<td>Accurate, relevant and reliable reporting against strategic plan objectives and core integration indicators. Compliance with DL 2016 (05) and wider public performance reporting requirements</td>
</tr>
<tr>
<td></td>
<td>Commissioning management - Parties</td>
<td>Monitoring of delivery. Identification of priorities for improvement and effective remedial action</td>
</tr>
<tr>
<td>CLINICAL GOVERNANCE</td>
<td>Clinical and Care Governance Committee</td>
<td>Clinical governance and improvement, clinical risk management and assurance</td>
</tr>
<tr>
<td></td>
<td>Clinical and Care Governance Framework and Assurance</td>
<td>Clinical governance and improvement, clinical risk management and assurance</td>
</tr>
<tr>
<td></td>
<td>Quality of Service</td>
<td>Monitoring of quality, safety, experience and effectiveness</td>
</tr>
<tr>
<td>STAFF GOVERNANCE</td>
<td>Staff Governance arrangements</td>
<td>Workforce Planning</td>
</tr>
<tr>
<td></td>
<td>Workforce Planning</td>
<td>Workforce and Organisational Development Strategy</td>
</tr>
<tr>
<td>FINANCIAL ASSURANCE</td>
<td>FINANCIAL MANAGEMENT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Financial Control</td>
<td>Strategic financial planning and prioritisation to support Corporate strategies and priorities</td>
</tr>
<tr>
<td></td>
<td>Financial Planning</td>
<td>Budgetary control; reporting, remediation and data accuracy</td>
</tr>
<tr>
<td></td>
<td>Financial Management</td>
<td>Identification, delivery and reporting of savings</td>
</tr>
<tr>
<td></td>
<td>Savings programme</td>
<td>Shadow year - Due diligence. 1st year - Post-integration (also reported to Local Authority and Health Board Audit Committees).</td>
</tr>
<tr>
<td></td>
<td>Due Diligence</td>
<td>Bribery Act, Standards of Business Conduct, annual fraud checklist, responding to fraud risk assessment</td>
</tr>
<tr>
<td></td>
<td>Fraud and Probity Arrangements</td>
<td>Bribery Act, Standards of Business Conduct, annual fraud checklist, responding to fraud risk assessment</td>
</tr>
</tbody>
</table>
1. **Purpose of Report**

   1.1. The purpose of the report is to:

   - provide details of the proposed efficiency savings recommended by the Council in order to mitigate the proposed reduction in the Council budget transferring to the IJB in 2017/2018

2. **Recommendation(s)**

   2.1. The Integration Joint Board is asked to approve the following recommendation(s):

   (1) that it is noted the local government financial settlement for 2017/2018 is expected in December 2016;

   (2) that the proposed adjustment in the Council budget transferring to the IJB in 2017/2018 is noted; and

   (3) that the 2017/2018 proposed savings totalling £1.898 million (Appendix 1), recommended for acceptance by the Council are noted.

3. **Background**

   3.1. At its meeting on 06 July 2016, South Lanarkshire Council’s Executive Committee approved their Revenue Budget Strategy for 2017/2018. This Budget Strategy reflected assumptions relating to grant reductions, pay and pension increases, price increases, funding for priorities and revenue consequences of capital.

   3.2. The Council’s Budget Strategy included the additional costs added to the Council’s budgets specifically relating to the functions and delegated budget for the Partnership, including pay and pensions, price increases and apprenticeship levy. An amount of £2.399m will be added to the IJB budget for 2017/2018 in relation to these additional costs.

   3.3. While the Council’s base savings requirement was noted as £34.961m, this was reduced to £22.461m as a result of a number of corporate funding solutions. This paper will detail the anticipated level of savings from services delegated to the IJB.

   3.4. The local government financial settlement for 2017/2018 is expected in December 2016. In the event that the Council’s financial strategy changes following the Settlement announcement, and that any change affects the IJB, a further paper will be brought to the Board.
4. **Savings Relating to the IJB**

4.1. The Council’s proposed savings have been presented to its Executive Committee for approval. Within the social work savings proposals, there are savings relating to services delegated to the IJB. As those savings relate to the Council’s Social Work Resources they form part of the Council’s overall savings package for approval.

4.2. In considering these savings for approval, the Council’s Executive Committee is being asked to approve a reduction in the financial allocation to the IJB.

4.3. Whilst the Council is being asked to approve the reduction in the allocation to the IJB as part of their budget strategy, it is the role of the IJB to approve the specific savings relating to IJB delegated services.

4.4. Details of proposed savings on services delegated to the IJB totalling £1.898m are attached at Appendix 1. These savings are mainly in relation to efficiencies. As the Council have yet to approve their savings, the IJB is asked at this point to consider and note the savings proposals. When the Council has approved their savings, a report will be brought back to the IJB to allow formal approval of the savings appended to this report.

4.5. There is one saving which relates to an increase in charges (savings reference IJB12). Legally, the Council must set charges – the IJB cannot do so. While it cannot approve the setting of the charge, the IJB is being asked to agree that the additional income generated from the charge offsets the budget reduction being passed from the Council.

5. **Employee Implications**

5.1. Each saving proposed in the appendix shows the number of full time equivalent posts that will be affected. The savings options here would require a net reduction of 2 FTE posts in 2017/2018. It is anticipated that these can be managed through anticipated natural turnover, vacant posts, the removal of temporary posts, or if necessary, a combination of redeployment and voluntary severance/early retirement.

6. **Financial Implications**

6.1. The financial details are as detailed in the report.

7. **Other Implications**

7.1. The assumptions on which the Council’s savings target is based are defined within the Financial Strategy for the Council as approved by the Executive Committee on 06 July 2016. The Financial Strategy is a way of managing a number of key risks which directly impact on the funding available to deliver the Council’s Objectives.

7.2. In relation to the proposed efficiency savings recommended by the Council to the IJB for approval, work has been carried out within Social Work Resources to ensure their deliverability. Through this exercise, risks which may impact on service delivery have been considered.

8. **Equality Impact Assessment and Consultation Arrangements**

8.1. The Equality Act 2010 expects that those making decisions give ‘due regard’ to equality considerations during the course of decision-making. The Equality Impact Assessments and their outcomes should help inform board members so that their decisions have taken account of the different needs and rights of members of the community. This does not mean that difficult decisions cannot be made, but that they are made in a fair and transparent way.
8.2. In terms of the public sector duties under the Equality Act 2010, initial Equality Impact Assessments (EQIA's) have been carried out on all the proposals which require them. Any proposal which has identified potential adverse impacts will also have mitigating actions to remove or lessen the impact on protected groups. The protected characteristics are age, disability, sex, sexual orientation, pregnancy and maternity, marriage and civil partnership, race, religion and beliefs and transgender identity.

8.3. Further information on the Equality Impact Assessments is available from the Council’s Employee Development and Diversity Manager.

8.4. In terms of consultation on savings, the Trade Unions have been consulted. With regard to consultation with the public, all members of the public will be invited to comment on all council budget proposals through a dedicated e-mail address.

8.5. In addition, as in previous years, the Council will undertake targeted public consultation on the budget using members of the Citizens’ Panel as well as budget consultation events which will take place with representatives of a number of groups

Val de Souza
Director, Health and Social Care

Date created: 16 November 2016

Previous References
♦ none

List of Background Papers
♦ none

Contact for Further Information
If you would like to inspect the background papers or want further information, please contact:-
Marie Moy, Chief Financial Officer
Ext: 3709 (Phone: 01698 453709)
Email: marie.moy@southlanarkshire.gcsx.gov.uk
## Integrated Joint Board Efficiency and Outturn Savings 2017/2018

<table>
<thead>
<tr>
<th>Service</th>
<th>Resource</th>
<th>Savings Type (Approved, Efficiency and Outturn, Charging, Charging non Inflationary, Service Impact)</th>
<th>Name, and Brief description of Saving</th>
<th>Employee FTE</th>
<th>Saving £m</th>
</tr>
</thead>
</table>
| **IJB01**                       | IJB      | Efficiency and Outturn                                                                         | Administrative Support  
A proportionate reduction in associated posts and costs will be achieved through a consolidated management structure and the combining of administrative support, where appropriate, within the Council. This will include back office services and consolidated supervision and will not impact on service delivery to the public.  
The saving will be achieved by increasing management spans of control and eliminating duplication of tasks and releasing staff time. This will be managed through a combination of non-filling of vacancies, a reduction in temporary employees and some limited redeployment via SWITCH2.  
The element attributed to the IJB is £0.050m (1.9 FTE posts). | 2.0         | 0.050     |
| **IJB02**                       | IJB      | Efficiency and Outturn                                                                         | Overtime Criteria  
This saving is a further conversion of premium rate working to employment opportunities, building on the work carried out in partnership with the Trade Unions over 2016/2017.  
By continuing to review the overtime criteria, the amount of additional hours required to be worked will reduce, and the requirement for regular overtime will be translated into more established hours at Plain Time, reducing the cost to the Council. As part of this saving there will be engagement with the Trade Unions, and this saving will have no impact on service delivery.  
The element attributed to the IJB is £0.100m. | -            | 0.100     |
<table>
<thead>
<tr>
<th>Service</th>
<th>Resource</th>
<th>Savings Type (Approved, Efficiency and Outturn, Charging, Charging non Inflationary, Service Impact)</th>
<th>Name, and Brief description of Saving</th>
<th>Employee FTE</th>
<th>Saving £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>IJB03</td>
<td>IJB</td>
<td>Efficiency and Outturn</td>
<td><strong>Utilities</strong></td>
<td>-</td>
<td>0.017</td>
</tr>
<tr>
<td>(Council Savings Reference COR04)</td>
<td>(Council Savings Reference COR04)</td>
<td></td>
<td>This saving is a result of a net price reduction in the cost of utilities moving from 2015/2016 into 2016/2017.</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>IJB04</td>
<td>IJB</td>
<td>Efficiency and Outturn</td>
<td><strong>Enhanced Leave / Travel</strong></td>
<td>-</td>
<td>0.049</td>
</tr>
<tr>
<td>(Council Savings Reference SWR02)</td>
<td>(Council Savings Reference SWR02)</td>
<td></td>
<td>An analysis of the level of enhanced leave purchased by employees over the past 3 years has shown a consistent level of unbudgeted income. In addition, a programme of reduced travel has been implemented. The element relating to the IJB is £0.049m.</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>IJB05</td>
<td>IJB</td>
<td>Efficiency and Outturn</td>
<td><strong>Administration Costs and Supplies and Services Budgets</strong></td>
<td>-</td>
<td>0.086</td>
</tr>
<tr>
<td>(Council Savings Reference SWR03)</td>
<td>(Council Savings Reference SWR03)</td>
<td></td>
<td>Through targeting areas of non-essential spend and reviewing current service delivery requirements, a saving can be made across a number of budget lines including computer equipment purchase, printing and stationery and other administration costs. The element relating to the IJB is £0.086m.</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>IJB06</td>
<td>IJB</td>
<td>Efficiency and Outturn</td>
<td><strong>Furniture</strong></td>
<td>-</td>
<td>0.027</td>
</tr>
<tr>
<td>(Council Savings Reference SWR04)</td>
<td>(Council Savings Reference SWR04)</td>
<td></td>
<td>It is proposed to remove all furniture budget as an efficiency in 2017/2018. This budget has generally been underspent in recent years</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>IJB07</td>
<td>IJB</td>
<td>Efficiency and Outturn</td>
<td><strong>Training</strong></td>
<td>-</td>
<td>0.041</td>
</tr>
<tr>
<td>(Council Savings Reference SWR05)</td>
<td>(Council Savings Reference SWR05)</td>
<td></td>
<td>This saving will be achieved through the centralisation and review of the training budgets. Through focusing on mandatory training and reviewing training requirements in line with current service delivery, 90% of the budget can be saved in 2017/2018, with the balance moving to Corporate Personnel.</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Resource</td>
<td>Savings Type</td>
<td>Name, and Brief description of Saving</td>
<td>Employee FTE</td>
<td>Saving £m</td>
</tr>
<tr>
<td>-----------</td>
<td>----------</td>
<td>-----------------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>-----------</td>
</tr>
</tbody>
</table>
| IJB08     | IJB      | Efficiency and Outturn           | **Foodstuffs / Provisions / Food Purchases / Beverages**  
Through reviewing the purchase methods and types of food purchases made, a saving of £0.077m will be made on this budget. | -            | 0.077     |
| IJB09     | IJB      | Efficiency and Outturn           | **Payment to Other Bodies / Voluntary Organisations**  
Social work currently incurs significant expenditure on payments to external bodies and voluntary organisations to provide service and support. It is proposed to reduce the payments to other bodies and voluntary organisations through prioritisation of the services required. The total saving of £0.125m represents a 3.5% reduction on a Resource budget of £3.601m.  
The total saving of £0.125m represents a 3.5% reduction on a Resource budget of £3.601m.  
The element relating to the IJB is £0.051m. | -            | 0.051     |
| IJB10     | IJB      | Efficiency and Outturn           | **Home Care**  
The saving will be delivered from increasing the efficiency of the service through:  
- the roll out of mobile working across the service  
- streamlining the roles/functions of the internal team to identify and implement an optimum model of operation  
- through strategic consideration of the work undertaken in-house, and looking to external partners to deliver appropriate levels of home care to accommodate growth in service, a more efficient delivery of service can be achieved. This will not impact on the level of in-house provision  
- re-assess service standards, whilst ensuring that the Council's high level of service is maintained  
An increased demand for the service will mean that in the case of this saving there is no net loss of posts. | -            | 1.070     |
<table>
<thead>
<tr>
<th>Service</th>
<th>Resource</th>
<th>Savings Type (Approved, Efficiency and Outturn, Charging, Charging non Inflationary, Service Impact)</th>
<th>Name, and Brief description of Saving</th>
<th>Employee FTE</th>
<th>Saving £m</th>
</tr>
</thead>
</table>
| IJB11   | IJB      | Efficiency and Outturn                                                                         | **Re-provision of Supported Placements**  
Through this saving, the existing operating cafes will remain open and there will be no impact on the number of students supported.

The supported placements, currently carried out in the Coalyard and associated café facilities, will be aligned with existing council supported employment provision making best use of available employability funding, existing facilities and staff.

The closer tie in with supported employment will lead to improved outcomes for students, and funding through an employability route rather than through social work budgets releasing a saving of £0.180m per annum. | - | 0.180 |

**Integrated Joint Board Efficiency and Outturn Savings 2017/2018**

| 2.0 | 1.748 |
## Integrated Joint Board Charging - Non Inflationary Savings 2017/18

<table>
<thead>
<tr>
<th>Service</th>
<th>Resource</th>
<th>Savings Type (Approved, Efficiency and Outturn, Charging, Charging non Inflationary, Service Impact)</th>
<th>Name, and Brief description of Saving</th>
<th>Employee FTE</th>
<th>Saving £m</th>
</tr>
</thead>
</table>
| IJB12   | IJB      | Charging - Non Inflationary                     | **Increase in Taper Applied to Non-Residential Care Services**  
Non residential care is all care provided in the community or in the service users homes, including day care, supported living and social care, but excluding alert alarms and meals on wheels. The current charges to service users are based on ability to pay and the Council has discretion to apply a taper. The proposal is to increase the taper from 60% to 65% and the change will affect 701 service users. There are 10 other councils who currently apply tapers of 65% or above.  
There are 701 service users affected by the proposed increase as detailed below:  
|         |          |                                                 |                                     |         | 0.150    |

<table>
<thead>
<tr>
<th>Range increase (per week)</th>
<th>No. of Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;£1</td>
<td>71</td>
</tr>
<tr>
<td>£1.01 to £2</td>
<td>115</td>
</tr>
<tr>
<td>£2.01 to £3</td>
<td>69</td>
</tr>
<tr>
<td>£3.01 to £4</td>
<td>84</td>
</tr>
<tr>
<td>£4.01 to £5</td>
<td>119</td>
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<tr>
<td>£5.01 to £6</td>
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<tr>
<td>£6.01 to £7</td>
<td>82</td>
</tr>
<tr>
<td>£7.01 to £8</td>
<td>21</td>
</tr>
<tr>
<td>£8.01 to £9</td>
<td>10</td>
</tr>
<tr>
<td>£9.01 to £10</td>
<td>3</td>
</tr>
<tr>
<td>&gt;£10.00</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>701</td>
</tr>
</tbody>
</table>
## Appendix 1 – Savings Proposals

<table>
<thead>
<tr>
<th>Service</th>
<th>Resource</th>
<th>Savings Type (Approved, Efficiency and Outturn, Charging, Charging non Inflationary, Service Impact)</th>
<th>Name, and Brief description of Saving</th>
<th>Employee FTE</th>
<th>Saving £m</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Integrated Joint Board Charging - Non Inflationary Savings 2017/2018**

<table>
<thead>
<tr>
<th>Total IJB Savings Proposals 2017/2018</th>
<th>2.0</th>
<th>1.898</th>
</tr>
</thead>
</table>

**Savings Summary Across Categories**

<table>
<thead>
<tr>
<th>Total</th>
<th>FTE</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Efficiency and Outturn</td>
<td>2.0</td>
<td>1.748</td>
</tr>
<tr>
<td>Charging Inflationary</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Charging Non Inflationary</td>
<td>-</td>
<td>0.150</td>
</tr>
<tr>
<td>Service Impact</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Social Work Resources Savings Proposals 2017/2018</strong></td>
<td>2.0</td>
<td>1.898</td>
</tr>
</tbody>
</table>
1. **Purpose of Report**

1.1. The purpose of the report is to:-

- update the Board on the development of an Integrated Structure across the Health and Social Care Partnership
- identify the management roles within an Integrated Structure that are reserved in legislation by a professionally qualified Social Worker at an appropriate level of seniority
- seek approval of the recommendations contained within the report

2. **Recommendation(s)**

2.1. The Integration Joint Board is asked to approve the following recommendation(s):-

1. that the recruitment of 4 posts of Health and Social Care Locality Manager, as detailed at Paragraph 5.2 of the report, with effect from April 2017, be supported;
2. that the recruitment of the following temporary posts for a period of 2 years, as detailed at Paragraphs 5.7 and 5.12 of the report, be supported:-
   - 1 post of Social Work Services Manager Transitions
   - 2 posts of Change Manager
3. that the governance arrangements to meet the statutory requirements of NHS Lanarkshire and South Lanarkshire Council be noted;
4. that the lead responsibilities for localities and/or hosted arrangements be noted;
5. that the management arrangements for the Chief Social Work Officer (CSWO) responsibilities that are reserved in legislation for a professionally qualified Social Worker be noted; and
6. that the proposals detailed above be supported, subject to approval by both the Council and NHS Lanarkshire.

3. **Background**

3.1. The Integration Joint Board approved the establishment of a senior management team on 19 April 2016. The Board also approved the establishment of the Nursing and Medical Structures on 28 June 2016. Appendix 1 shows the current Health and Care Management Team arrangements.
3.2. The Director, Health and Social Care has undertaken a review of the proposed structure for localities with the support of the Senior Management Team and wider engagement with senior leaders across the Health and Social Care Partnership.

3.3. The local authority Children and Justice Services are not formally part of the Integrated Joint Board (IJB), however, it is recognised that in the development of a locality model, Children and Justice Services needs to be aligned with the developments of the Health and Social Care Partnership.

3.4. A review of the current structure of Children and Justice Services is underway and a report will be brought to the Council for approval.

4. Progress to Date
4.1. Development sessions were held to discuss the proposed locality structures for the Health and Social Care Partnership. A staff brief was prepared for Managers to discuss with their teams and feedback used to further inform the way forward.

4.2. It is recognised that integration is an opportunity to improve communication, engagement and outcomes for service users provided the change in delivery is well managed.

4.3. Appendix 2 identifies the current locality management arrangements that are not integrated.

5. Proposals
5.1. A fully integrated locality model of delivery will be implemented. Appendix 3 identifies the proposed integrated management structure and arrangements to prepare for a fully integrated model of delivery.

5.2. The recruitment for 4 Health and Social Care Locality Managers can be scheduled to take place for April 2017. The remit of the posts would include direct line management responsibility of all staff within a locality as well as hosted services. They would also link into NHS Lanarkshire (NHSL) and Social Work professionals as part of the hosted arrangements. See Appendix 5 which details the span of control and working relationships.

5.3. These posts will be pivotal in driving service transformation working with local communities and staff to provide services which are responsive and tailored to local need.

5.4. Agreed recruitment processes between NHSL and South Lanarkshire Council HR will be developed and posts will be ring fenced to those employees affected by the review. Match-in or redeployment will take place as appropriate and in accordance with organisational policies.

5.5. The appointments of the Health and Social Care Locality Managers will reflect the management and business requirements to support sharing of knowledge and understanding across Health and Social Care and maintain a stable management environment during a period of significant change. In the transition, this will result in two Health Managers and two South Lanarkshire Council Social Work Managers being recruited to the Health and Social Care Locality Manager Posts. This will mitigate any risk in service delivery and aid shared learning.
5.6. Within Health, there are a number of registered disciplines regulated by professional bodies including Nursing, Allied Health Professionals and Medics. Professional lines of accountability are established through the Medical Director, Nurse Director and Allied Health Professional Director.

5.7. In order to satisfy the statutory arrangements for the Local Authority, the Chief Social Work Officer (CSWO), Children and Justice Services will continue to report to the Chief Executive and Elected Members for the Local Authority. The proposed structure will provide assurance to the local authority that statutory requirements are delegated to an appropriate level.

5.8. In moving to the new integrated locality arrangements, there is a need to ensure that current service projects are successfully concluded. To achieve this, there is a need for a Social Work Service Manager Transitions. The remit of this post will include:

Home Care Review, Self Directed Support, remodelling of Older Peoples Residential Care Homes, Care and Support Services (Supported Living) Review and the Adult Day Opportunities Review. There will be a focus on delivery of the Intermediate Care intentions within the Strategic Commissioning Plan. This post is identified as an interim post for a two year period.

5.9. Appendix 4 gives an illustration of the locality management arrangements across the four localities.

5.10. In terms of home care, it is proposed that the operational management of Home Care Services is devolved to localities. There are five Operational Managers in place and these posts would no longer report to a Service Manager post at the centre but to the new post of Locality Manager. (Appendix 4).

5.11. Hosted services across NHSL are currently managed within localities with the exception of Physiotherapy which, prior to the establishment of Health and Social Care Partnerships, was hosted in Hairmyres Hospital. These services will be devolved to the localities as part of the transition.

5.12. The interim posts of Organisational Development Manager and Learning and Development Advisor will report to the Head of Commissioning and Performance. These posts will also be crucial in linking all staff, partner agencies and the local public in delivering new and more effective and integrated services in a locality setting.

5.13. There is a requirement for additional support to achieve a successful transition. The addition of two interim Change Manager posts to support localities in transformation, collaborative leadership and team development will assist to embed the change. These will report through the Head of Commissioning and Performance. (Appendix 3). This will provide support to each Locality Manager. These are interim posts for a two year period to create capacity to support the change process.

5.14. There are two Operations Managers, Community Living; one for adult and one for older people currently located at the centre who report to the Service Manager for Adult and Older People. They have operational line management responsibility as well as strategic responsibilities. These posts will be hosted within a locality, and report to the appropriate Locality Manager with a Council background in the transition period. (Appendix 4). This arrangement will ensure the governance of all
regulated community based services across adult and older people – residential establishments and day care services.

5.15. The same approach for health hosted service arrangements such as Allied Health Professions, Mental Health and Learning Disability will be developed to enable services to be devolved to Localities in line with the Hosted Services agreement agreed by NHSL CMT on 31 October 2016. (Appendix 4).

5.16. The Planning and Performance Manager has been seconded for a period of 6 months from the Local Authority to the Health Care Management Team (HCMT), to the role of Programme Manager to support the transition arrangements and service redesign as part of the change process

6. Next Steps

6.1. A programme management approach has been established for the Health and Social Care Transformation. The development of Integrated Structures will be project managed through the Programme Manager to the HCMT ensuring alignment with the Partnership’s priorities, planning and performance.

6.2. The transition into a fully integrated model will commence with the recruitment of the four Health and Social Care Locality Managers for April 2017. The programme management approach will identify timescales and milestones for implementation as Localities develop. Services that will be prioritised are: Homecare, Residential Day Care, Allied Health Care Professionals, Mental Health, Learning Disability and Substance Misuse.

6.3. The development of locality models of delivery will be flexible enough to manage future pan-Lanarkshire health board services and strategic forums that may be devolved to the respective IJBs, examples of which may be, Alcohol and Drug Partnership, Mental Health and Learning Disability Services and other hosted services as defined in the Integration Scheme.

6.4. Appendix 5 gives an illustration of the direct line management arrangements for a Locality Manager and the aligned professional roles to deliver services at a locality level. The Locality Manager will be supported by a wider infrastructure of the Health and Care management Team as well as the corporate functions from NHS Lanarkshire and South Lanarkshire Council.

7. Governance Arrangements.

7.1. A Support, Care and Clinical Governance Group has been established to support the delivery of safe, effective and person centred services in an integrated way. The Chief Social Work Officer along with the Medical Director will co-chair this group.

7.2. As well as the Support, Care and Clinical Governance Group in order to give assurance to the local authority, the CSWO will establish a Social Work Governance Group within each locality. This will include Social Work professional leads from the localities.

7.3. Children and Justice Services are currently in the process of reviewing their current structure to ensure that their services are aligned and delivered in partnership with the HSCP.
8. **Employee Implications**

8.1. All HR processes will be developed and agreed jointly through NHSL and the Local Authority. Posts will be ring fenced to those employees affected by the review and match-in/redeployment will take place as appropriate.

8.2. Engagement and communication will continue to take place with staff and consultation with the relevant Trades Unions will take place as appropriate.

### Council Structure Developments

<table>
<thead>
<tr>
<th>Post (Social Work)</th>
<th>Current Number of Posts (FTE)</th>
<th>Proposed Number of Posts (FTE)</th>
<th>Grade</th>
<th>SCP Range</th>
<th>Hourly Rate</th>
<th>Annual Salary</th>
<th>Gross Cost incl on costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Manager</td>
<td>3</td>
<td>0</td>
<td>G5 L1 – L8</td>
<td>93 – 108</td>
<td>£25.42 - £31.79</td>
<td>£46,388.96 - £58,014</td>
<td>£77,216</td>
</tr>
<tr>
<td>Field Work Manager</td>
<td>5</td>
<td>5</td>
<td>G5 L1</td>
<td>93 – 97</td>
<td>£25.42 - £26.98</td>
<td>£46,389 - £49,236</td>
<td>£61,743 - £65,533</td>
</tr>
<tr>
<td>Operations Manager Community Living</td>
<td>2</td>
<td>2</td>
<td>G5 L1</td>
<td>93 - 97</td>
<td>£25.42 - £26.98</td>
<td>£46,389 - £49,236</td>
<td>£61,743 - £65,533</td>
</tr>
<tr>
<td>Health and Social Care Locality Manager</td>
<td>0</td>
<td>2</td>
<td>G5 L1 – 8*</td>
<td>93 – 108</td>
<td>£25.42 - £31.79</td>
<td>£46,388.96 - £58,014</td>
<td>£61,743 - £77,216</td>
</tr>
<tr>
<td>Social Work Service Manager</td>
<td>0</td>
<td>1</td>
<td>G5 L1 – L8*</td>
<td>93 – 108</td>
<td>£25.42 - £31.79</td>
<td>£46,388.96 - £58,014</td>
<td>£61,743 - £77,216</td>
</tr>
<tr>
<td>Social Work Service Manager Transition Manager (2 years interim)</td>
<td>0</td>
<td>1</td>
<td>G5 L1 – L8*</td>
<td>93 – 108</td>
<td>£25.42 - £31.79</td>
<td>£46,388.96 - £58,014</td>
<td>£61,743 - £77,216</td>
</tr>
</tbody>
</table>

*Grades subject to evaluation under the Council’s job evaluation scheme.

### Health Structure Developments

<table>
<thead>
<tr>
<th>Post (NHSL)</th>
<th>Current Number of Posts (WTE)</th>
<th>Proposed Number of Posts (WTE)</th>
<th>Grade</th>
<th>SCP Range</th>
<th>Hourly Rate</th>
<th>Annual Salary</th>
</tr>
</thead>
<tbody>
<tr>
<td>South West/ East Unit General Managers</td>
<td>2</td>
<td>0</td>
<td>Exec level B</td>
<td></td>
<td>£26.04 - £35.48</td>
<td>£50,910 - £69,383</td>
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<tr>
<td>Health and Social Care Locality Manager</td>
<td>0</td>
<td>2</td>
<td>Agenda for Change Band 8C</td>
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<td>£28.98 - £35.73</td>
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<td>Change Manager</td>
<td>0</td>
<td>2</td>
<td>Agenda for Change Band 6*</td>
<td></td>
<td>£13.59 – £18.20</td>
<td>£26,565 - £35,577</td>
</tr>
</tbody>
</table>

*Grade subject to evaluation under the NHSL Agenda for Change evaluation scheme.
9. **Employee Implications**

9.1. Through these proposals, there will be three additional two year temporary posts created for the Partnership - One Service Manager Transition and Two Change Managers. In addition, matching will take place against the identified roles.

10. **Financial Implications**

10.1. In respect of the permanent changes to the Council structure, there is no additional cost. In respect of the permanent changes to the Health Structure, based on the top point of the grade, the additional cost is minimal at £954 per annum. This will be met from within IJB resources.

10.2. In respect of the three temporary posts, the additional cost will range from £123,486 up to a maximum of £154,432 per annum, depending on placement. Over the two year period, the total cost would therefore range from £246,972 up to £308,864. This additional non-recurring cost will be met from IJB resources over the two year period of the temporary appointments.

11. **Other Implications**

11.1. There is a risk if change is not well managed, then service delivery could decline. This is mitigated through the transitional arrangements identified in this report.

11.2. There are no implications for sustainability in relation to this report.

12 **Equality Impact Assessment and Consultation Arrangements**

12.1. This report does not introduce a new policy function or strategy, nor does it recommend a change to existing policy, function or strategy, therefore, no impact assessment is required.

12.2. Consultation has taken place with senior managers of the Extended Health and Care Management Team. Views have been sought from teams in relation to the proposed management arrangements. The views of the Chief Social Work Officer have been sought and agreed in relation to the statutory requirements reserved in relation to Local Authority responsibilities. The Trade Unions have been advised of the proposals. Engagement with the wider staff group will take place as part of the implementation.

Val de Souza  
Director, Health and Social Care

Date created: 3 November 2016

**Previous References**

None

**List of Background Papers**

None
Contact for Further Information
If you would like to inspect the background papers or want further information, please contact:-
Liam Purdie, Head of Children and Justice Services
Ext: 4887 (Phone: 01698 454887)
Email: liam.purdie@southlanarkshire.gcsx.gov.uk

Brenda Hutchinson, Head of Adult and Older People Services
Ext: 3701 (Phone: 01698 453701)
Email: Brenda.hutchinson@southlanarkshire.gcsx.gov.uk
Phase 1 Locality Teams

Locality Manager

Fieldwork Manager Adult and Older People
Operational Manager Home Care
Service Manager Health
Community Living or Health Hosted Service
Children and Family Locality Lead
Senior Nurse
GP Lead 0.4 wte
Assistant Health Promotion Manager 0.5 wte
NHSL Mental Health Service Manager 0.5 wte

Key
SLC employee
Health or SLC employee
Interim Post
Health employee
wte whole time equivalent if </>1
NH&SCP hosted service

Appendix 5
1. Purpose of Report
1.1. The purpose of the report is to:

- present to the Integration Joint Board (IJB) a summary of the recent Audit Scotland Report which provides annual review information on the NHS information with regards to finance, service overview performance and progress with service reform.

2. Recommendation(s)
2.1. The Integration Joint Board is asked to approve the following recommendation(s):

(1) that the main findings of the Audit Scotland report are noted.

3. Background
3.1. Audit Scotland, as part of its national programme of audits, recently undertook the annual audit of the NHS in Scotland. The findings from this audit have now been completed and a report published.

3.2. The scope of this audit was to consider how the NHS in Scotland is performing and how well equipped it is to face future challenges, specifically in the areas of:

- how well is the NHS managed from a finance and performance perspective
- how well placed is the NHS to deal with the financial challenges in 2016/17 and those which lie ahead
- is the NHS making sufficient progress with regards to public service reform

3.3. A number of sources of evidence were gathered to inform the findings of this report, with Audit Scotland undertaking to review and engage as follows:

- the 2015/16 Annual Accounts of NHS Boards
- the Local Delivery Plans (LDPs) for NHS Board areas
- financial performance returns
- activity and performance data prepared by the Information Services Division (ISD)
- interviews with senior staff from the Scottish Government and NHS Boards
3.4. By way of background, it is recognised that the NHS in Scotland is facing a number of pressures such as rising costs and an increased demand for services. This is against a backdrop of a reducing public sector budget, whilst at the same time a major reform programme in relation to health and social care integration, an increased focus on prevention, anticipation and self management, a new GP Contract and a National Clinical Strategy.

3.5. The report takes account of, and factors in, such challenges as part of the findings and conclusions highlighted.

3.6. The report is split into two distinct sections, with the first covering finance and service performance and the second covering service reform. Detailed below are some of the key messages within each section.

4. **NHS in Scotland Finance and Service Performance**

4.1. Within this section of the report, the following issues and messages were reported:

4.1.1. Although health spending has increased, it is not keeping pace with growing demand and the needs of an ageing population.

4.1.2. A total of £12.2bn is spent on NHS services in Scotland and this accounts for 40% of the total Scottish Government budget of £30.1bn. Although the health budget increased by 16% in cash terms between 2008/09 and 2015/16, the real terms rise only 2.7%, once the effects of inflation are accounted for. Working alongside, are aspects such as demographic growth, for example across the same period, the 75+ population rose by 11.8% and the number of people waiting for an inpatient or day case appointment rose by 5.6%. The equivalent figure for outpatient appointments rose significantly by 89%.

4.1.3. At the same time, other pressures on costs were experienced, particularly in relation to funding to Alcohol and Drugs Partnerships, which reduced overall by 22%, whilst funding for 11 discrete ring fenced budgets which focus on health inequality, prevention, dental and maternity services reduced by 7.5%.

4.1.4. NHS Boards struggled to achieve financial balance in 2015/16.

4.1.5. NHS Boards are given a financial target of reaching a break-even position by the financial year–end. At the end of March 2016, the NHS in Scotland had a surplus of £4.5m, with all NHS Board reporting a balanced revenue and capital expenditure position. That said, this break–even position was not without significant challenges for many of the NHS Boards in Scotland, with a number of short and longer–term strategies deployed to achieve this, including brokerage, delaying spending on capital projects, switch capital to revenue funding (virement) and receiving additional funding from the Scottish Government at the year–end. It is noteworthy that some of these approaches are not sustainable and thus compromise the ability to NHS Boards to shift the balance of care through investment in community based services.

4.1.6. Some NHS Boards are still below their funding allocation.

4.1.7. Since 2009/10, the Scottish Government has used a formula developed by the National Resource Allocation Committee (NRAC) to allocate funding to territorial NHS Boards and this is based upon factors such as demography, deprivation and gender. When the formula was introduced, some NHS Boards were significantly below their target allocation, with NHS Lanarkshire being one of these to the value of
£15.9m or 1.5% below target. While the amount is relatively small as a proportion of Lanarkshire’s overall budget, financial challenges and meeting key performance targets results in added pressure.

4.1.8. NHS Boards found it difficult to achieve the savings required in 2015/16 and this will be even more challenging in 2016/17.

4.1.9. In March 2016, NHS Boards reported overall savings of £291.3m, which was below the target by £1.8m. The noticeable trend in savings, is that NHS Boards have demonstrated the ability to make high levels of non–recurring savings but much more challenging in identifying new recurring savings.

4.1.10. NHS Boards need to find a balance to maintain high quality hospitals with increasing investment in community based care.

4.1.11. NHS Boards manage physical assets which have a high residual value. Consequently, it is important that assets such as hospital and community buildings and medical equipment are maintained to a high standard. However, this comes at a significant cost and Audit Scotland was of the view that adequate accounting records had not been maintained in relation to elements of property, plant and equipment assets. In 2015, the outstanding maintenance required to keep the NHS across Scotland up to good standard was £898m. That said, there will be significant investment of £2.8 billion over the next five years in relation to asset management. However, one of the challenges that NHS Boards face is maintaining these assets, whilst at the same time shifting investment in community based services. Audit Scotland concluded that a clear national strategy is required to support this shift in the balance of care. The National Clinical Strategy, which recommends that more specialist care should be provided on a regional and national basis, could facilitate some of this, in that current assets could then be used differently.

4.1.12. NHS Boards continue to face increasing cost pressures.

4.1.13. With people living longer and not always healthier, NHS Boards, similar to other public service organisations, are facing increasing pressures on already stretched resources. Significant health inequalities and lower life expectancy in more deprived areas, coupled with rising expenditure on drugs, translates to NHS Boards managing a number of competing demands on resources. The NHS in 2014/15 spent £150m more on drugs and this is an increase of 10% when compared with 2012/13. Conditions such as asthma, stomach acid, arthritis leads to dispensing increasing in relation to paracetamol, ibuprofen and antihistamines. The costs of existing drugs have increased too and this has mainly been attributed to increasing global demand, shortages of certain drugs and smaller pharmaceutical companies selling on the rights of branded drugs to other larger companies, with the knock on effect of price increases. New drugs are also a cost pressure for NHS Boards and the Scottish Medicines Consortium assesses new drugs for use in Scotland. However, due to research and development, there are a number of conditions, particularly rare ones, where there are treatment options now, where previously none existed.

4.1.14. Staff costs are a major cost pressure for NHS Boards.

4.1.15. The number of people working in the NHS in Scotland continues to rise, despite the fact that almost one third of NHS Boards are reducing their staff numbers. A total of 138,458 people now work in the NHS in Scotland and staff costs represent the most significant element of the NHS budget, totalling £6.2 billion. However, the NHS is facing a number of challenges with regards to recruitment and retention, filling Junior
Doctor training posts, rising costs associated with temporary and agency staff and staff shortages which affect the overall quality of care. Some interesting findings in the report regarding these areas were:

- health visitor nursing posts had the highest vacancy rates of all nursing specialties at 9%
- consultant vacancy rates were 6.5% overall
- GP vacancy rates were 4.8% overall but again variation is wide across NHS Board areas. Also noteworthy is that there are now 5% of GP practices being directly run by NHS Boards
- sickness absence was 5.2% overall against a target of 4% nationally
- the use of temporary staff to manage pressures such as waiting times, grew from 1.6% in 2012/13 to 208% in 2015/16. Significant sums of budget are being spent on areas such as bank nursing and midwifery and medical locums
- the use of agency staff can often cost twice as much as a salaried post which is already on the payroll
- the use of temporary staff can result in an increased risk to the service, particularly in the areas of continuity of care, patient safety and quality.

Healthcare Improvement Scotland (HIS) found that most areas of service delivery were largely positive, however, there were some concerns in line with the above.

4.1.16. NHS Boards continue to struggle to meet key national performance targets.

4.1.17. The Scottish Government agrees a performance contract with NHS Boards through the Local Delivery Planning or LDP process. NHS Boards have found it increasingly difficult to meet LDP targets over recent years. As at March 2016, seven out of eight targets had failed to be met, the only exception being alcohol and drug treatment. This position is seen as an indication of the building pressures that NHS Boards are facing from increasing demand. That said, there has been improvement in other areas of performance, including a decreasing number of people smoking in deprived areas, antenatal care and improving diagnosis and treatment of breast, colorectal and lung cancer. Resulting from this, the Scottish Government has committed to reviewing national NHS targets, with the focus being on better outcomes for patients and making the best use of resources.

5. Service Reform

5.1. As part of the Audit Scotland report, consideration was also given to service reform which the NHS is currently facing. In summary, a number of important points were highlighted by Audit Scotland as follows:

5.1.1. The NHS is undergoing significant change.

5.1.2. Over recent years’ there has been improvements in the way health services in Scotland are delivered as evidenced by reductions in waiting times and the fact that overall health and life expectancy have improved. However, the health of Scotland’s population is still lower than that of similarly developed European countries. The NHS is currently undergoing significant service reform through strategies such as the 2020 Vision for Health and Social Care, the integration of health and social care, the National Clinical Strategy, GP Contract and a review of the structure of NHS Boards.

5.1.3. The Scottish Government’s long–term aim to shift the balance of care has still be realised.
5.1.4. Since 2005, there has been improvements in the way services are delivered, focusing on community based interventions. However, over the last five years, the percentage split of services provided through hospitals services and community based services has remained at 62% and 38% respectively. Part of the issue which Audit Scotland found, is that it is not clear what the Scottish Government’s aim of shifting the balance of care looks like and how it will be achieved. What is clear is that, in the future, the NHS cannot afford to do everything and needs to reduce demand on hospital care in favour of community based interventions.

5.1.5. New Integration Authorities are still developing.

5.1.6. Last year, Audit Scotland published a report on progress with the integration of health and social care, recognising that it was at an early stage of implementation. New Integration Authorities are expected to coordinate health and social care services and to commission NHS Boards, Councils and other partners to deliver services in line with an approved Strategic Commissioning Plan. Over time, it is expected that this will lead to changes in service design and delivery, whilst securing a stronger focus on prevention and early intervention. A number of challenges remain, which are broadly consistent across all 31 Integration Authorities as follows:
- challenges agreeing budgets which is not assisted by the differing timelines between NHS Boards and Councils in relation to the budget setting process
- governance arrangements can be complex and there needs to be improvement between IJBs and NHS Boards
- there are differing priorities which are evident between IJBs and NHS Boards
- accountability is not always clear in terms of who has strategic and operational responsibility

5.1.7. Some progress is being made in developing approaches to transformational change.

5.1.8. It is recognised that progress is being made to transform services fit for the future. However, in a recent Audit Scotland report, Changing Models of Health and Social Care (published earlier this year), the findings pointed to the fact that there were new models being implemented but that they were often too small in scale and not sufficiently widespread. Therefore, from a transformational change perspective, the pace and extent of change needs to be commensurate with demand and changing demographics.

5.1.9. A clear plan for change is needed.

5.1.10. Audit Scotland concluded that the Scottish Government is not making sufficient progress in achieving its policy aim to shift the balance of care. For example, the 2020 Vision for Health and Social Care lacks a clear framework of how it expects NHS Boards and councils to achieve transformational change, particularly from a cost and progress measurement perspective. It was also reported that workforce development is progressing slow and that the National Clinical Strategy focuses too much on hospital care and, therefore, contradicts the vision to shift the balance of care. To address some of these significant strategic issues, the Scottish Government has established a Transformational Change Programme Board.
6. **Next Steps**

6.1. There are a number of significant themes mentioned in this report which are consistent with the challenges being faced by NHS Lanarkshire and the South Lanarkshire Health and Social Care Partnership. However, and to manage aspects such as increasing demand, tighter fiscal arrangements and service redesign, the South Lanarkshire Health and Social Care Partnership is progressing the following:

- an approved Strategic Commissioning Plan which places a strong emphasis on self care, self management, reablement and intermediate care options to reduce the demand on the hospital front door
- a needs assessment electronic tool has been developed and rolled out to localities to support better understanding of need
- work being led by the Director of Health and Social Care to propose transformational change in a number of areas such as strengthening the relationship with Commissioning Partners, reshaping elements of community services including aspects such as Primary Care and Care at Home and considering the future model of care required on a residential and nursing context
- developing a locality planning approach which supports decisions being taken closer to the point of health and social care service delivery
- continuing with the support and development of the IJB to assist in discharging its duties in line with the Public Bodies (Joint Working) (Scotland) Act 2014

7. **Employee Implications**

7.1. There are no employee implications associated with this report.

8. **Financial Implications**

8.1. There are no financial implications associated with this report.

9. **Other Implications**

9.1. There are no additional risks associated with this report.

9.2. There are no sustainable development issues associated with this report.

9.3. There are no other issues associated with this report.

10. **Equality Impact Assessment and Consultation Arrangements**

10.1. An equality impact assessment is not required for this report.

10.2. This is a national report undertaken by the independent body and is available to members of the public. There was no requirement to undertaken any consultation arrangements.

_val de Souza_
_Director, Health and Social Care_

Date created: 10 November 2016

**Previous References**

None
List of Background Papers
None

Contact for Further Information
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### Links

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### 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.
**Key facts**

- Total health budget in 2015/16: £12.2 billion
- Total savings planned by NHS boards in 2016/17: £492 million
- Total savings reported by NHS boards in 2015/16: £291 million
- NHS Scotland key performance targets met at March 2016: 1 out of 8
- Increase in drug costs between 2012/13 and 2014/15: 10 per cent
- Number of outpatients waiting for an appointment at March 2015 and March 2016: 254,911 to 275,517
Summary

Key messages

1 Over the last decade, there have been improvements in the way health services are delivered and reductions in the time that patients need to wait for hospital inpatient treatment. There have also been improvements in overall health, life expectancy, patient safety and survival rates for a number of conditions, such as heart disease. At the same time, demands on health and social care services have been increasing because of demographic changes. People are living longer with multiple long-term conditions and increasingly complex needs.

2 NHS funding is not keeping pace with increasing demand and the needs of an ageing population. NHS boards are facing an extremely challenging financial position and many had to use short-term measures to break even. NHS boards are facing increasing costs each year, for example drug costs increased by ten per cent, allowing for inflation, between 2012/13 and 2014/15. NHS boards will need to make unprecedented levels of savings in 2016/17 and there is a risk that some will not be able to achieve financial balance.

3 Despite the significant financial challenges facing NHS boards, there have been improvements in some areas, for example in reducing the overall number of bed days from delayed discharges. However, boards are struggling to meet the majority of key national standards and the balance of care, in terms of spending, is still not changing. It is difficult balancing the demand for hospital care, alongside providing more care in the community. Boards need to ensure they maintain high-quality hospitals, while investing in more community-based facilities.

4 The NHS workforce is ageing and difficulties continue in recruiting and retaining staff in some geographical and specialty areas. Workforce planning is lacking for new models of care to deliver more community-based services. There is uncertainty about what these models will look like and the numbers and skills of the workforce required. NHS boards’ spending on temporary staff is increasing and this is putting pressure on budgets.

5 The NHS is going through a period of major reform. A number of wide-ranging strategies propose significant change, including the National Clinical Strategy, integration of health and social care services and a new GP contract. These need to be underpinned by a clear plan for change. Some progress is being made in developing new models of care, but this has yet to translate to widespread change in local areas and major health inequalities remain.
Recommendations

The Scottish Government should:

- provide a clear written plan for implementing the 2020 Vision and National Clinical Strategy, including:
  - immediate and longer-term priorities, including a public health strategy to help NHS boards focus on preventing ill health and tackle health inequalities
  - support for new ways of working and learning at a national level
  - long-term funding plans for implementing the policies
  - a workforce plan outlining the workforce required, and how it will be developed
  - ongoing discussion with the public about the way services will be provided in the future to manage expectations (paragraphs 88-92)
- set measures of success by which progress in delivering its national strategies can be monitored, including its overall aim to shift from hospital to more community-based care. These should link with the review of national targets and align with the outcomes and indicators for health and social care integration (paragraph 69)
- consider providing NHS boards with more financial flexibility, such as three-year rolling budgets rather than annual financial targets, to allow better longer-term planning (paragraphs 13-19).

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

- model the cost of implementing its National Clinical Strategy and how this will be funded, including the capital investment required (paragraph 93)
- share good practice about health and social care integration, including effective governance arrangements, budget-setting, and strategic and workforce planning (paragraphs 81-85)
- in line with the national policy on realistic medicine:
  - work to reduce over-investigation and variation in treatment
  - ensure patients are involved in making decisions and receive better information about potential treatments (paragraph 87).

NHS boards, in partnership with integration authorities, should:

- take ownership of changing and improving services in their local area, working with all relevant partner organisations (paragraph 96)
• develop long-term workforce plans (more than five years) to address problems with recruitment, retention and succession planning and to ensure high quality of care (paragraphs 94-95)

• work with the public about the need for change in how they access, use and receive services and to take more responsibility for looking after their own health and managing their long-term conditions (paragraph 33).

Background

1. The NHS in Scotland provides a range of vital services across the country to thousands of people every day, often in partnership with other bodies. Increasing costs and growing demand for services, combined with continuing pressures on public finances, mean the NHS continues to face significant challenges in delivering its services. The NHS is going through a period of major reform. The Scottish Government has an overarching policy to provide integrated health and social care, with a focus on prevention, anticipation and supported self-management. A number of wide-ranging strategies are proposing significant change, including the National Clinical Strategy, integration of health and social care services and a new GP contract. New integration authorities have been in place since April 2016. They manage more than £8 billion of resources that NHS boards and councils previously managed separately.

About this audit

2. This is our annual report on how the NHS in Scotland is performing. The overall aim of the audit was to answer the question: How well is the NHS in Scotland performing and is it equipped to deal with the challenges ahead?

The specific audit questions were:

• How well did the NHS manage its finances and performance in 2015/16?

• Is the NHS in Scotland equipped to deal with the financial challenges in 2016/17 and beyond?

• Is the NHS making good progress towards implementing public service reform?

3. The report has two parts:

• Part 1 Financial and service performance

• Part 2 Service reform.

4. Our findings are based on evidence from sources that include:

• the audited annual accounts and auditors’ reports on the 2015/16 audits of the 23 NHS boards
• 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 to five years

• monthly Financial Performance Returns (FPRs) that each NHS board submits to the Scottish Government throughout the year

• activity and performance data published by Information Services Division (ISD), part of NHS National Services Scotland

• interviews with senior staff in the Scottish Government and a sample of NHS boards.

5. 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 NHS boards is included in the Appendix.

6. Alongside this report we have published a self-assessment checklist for NHS non-executive directors. Its purpose is to help non-executive directors in scrutinising and challenging their board’s performance and to help them gain assurance on the board’s approach to dealing with the issues raised in this report.
Part 1

Financial and service performance

Key messages

1. In 2015/16, the total health budget was £12.2 billion, 40 per cent of the Scottish Government’s budget. Although the budget increased by 2.7 per cent in real terms from the previous year, it is not keeping up with growing demand and the needs of an ageing population. In addition, NHS boards continue to face increasing pressures from rising staff and drug costs.

2. Many NHS boards struggled to achieve financial balance in 2015/16 and many had to use short-term measures to break even. Boards found it difficult to achieve the savings required and this will be even more challenging in 2016/17.

3. NHS boards need to look at reorganising acute services to free up more resources for investing in community-based facilities, but they are often faced with considerable public and political resistance to proposed changes to local services. Along with the Scottish Government, they need to engage with the public about the need for and benefits of changing how services are provided.

4. NHS boards continue to find it difficult to meet key national performance targets. Overall NHS Scotland failed to meet seven out of eight key targets. The only standard met nationally was the drug and alcohol treatment standard. The cancer 31 days referral to treatment standard was just missed by 0.1 per cent.

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Although health spending has increased it is not keeping up with growing demand and the needs of an ageing population

7. The Scottish Government is responsible for managing the overall health budget and allocating budgets to individual boards. Our NHS in Scotland 2014 supplement provides a summary of how health budgets are managed. In 2015/16, the total health budget for spending on core services, known as the departmental expenditure limit (DEL), was £12.2 billion. This accounts for 40 per cent of the Scottish Government’s budget (£30.1 billion). The Scottish Government allocated:

- £10.4 billion to the 14 territorial NHS boards that serve each area of Scotland and deliver frontline healthcare services
• £1.3 billion to Healthcare Improvement Scotland, the Mental Welfare Commission and the seven special NHS boards that provide specialist and national services (for example, the Scottish Ambulance Service and NHS 24)

• £0.5 billion to national programmes, such as immunisations, health and social care integration, health improvement and health inequalities.

8. Between 2008/09 and 2015/16, the total health budget increased by 16 per cent in cash terms. Taking into account inflation, the real-terms increase was five per cent. In 2015/16, the health budget increased by 2.7 per cent in real terms from the previous year. This includes a:

• 3.2 per cent increase in the revenue budget (for meeting day-to-day expenses, such as staff costs, medical supplies, rent and maintenance)

• 20.3 per cent decrease in the capital budget (for developing long-term assets, such as buildings or major IT programmes).

9. Following the economic recession in 2008/09, available public money has reduced overall. Between 2010/11 and 2014/15, the annual percentage change in the total health budget has been less than one per cent and below the UK inflation rate. Health inflation is generally higher and is estimated to be 3.1 per cent in 2016/17. Although the total health budget increased recently, this was preceded by much smaller increases and some decreases (Exhibit 1). The overall trends in revenue and capital expenditure are quite different. Between 2008/09 - 74 -

Exhibit 1
Trend in the health budget in Scotland, 2008/09 to 2015/16, and draft budget figures for 2016/17
Since 2008/09, the health budget has increased in cash terms and had small real-terms increases and decreases each year.

Note: Figures include both the revenue and capital DEL budgets.
Source: Scottish Government
and 2015/16, the revenue budget increased by 8.6 per cent while the capital budget decreased by 64.7 per cent.

10. Despite the recent real-terms increase in the revenue budget, NHS spending is not keeping pace with the growing and ageing population, increasing demand and rising costs. Spending on drugs increased by over ten per cent between 2012/13 and 2014/15 and the Scottish Government predicts that drugs spending will continue to rise by five to ten per cent each year (paragraph 37-38, page 18). The number of emergency admissions increased by six per cent and the associated costs increased by five per cent (between 2010/11 and 2013/14). Since 2008/09, although the real-terms increase in the total health budget was five per cent:

- the budget per head of population only increased by 1.6 per cent
- the population aged 75 and over increased by 11.8 per cent
- the number of patients waiting for an inpatient or day case appointment increased by 5.6 per cent and the number waiting for an outpatient appointment increased by 89 per cent.

11. The Scottish Government forecasts that the overall health budget for 2016/17 will increase by 5.6 per cent to £12.9 billion in cash terms. This includes a smaller increase in the revenue budget compared to 2015/16 (1.8 per cent in real terms). The Scottish Government has ring-fenced just under two per cent of the health budget for 2016/17 (£250 million) for health and social care integration. This funding is to be transferred to integration authorities to support additional spending on social care aimed at improving outcomes in social care. The remaining £12.6 billion of the NHS budget equates to a 0.3 per cent real-terms reduction in the revenue budget and a 2.1 per cent real-terms increase in the total budget. In 2016/17, the Scottish Government has reduced some of the funding allocations to territorial NHS boards. For example:

- Funding for Alcohol and Drug Partnerships has reduced by 22 per cent in cash terms, from £69.2 million in 2015/16 to £53.8 million in 2016/17. However, NHS boards are expected to maintain existing services, resources and outcomes at 2015/16 levels. A further £1.5 million is being provided centrally for developing alcohol and drug treatment services.
- Eleven funding streams have been combined into one single source of funding of £161.2 million. An efficiency saving of 7.5 per cent has been applied to the overall fund in 2016/17, which boards are expected to manage locally. This funding is part of an overall outcomes framework that aims to provide boards with more local flexibility on decisions about the funding. It focuses on prevention and reducing health inequalities, including dental services, infant nutrition and maternity services.

12. The capital budget is set to more than double, from £202.5 million in 2015/16 to £494.5 million in 2016/17. The increase is mainly to fund a £215 million investment in four new facilities. These are: the Royal Hospital for Sick Children and Department of Clinical Neurosciences in Edinburgh; the Dumfries and Galloway Royal Infirmary; the Scottish National Blood Transfusion Service Centre; and a new hospital in Orkney. The Scottish Government expects to reduce the capital budget again after 2016/17.
NHS boards struggled to achieve financial balance in 2015/16

13. To meet Scottish Government annual financial targets, NHS boards must end the financial year with at least a break-even position. This means they must spend no more than the limits of their revenue and capital budgets. All boards ended 2015/16 within their final revenue and capital limits.

14. After spending more than planned for every month during the year, the NHS in Scotland had an overall surplus of £4.5 million against its revenue budget of £10.9 billion (0.04 per cent) at the end of March 2016. This was a turnaround from having spent £12 million more than planned at February 2016. All boards reported at least a balanced revenue position (break-even or surplus), with surpluses ranging up to £0.7 million. There was an overall surplus for the NHS in Scotland of £0.4 million against the final capital budget of £329 million. All boards reported at least a balanced capital position, with surpluses ranging up to £0.147 million.

15. The break-even position was achieved in a number of ways. For example, NHS Tayside required a loan from the Scottish Government (known as brokerage) of £5 million. This was on top of brokerage of £15 million received in previous years that the board was not able to repay. The board and the Scottish Government are discussing a revised timescale for repaying the total £20 million brokerage. NHS 24 was also unable to repay brokerage in 2015/16. At the start of 2015/16, the board repaid £0.79 million of a total £20.36 million brokerage received in previous years, but this was returned by the Scottish Government later in the financial year. NHS 24 was due to repay its outstanding brokerage by 2019/20. It has now agreed with the Scottish Government that it will not make any repayment in 2016/17. Instead repayments will recommence in 2017/18 and be made over a five-year period up to 2021/22. We have prepared separate reports on the 2015/16 audits of NHS Tayside and NHS 24.

16. Three other boards that received brokerage in previous years are due to conclude repayment in 2016/17. The boards and amounts due to be repaid are NHS Highland (£1 million), NHS Orkney (£1.06 million) and NHS Western Isles (£0.54 million). The need for small amounts of brokerage highlights that NHS boards are facing real challenges in managing their budgets. Repaying brokerage reduces the amount boards have available to spend in future years.

17. There is evidence of boards increasingly using short-term approaches to meet the annual financial targets in 2015/16. Some boards only managed to achieve financial balance through one-off measures. In NHS Ayrshire and Arran, the auditors identified a prepayment for the cost of public holidays of over £1 million that was contrary to proper accounting practice. This involved the board moving costs from 2015/16 into 2016/17 to achieve financial balance. The auditor concluded that this was not an acceptable approach by the board to achieve its financial targets and the board corrected the accounting treatment.

18. Other approaches that enabled boards to break even in 2015/16 include:

- additional funding allocations from the Scottish Government late in the financial year or after the year-end
- making savings by delaying or under-spending on services or capital projects
- transferring capital funding to revenue funding to allow it to be used to cover increasing operational costs
• reclassifying core funding as non-core to release additional funding for operational costs (non-core funding is provided to boards for unpredictable costs such as capital and pension accounting adjustments)

• other approaches, such as one-off benefits from rates and VAT.

19. These short-term approaches, and the significant amounts (up to £17 million) involved in some cases, illustrate how much pressure NHS boards’ budgets were under in 2015/16 and into 2016/17. These approaches are unsustainable and make it difficult for boards to plan and invest in longer-term policy aims, such as developing more community-based services and treating people in homely settings.

20. A new sustainability and value programme board, jointly chaired by the chief executive of NHS Dumfries and Galloway and the Scottish Government’s Director of Health Finance, was set up in September 2016. It is overseeing four work streams that will focus on delivering efficiencies. The aim is to make efficiency savings of up to two per cent over the next three years. The four areas are:

• **Clinical transformation**: improving theatre and outpatient productivity and eliminating unwarranted clinical variation.

• **Effective prescribing**: minimising harm, waste and unwarranted variation in prescribing.

• **NHS workforce**: improving recruitment and retention of the workforce and reducing locum and agency staff costs.

• **Shared services**: identifying opportunities for shared use of buildings and facilities and improving procurement of services.

### Some boards are still below their target funding allocation

21. Since 2009/10, the Scottish Government has used a formula developed by the National Resource Allocation Committee (NRAC) to allocate most of territorial boards’ budgets. The formula is based on the number of people living in each board area and adjusted to reflect age and gender within the local population. It is also adjusted for additional needs based on local circumstances such as geography, sickness and deprivation levels. When the formula was introduced, some boards’ allocations were considerably below the amount proposed by the formula. Territorial boards receive an increase in funding each year and boards below their target allocation have received additional funding to gradually bring them closer to it. The Scottish Government made a commitment that all boards would be within one per cent of the target allocations by 2016/17. However, initial funding allocations provided to NHS boards for 2016/17 (excluding the £250 million for integration) indicate that four boards are still more than one per cent under their target allocation:

- NHS Grampian: 1.4 per cent below target (£12.2 million)
- NHS Highland: 1.5 per cent below target (£8.5 million)
- NHS Lanarkshire: 1.5 per cent below target (£15.9 million)
- NHS Lothian: 1.5 per cent below target (£18.8 million).
22. While these amounts are relatively small in terms of the overall budgets for each NHS board, all four of these boards are finding it challenging to meet key performance targets and have seen large increases in spending on temporary staff. NHS Lothian subsequently received a further £6 million and NHS Lanarkshire further £2 million of recurring funding from the Scottish Government in 2016/17. This was to bring the two boards closer to their target allocations and help them deliver their financial and performance targets. Three other boards that have previously received less than their target allocations are now within one per cent: NHS Fife (0.2 per cent below target), NHS Forth Valley (1.0 per cent below) and NHS Shetland (0.9 per cent below). The remaining territorial boards have received more than their target allocations (up to 9.4 per cent more in NHS Western Isles).

NHS boards found it difficult to achieve the savings required in 2015/16 and this will be even more challenging in 2016/17

23. At March 2016, boards reported overall savings of £291.3 million, which was £1.8 million (0.6 per cent) less than the target savings of £293.1 million stated in their local delivery plans (LDPs). Special boards exceeded their target by 25 per cent, while territorial boards were three per cent behind. Three territorial boards missed their savings targets: NHS Lothian (by 17 per cent), NHS Tayside (by 13 per cent) and NHS Western Isles (by one per cent). Boards retain the savings they make for reinvestment in local services.

24. Recurring savings are savings that, once achieved, recur year-on-year from that date, for example savings on costs as a result of streamlining services. Non-recurring savings are one-off savings that apply to one financial year, and do not result in ongoing (recurring) savings in future years, for example not filling a vacancy on a temporary basis. Identifying new recurring savings becomes more difficult for NHS boards each year. Boards that make high levels of non-recurring savings will have to find further savings in future years. Non-recurring savings are typically short-term decisions rather than initiatives to change the way services are provided.

25. In 2015/16, five territorial boards and one special board achieved around 60 per cent of their planned savings through non-recurring means (NHS Borders, Fife, Highland, Shetland and Tayside and The State Hospital). Only three boards (Healthcare Improvement Scotland the National Waiting Times Centre Board and NHS Forth Valley) were successful in achieving more recurring savings than they had planned in their LDP. Overall non-recurring savings were 32 per cent of total savings (compared to 25 per cent in 2014/15).

26. Boards are setting higher savings targets, from an average of three per cent in 2015/16 to an average of 4.8 per cent in 2016/17. Some boards are reporting that they will need to make unprecedented levels of savings in 2016/17, up to around eight per cent in NHS Shetland and NHS Tayside. The total savings that boards are aiming to make has increased by 65 per cent in real terms, from £293 million in 2015/16 to £484 million in 2016/17 (£492 million in cash terms). This is by far the largest annual percentage increase in the savings target over the last four years. Case study 1 (page 15) illustrates the level of savings NHS Lothian needs to make to break even in 2016/17. The percentage of savings that NHS boards have classified as at high risk of not being achieved increased from nine per cent in 2013/14 to 14 per cent for 2016/17. Seventeen per cent of savings had yet to be identified by boards, and boards estimated that 30.5 per cent of savings will be non-
recurring (these are both higher compared to previous years) (Exhibit 2, page 16). This will put considerable pressure on boards during 2016/17 and there is a significant risk that some boards will not be able to remain within their budgets.

**NHS boards need to balance maintaining high-quality hospitals with increasing investment in community-based care**

27. NHS boards need to manage their hospital and community buildings and other assets, such as medical equipment, to ensure patients receive high-quality care. This includes:

- investing capital funding in new assets in line with national policy and local requirements
- maintaining and modernising current assets to ensure they are of a good standard, fit for purpose and used efficiently
- disposing of assets that are no longer fit for purpose or not required.

28. The NHS owns physical assets worth around £6.3 billion. This includes an estate of land and buildings of £5.7 billion. The remaining £0.6 billion relates to medical equipment, IT equipment and vehicles. Because of their significant value, it is important for NHS boards to manage assets well. In 2015/16, NHS Shetland was unable to locate over four per cent of its assets included in its fixed asset register. The total cost of assets which could not be located was £1.4 million (the value of these was £48,000 allowing for depreciation). The auditor’s overall conclusion was that adequate accounting records had not been kept in relation to elements of property, plant and equipment assets.

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**Case study 1**

**NHS Lothian's financial position in 2016/17 and level of savings required to break even**

NHS Lothian identified a gap of £20.1 million in its budget for 2016/17. It received a further £6 million from the Scottish Government to bring it closer to its target NRAC position. To break even in 2016/17, the board needs to deliver £73.1 million of savings; at July 2016, it had still to identify £14.9 million of these. It carried over unmet efficiency savings from previous years of around £13 million. At 31 July 2016, NHS Lothian had overspent against its revenue budget by £7.1 million, mainly driven by over-spending on pay and prescribing. NHS Lothian has a financial recovery plan in place and is closely monitoring its financial position, which has been reported clearly to its Board. A new clinical quality approach is being led by a Quality Director to improve patient care and efficiency. This includes identifying and reducing unwarranted variation and cost across specialties.

Exhibit 2
Percentage of planned non-recurring, unidentified and high-risk savings by NHS board, for 2016/17
Across many boards, a significant proportion of planned savings for 2016/17 are non-recurring, at risk of not being achieved or still to be identified.

<table>
<thead>
<tr>
<th>Territorial boards</th>
<th>Total savings as % baseline resource funding</th>
<th>Of the total planned savings:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% non-recurring</td>
<td>% unidentified</td>
<td>% high risk</td>
<td></td>
</tr>
<tr>
<td>Ayrshire and Arran</td>
<td>3.7%</td>
<td>0.0%</td>
<td>27.4%</td>
<td>9.7%</td>
</tr>
<tr>
<td>Borders</td>
<td>5.9%</td>
<td>33.0%</td>
<td>0.0%</td>
<td>54.8%</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>4.6%</td>
<td>45.1%</td>
<td>11.0%</td>
<td>28.4%</td>
</tr>
<tr>
<td>Fife</td>
<td>5.1%</td>
<td>42.2%</td>
<td>33.0%</td>
<td>44.2%</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>5.5%</td>
<td>0.0%</td>
<td>7.9%</td>
<td>26.6%</td>
</tr>
<tr>
<td>Grampian</td>
<td>3.0%</td>
<td>55.4%</td>
<td>28.0%</td>
<td>20.9%</td>
</tr>
<tr>
<td>Greater Glasgow and Clyde</td>
<td>5.0%</td>
<td>24.5%</td>
<td>24.5%</td>
<td>8.3%</td>
</tr>
<tr>
<td>Highland</td>
<td>5.0%</td>
<td>10.4%</td>
<td>8.0%</td>
<td>13.7%</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>4.1%</td>
<td>15.5%</td>
<td>8.8%</td>
<td>22.1%</td>
</tr>
<tr>
<td>Lothian</td>
<td>5.6%</td>
<td>45.2%</td>
<td>20.4%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Orkney</td>
<td>5.1%</td>
<td>27.4%</td>
<td>4.0%</td>
<td>15.4%</td>
</tr>
<tr>
<td>Shetland</td>
<td>8.7%</td>
<td>37.7%</td>
<td>0.0%</td>
<td>20.6%</td>
</tr>
<tr>
<td>Tayside</td>
<td>8.4%</td>
<td>60.0%</td>
<td>10.2%</td>
<td>12.1%</td>
</tr>
<tr>
<td>Western Isles</td>
<td>5.9%</td>
<td>38.8%</td>
<td>18.3%</td>
<td>11.5%</td>
</tr>
<tr>
<td><strong>Special boards</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Waiting Times Centre</td>
<td>8.5%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>11.4%</td>
</tr>
<tr>
<td>NHS 24</td>
<td>5.1%</td>
<td>2.3%</td>
<td>7.8%</td>
<td>0.0%</td>
</tr>
<tr>
<td>NHS Education for Scotland</td>
<td>0.5%</td>
<td>15.9%</td>
<td>15.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>NHS Health Scotland</td>
<td>5.3%</td>
<td>8.8%</td>
<td>6.3%</td>
<td>0.0%</td>
</tr>
<tr>
<td>NHS National Services Scotland</td>
<td>5.1%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>3.2%</td>
</tr>
<tr>
<td>Healthcare Improvement Scotland</td>
<td>11.3%</td>
<td>17.2%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Scottish Ambulance Service</td>
<td>4.4%</td>
<td>33.3%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>The State Hospital</td>
<td>5.2%</td>
<td>72.2%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>All territorial boards</td>
<td>5.0%</td>
<td>31.9%</td>
<td>18.0%</td>
<td>15.4%</td>
</tr>
<tr>
<td>All special boards</td>
<td>3.5%</td>
<td>13.9%</td>
<td>1.7%</td>
<td>2.4%</td>
</tr>
<tr>
<td>All boards</td>
<td>4.8%</td>
<td>30.5%</td>
<td>16.7%</td>
<td>14.4%</td>
</tr>
</tbody>
</table>

**Key**

- **High**: >5% >50% >20% >20%
- **Medium**: 3-5% 20-50% 1-20% 3-20%
- **Low**: <3% <20% <1% <3%

Notes:
1. Total savings as a percentage of baseline resource funding was calculated using baseline funding allocations that include £250 million funding for health and social care integration.
2. The Mental Welfare Commission for Scotland does not provide savings figures.
3. The key is based on Audit Scotland’s assessment of the level of savings in each category.

Source: Audit Scotland using information from NHS boards’ Local Delivery Plans, June 2016
29. The Scottish Government’s latest annual review of NHS assets (for 2015) shows a number of improvements overall in the management and physical condition of property assets, but this varies considerably by board:

- Overall 79 per cent are less than 50 years old (compared to 75 per cent in 2014). More than 60 per cent of properties are 30 years and older in four NHS boards (NHS Ayrshire and Arran, Dumfries and Galloway, Tayside and Shetland). In NHS Shetland, 47 per cent of properties are over 50 years old.

- 66 per cent are in good condition (compared to 59 per cent in 2014), with 29 per cent requiring investment to improve their condition. The remaining five per cent are in an unsatisfactory condition and require major investment or replacement. In NHS Ayrshire and Arran, Highland and Orkney, more than 50 per cent of buildings require some level of investment to improve their condition (including Balfour Hospital in NHS Orkney which is being replaced).

- 81 per cent are fully utilised (compared to 77 per cent in 2014). NHS Ayrshire and Arran and NHS Dumfries and Galloway have high levels of overcrowded properties (24 and 30 per cent). NHS Highland and NHS Orkney have high levels of under-used properties (59 and 40 per cent). Both of these boards face challenges in providing critical healthcare facilities in locations with relatively low levels of population. In four boards, over five per cent of properties were empty (NHS Dumfries and Galloway, Fife, Grampian and Tayside). These boards have plans to sell unused properties over the next five years.

30. In 2015, the outstanding maintenance required to keep the NHS estate across Scotland up to a good standard amounted to £898 million. This is £101 million (13 per cent) more than in 2014. High-risk and significant maintenance requirements reduced to 44 per cent overall in 2015, compared to 47 per cent in 2014. However, in some boards it increased, particularly in NHS Dumfries and Galloway, Greater Glasgow and Clyde, and Tayside. In five boards, the level of high-risk and significant backlog maintenance is over 50 per cent (NHS Dumfries and Galloway, Greater Glasgow and Clyde, Lothian, Tayside and Shetland). Most of these boards have new properties recently completed or under way and are rationalising their property portfolios.

31. Based on NHS boards’ property and asset management strategies, and depending on approval and availability of funding, around £2.8 billion investment in assets is planned over the next five years. This relates to property, medical equipment, IT equipment and vehicles and will combine capital and revenue funding. Of the total of £1.1 billion planned for investment in major projects, the majority of this is for new hospitals (70 per cent). A further £290 million is planned for new primary and community care projects for new models of care, to help deliver the Scottish Government’s overarching health and social care policy which aims to provide more care in community-based and homely settings.

32. NHS boards need to balance maintaining high-quality hospitals with increasing investment into community-based care. A clear national strategy is required for capital investment that will support a shift in the balance of care. Boards can use revenue funding for major projects, rather than capital funding, to spread costs over a long period of time, such as non-profit distributing (NPD) projects. However, revenue budgets are under increasing pressure.
33. The National Clinical Strategy recommends that more specialist care should be provided on a regional or national basis. The capital budget has reduced significantly over recent years and the Scottish Government is providing limited additional funding for transforming services. NHS boards need to change the NHS estate to allow investment for new services. This includes reorganising acute services to free up more resources for investing in community-based facilities. This is happening to some extent, but boards can face considerable public and political resistance to proposed changes to local services. It is important that the Scottish Government has an ongoing discussion with the public about the way services will be provided in the future and manages expectations. A significant cultural shift is needed in terms of how people access, use and receive services. The Scottish Government, NHS boards and integration authorities need to work with the public about the need for and benefits of change, and develop and agree options for providing services differently.

NHS boards continue to face increasing cost pressures

34. The NHS is facing continuing pressure from increasing demand for services and a growing, ageing population, as we have highlighted in previous reports. The number of frail, elderly people is growing more rapidly than the rest of the population. People are living longer with multiple long-term conditions and increasingly complex needs. Overall, healthy life expectancy (the number of years people might live in good health) has improved. But significant health inequalities still exist and people living in the most deprived areas of Scotland have a much lower healthy life expectancy. The number of people being admitted to hospital in an emergency is increasing and GP practices are seeing increasing demand for their services.14

35. Other cost pressures include drug costs, salaries and wages, other staff costs, achieving national waiting time targets, and new technologies. In real terms, since 2010/11:

- total NHS staff costs have increased by 6.4 per cent to £6.2 billion in 2015/16
- NHS spending on national insurance has increased by 3.4 per cent, from £386 million to £399 million in 2015/16 (an increase of 2.2 per cent since 2014/15 from £390 million)
- total NHS spending on pensions increased by 18.6 per cent, from £550 million to £652 million in 2015/16 (an increase of 12 per cent since 2014/15 from £582 million).

36. Most NHS boards overspent on their acute budgets by a considerable amount in 2015/16. For example, NHS Ayrshire and Arran overspent on its acute budget by £8.5 million (3.2 per cent) and NHS Grampian overspent by £14.3 million (3.6 per cent).

Rising spending on drugs is a major pressure

37. Territorial NHS boards highlight spending on drugs, in both hospitals and the community, as a significant cost pressure.15 The NHS in Scotland’s total spending on drugs increased steadily between 2004/05 and 2011/12. Since decreasing by
Part 1. Financial and service performance

a small amount in 2012/13, spending has been rising at a higher rate

Exhibit 3 (page 20). The NHS spent £150 million more on drugs in 2014/15 than in 2012/13, after adjusting for inflation.\textsuperscript{16,17} This is an increase of over ten per cent. In 2014/15, three times more was spent on drugs in the community (£1.2 billion) than on hospital drugs (£388 million). In 2015/16, examples of the main drugs prescribed in terms of volume and cost were:

- omeprazole, prescribed for reducing stomach acid. This was the most commonly dispensed drug in the community (3.6 million items at a cost of £11.7 million)

- inhalers that contain salmeterol with fluticasone propionate, prescribed for respiratory conditions such as asthma. This drug had the highest total cost in the community (£35.5 million)

- adalimumab, used to treat inflammatory conditions including arthritis, Crohn’s disease and psoriasis. This accounted for the highest spending in hospitals on one drug (£32.5 million)

- paracetamol, ibuprofen and antihistamines; common drugs also available to buy over the counter. In total, over 4.3 million of these three drugs were dispensed at a cost of around £17 million.\textsuperscript{38} Over the last ten years, the quantity dispensed has increased by two-thirds. This is double that of the increase in quantity of all drugs dispensed in the community.

38. Between 2012/13 and 2014/15, spending on drugs in the community rose by nearly eight per cent in real terms, while spending on drugs in hospitals increased by 20 per cent (Exhibit 3, page 20). The Scottish Government is predicting that overall spending on drugs will continue to rise by five to ten per cent each year.\textsuperscript{19}

39. NHS boards in Scotland have been successful in increasing the prescribing of unbranded medicines rather than branded medicines to generate efficiencies.\textsuperscript{20} This is known as generic prescribing. Scotland, along with the rest of the UK, has one of the highest generic prescribing rates in the world.\textsuperscript{21} Generic prescribing rates have risen slowly and steadily over the last ten years and reached 83.6 per cent in 2015/16. Our 2013 report on GP prescribing found that most of the potential savings from switching to generic drugs have already been made.\textsuperscript{22}

Spending on drugs is rising because of increases in demand and cost

40. NHS spending on drugs has increased in recent years owing to:

- more drugs being dispensed

- rising costs of many existing drugs

- new drugs becoming available.

41. The quantity of drugs dispensed in the community increased by almost a third between 2006/07 and 2015/16.\textsuperscript{23} Reasons for this include an ageing population, more people living with long-term conditions and the increased use by GPs of evidence-based guidelines that recommend drugs to treat certain conditions. For example, statins (drugs to lower people’s cholesterol level) are routinely prescribed for patients with heart disease.\textsuperscript{24}
20. The cost of existing drugs has increased for a number of reasons:

- Increasing global demand for drugs has led to higher prices. Global pharmaceutical sales are projected to increase by an average of 6.9 per cent each year between 2014 and 2018.\(^{25}\)

- There has been a global shortage of some drugs, caused either by rising demand or by manufacturing problems. This has resulted in prices rising or patients being prescribed more expensive alternatives.

- Some pharmaceutical companies have sold the rights to a small, but significant, number of branded drugs to other companies that then sell them on under their generic name at a much higher price.\(^{26}\) These tend to be drugs that do not have a big market and have few, if any, alternatives. In many cases it is unsafe or difficult to switch patients away from these drugs and NHS boards have no choice but to pay the higher price. Exhibit 4 (page 21) illustrates the financial impact of this practice on the NHS between 2013/14 and 2015/16. For example, prescribing of dicycloverine hydrochloride (a drug commonly used for irritable bowel syndrome) fell by a third but the overall cost to the NHS rose by nearly 300 per cent (£2.3 million) because of an increase in price of nearly 500 per cent.\(^{27}\)

42. It can be difficult for NHS boards to predict these types of price increases as there is often little warning of which drugs will be affected. However, the UK Government has made progress in controlling excessively high prices of some unbranded medicines. The UK-wide Health Service Medical Supplies (Costs)
Bill, introduced in September 2016, intends to limit the price of unbranded medicines where competition in the market fails and companies charge the NHS unreasonably high prices. The Bill is expected to be enacted in spring 2017.

New drugs are a cost pressure for NHS boards. The Scottish Medicines Consortium (SMC) is the body that assesses new medicines for use in Scotland. The SMC analyses information supplied by the

### Exhibit 4
Examples of cost increases in four branded drugs sold under their generic name, 2013/14 to 2015/16

Four branded drugs that were sold under their generic name cost the NHS over £10 million (128 per cent) more in 2015/16 than in 2013/14. Over this period, overall demand for these drugs rose by seven per cent while prices rose by between 62 and 492 per cent.

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Change in overall cost</th>
<th>Change in cost per item</th>
<th>Change in items prescribed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nortriptyline hydrochloride</td>
<td>£2.3 million (66%)</td>
<td>£127.75 (187%)</td>
<td>15,634 (+38%)</td>
</tr>
<tr>
<td>Dicycloverine</td>
<td>£2.5 million (62%)</td>
<td>£57.01 (7%)</td>
<td>-10,850 (-35%)</td>
</tr>
<tr>
<td>Carbimazole</td>
<td>£3.1 million (492%)</td>
<td>£77.50 (7%)</td>
<td>2,487 (+7%)</td>
</tr>
<tr>
<td>Hydrocortisone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Drugs analysis provided to Audit Scotland by ISD, July 2016
medicine manufacturer on the health benefits of the medicine and justification of its price. The introduction of new approaches by the SMC, including an appeals process involving patients and clinicians, has increased access to new high-cost drugs. Between May 2014 and March 2016, the SMC approved 75 per cent of medicines (for treating very rare and rare conditions and for use at end of life). This compares to 48 per cent of medicines approved by the SMC between 2011 and 2013 (for cancer medicines and those for treating rare conditions).

45. Access to some of these new drugs can be life-changing for patients and their families. Advances in research mean that more treatments are becoming available for rare conditions that previously had no or little treatment options. The SMC assesses the effectiveness of new drugs, but not affordability. This means that NHS boards have to fund an increasing number of very high-cost drugs. This has a significant impact on boards’ budgets. For example, in 2015/16, the cost of drugs to treat:

- cardiovascular disease increased by nearly £14 million compared to 2013/14 as a result of the introduction of new anticoagulant drugs
- hepatitis C was £50 million compared to £32 million in 2014/15, an increase of over 50 per cent (Case study 2, page 23).

46. The Scottish Government has commissioned a review to consider how the changes made to the SMC process in 2014 have improved patient access to medicines for rare and end-of-life conditions. It will also look more broadly at how the whole system for getting patients access to newly licensed drugs safely and quickly is working. The review is due to report in late 2016. The SMC also provides early intelligence to NHS boards on new medicines in development through an annual horizon-scanning report with the aim of improving boards’ financial planning.

47. The Scottish Government has provided additional funding for new drugs through the New Medicines Fund (NMF). NHS boards received £21.5 million from the NMF in 2014/15, and £85 million in 2015/16. The NMF provides additional funding to NHS boards to cover costs incurred for increasing patient access to treatments for very rare conditions and end-of-life medicines. It does not cover the cost of high-cost new drugs, such as those to treat hepatitis C, or other new treatments for more common conditions. The Scottish Government has yet to advise boards of the total amount of additional funding available from the NMF in 2016/17. If the NMF reduces in 2016/17, this will place further pressure on boards’ drugs budgets.

**Staff costs are a major cost pressure for NHS boards**

48. The NHS is going through a period of major reform. A number of wide-ranging strategies including the National Clinical Strategy, integration of health and social care services and a new GP contract are likely to change the roles and skills required of the workforce. NHS staff provide a wide range of healthcare services and are essential to ensuring high-quality, safe and effective care. The number of people working in the NHS in Scotland continues to rise despite a third of NHS boards reducing their staff numbers during 2015/16. Overall staff levels are at the highest level ever, with 138,458 whole-time equivalent (WTE) staff employed as at March 2016. This is an increase of 0.6 per cent (855 WTE) in the last year.
Case study 2

Curative treatments for hepatitis C

It is estimated that around 37,000 people in Scotland are infected with hepatitis C (20,000 diagnosed, 17,000 undiagnosed). The effectiveness of treatments which eradicate hepatitis C infection has increased dramatically over the last 20 years. In 2014, new highly effective, short-duration, safe and easy-to-administer treatments became available and offered a cure to more than 90 per cent of hepatitis C patients for the first time. These cost over £13,000 per patient for a month’s supply in 2015/16 but are expected to reduce spending in the future. Courses of treatment tend to range from two to six months.

The key aim of investing in hepatitis C services in Scotland is to reduce the number of people who develop hepatitis C virus (HCV)-related liver failure, liver cancer and the number of people who die from HCV-related disease.

Given the current high cost of the new treatments, NHS boards are prioritising treatment for people at risk of developing severe life-threatening or seriously debilitating liver disease and non-liver hepatitis C-related disease. However, the longer-term aim is to offer therapy to all people with chronic hepatitis C, as early treatment is likely to deliver benefits throughout the population in terms of prevention and onward transmission.

It is estimated that a minimum of 1,500 patients need to start treatment each year during 2015-20 to reduce the number of new liver failure or cancer presentations from the current level of nearly 200 down to 50 presentations by 2020.

The annual cost to the NHS in Scotland of treating hepatitis C-related liver disease is estimated to more than double between 2008 and 2030, from £9.9 million to £20.2 million, totalling £362 million over this period. This figure does not include economic costs such as costs related to patients not being able to work. Further health economic work focusing on the cost-effectiveness of different models of diagnosis, assessment, treatment and care still needs to be carried out.

Source: Audit Scotland; ISD; Scottish Medicines Consortium - SMC No 964/14 (sofosbuvir), SMC No 1002/14 (daclatasvir); National Clinical Guidelines for the treatment of HCV in adults, Health Improvement Scotland, 2015; The Scottish Government Hepatitis C Treatment and Therapies Group Report, Health Improvement Scotland, Scottish Government, 2015; Expansion of HCV treatment access to people who have injected drugs through effective translation of research into public health policy: Scotland’s experience, Hutchison, S International Journal of Drug Policy 26 (2015) 1041–1049
recommend their workplace as a good place to work. However, only a third of respondents said there were enough staff to allow them to do their job properly. This has remained unchanged over the last three years. This tended to be more positive in special boards (around half of respondents said there were enough staff), excluding the Scottish Ambulance Service, where it was 15 per cent. In a survey of 1,800 GPs in Scotland in 2015, a quarter of GPs described their workload as unmanageable and over two-thirds felt that workload had a negative impact on their personal commitment to their career.

The NHS is facing problems recruiting and retaining staff

The NHS in Scotland is under pressure from rising staff vacancies owing to difficulties in recruiting and retaining staff on permanent contracts. Retaining staff has become an increasing problem for boards with turnover rates increasing since 2012/13 (Exhibit 5, page 25). In 2015/16:

- staff turnover was 6.4 per cent (WTE leavers divided by the number of staff in post as at 31 March). The highest turnover was at two special boards, NHS 24 (13 per cent) and NHS Health Scotland (14.8 per cent). Among the territorial boards, the three island boards had the highest turnover (9.5-11.5 per cent), followed by NHS Tayside (9.2 per cent). High turnover can be a way of getting new skills into the organisation on a short-term basis. However, it can also affect consistency and costs if boards are required to frequently provide training for new staff.

- nursing and midwifery vacancy rates were 3.6 per cent overall but this varied among boards. NHS Orkney and NHS Shetland had the highest rates at over eight per cent. NHS Ayrshire and Arran and NHS Western Isles both had rates of less than one per cent.

- health visitor nursing had the highest vacancy rates of all nursing specialties (nine per cent, 182 vacancies). This was followed by paediatric, district and public health nursing, which all had vacancy rates of almost five per cent. NHS Shetland had the highest vacancy rate of all boards for health visitor nursing and district nursing (39.6 and 22.8 per cent respectively).

- consultant vacancy rates were 6.5 per cent overall. This is a reduction from 7.7 per cent in 2015. However, there is variation among territorial boards. NHS Orkney had the highest rate by far at 37 per cent, followed by NHS Dumfries and Galloway, Ayrshire and Arran, and Fife at 14.5, 13.9 and 12.6 per cent. These vacancy rates are likely to be an underestimate owing to the way the data is collected.

- clinical radiology and anaesthetic consultants had the highest number of vacancies of all specialties, at 40.3 WTE (11 per cent) and 32 WTE (four per cent) vacancies. Psychotherapy and occupational medicine consultants had the highest vacancy rates (23 and 22 per cent) as a percentage of the establishment (when the total establishment was more than ten). Vacancy rates for other grades of hospital medical staff are not available.

- GP vacancy rates were 4.8 per cent (this figure is for the most recent data from 2015), but again there is wide variation. The three island boards had the highest vacancy rates (8.6 per cent in NHS Orkney, 16.5 per cent in NHS Western Isles and 17.9 per cent in NHS Shetland), along with NHS Forth Valley at 8.9 per cent.
Part 1. Financial and service performance

- five per cent of GP practices (49) are being run directly by their local NHS board, mainly due to GPs retiring, the rural location of practices and problems recruiting GPs. The number of practices taken over by boards has been steadily increasing since 2013/14.

- sickness absence was 5.2 per cent overall. The Scottish Government has set boards a target of a maximum of four per cent. Only three boards had rates below the target (NHS Education for Scotland, NHS Health Scotland and Healthcare Improvement Scotland). The highest rates were at NHS Western Isles (5.9 per cent), the Scottish Ambulance Service (7.6 per cent) and The State Hospital (8.1 per cent).

High sickness rates put more pressure on boards to cover posts on a temporary basis.

There are challenges filling junior doctor training posts

Junior doctors complete two-year foundation training after graduating from medical school. They can then apply for a core training post, which provides general grounding in a particular specialty and lasts around two to three years. After this, they can undertake higher-level specialist training that can ultimately lead to a consultant post. For some specialities, the core and higher-level specialist training is combined into one course, for example GP training.

Exhibit 5

Trends in key workforce indicators, 2012/13 to 2015/16

Rising sickness absence, turnover and vacancy rates are contributing to an increase in NHS boards’ spending on high-cost agency staff.

<table>
<thead>
<tr>
<th>Sickness absence</th>
<th>Turnover</th>
<th>Vacancy rate</th>
<th>Temporary staff numbers as % of establishment (WTE)</th>
<th>Total agency spending as % total staff costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012/13</td>
<td>2013/14</td>
<td>2014/15</td>
<td>2015/16</td>
<td></td>
</tr>
</tbody>
</table>

Notes:
1. Sickness absence rate is the number of hours lost as a percentage of total contracted hours. The LDP standard is four per cent.
2. Turnover is the number of WTE leavers divided by staff in post as at 31 March each year.
3. Vacancy rate is the number of vacant posts as a percentage of the establishment.
4. Data on GP vacancy rates and locums was only available for 2013 and 2015.
5. ISD do not publish data on temporary consultant numbers.
6. Total agency spending includes medical, nursing, other clinical and other non-clinical staff.

Source: Audit Scotland using NHS Scotland Workforce Information as at 31 March 2016, ISD Scotland; and for total agency spend, the Scottish Government consolidated accounts, June 2016
In 2016, there were 850 foundation year one posts advertised across the NHS in Scotland, with a 100 per cent fill rate. For recruitment and training commencing in August 2016, 820 core and specialty training posts were advertised across the NHS in Scotland. Only 718 of these posts were filled, leaving 12.5 per cent of posts unfilled. Most specialties were filled. The main exceptions were general practice (90 unfilled posts) and psychiatry (11 unfilled posts). This is eight per cent and seven per cent of the total establishment of funded training posts for each of these specialties. This has worsened compared to 2015, where 66 GP training posts and three psychiatry training posts were unfilled (six and two per cent of the training post establishment). For recruitment to higher-level specialty training, 374 posts were advertised. Only 266 of these posts were filled, leaving 29 per cent of posts unfilled. Specialties with the highest unfilled vacancy rates were old age psychiatry (eight posts and 32 per cent of the establishment) and clinical oncology (nine posts and 22 per cent of the establishment). While the unfilled vacancy rate for old age psychiatry is equal to that in 2015, the rate for clinical oncology has worsened since 2015, when it was 15 per cent.

Rising costs for temporary staff are a significant pressure

As a result of these recruitment and retention problems, and pressure to meet waiting time targets, the amount NHS boards are spending on temporary staff has increased each year over the last four years. It increased from 1.6 per cent of total staff costs in 2012/13 to 2.8 per cent in 2015/16. In 2015/16, NHS boards spent:

- £135 million on internal bank nursing and midwifery staff, an increase of four per cent compared to 2014/15. The largest percentage increase was at NHS Borders (14 per cent, to £1.8 million) and The State Hospital (16 per cent, to £0.2 million). NHS Greater Glasgow and Clyde spent the highest amount (£48.7 million)

- £23.5 million on agency nursing and midwifery staff, an increase of 47 per cent compared to 2014/15. Spending more than doubled at five boards (NHS Ayrshire and Arran, Borders, Forth Valley, Grampian, and Lanarkshire). Of all territorial boards, NHS Tayside spent the most (£5 million), followed by NHS Lothian (£4.8 million)

- £30 million on internal medical locums, four per cent less than 2014/15. Eight boards spent less on internal medical locums. NHS Borders, Highland, Greater Glasgow and Clyde, Lanarkshire, Orkney and Tayside spent more. In NHS Highland, spending increased by 78 per cent to £2.9 million

- £101 million on agency medical locums, an increase of 33 per cent compared to 2014/15. NHS Lanarkshire saw the biggest percentage increase (80 per cent), to £11 million. NHS Greater Glasgow and Clyde spent the highest amount of £20 million.

The increasing use of temporary staff, that can cost significantly more than permanent staff, is putting considerable pressure on NHS boards’ budgets and does not represent value for money. For example, in 2015, while the average cost of salaried nursing staff was £36,000 per WTE, agency nursing staff cost more than twice this, at £84,000 per WTE. A review of the use of temporary staff in NHS Greater Glasgow and Clyde by auditors found that the board is using agency medical
locums to cover long-term vacancies. An analysis of the top value invoices by individual agency workers identified a small number of individual consultants being paid over £400,000 to provide cover for periods of less than a year.

56. The Scottish Government launched a national Managed Agency Staffing Network in December 2015 to review temporary staffing across Scotland. It aims to reduce spending, improve the quality and governance of temporary staffing, and roll out good practice. The steering group is exploring several options and has still to identify the level of efficiency savings for 2016/17. Options under consideration include:

- ensuring consistent and reasonable rates for temporary staff
- ensuring nursing and medical staff banks are set up in all boards to reduce the need for higher-cost agency staff
- preventing permanent staff within a board from carrying out some shifts through an agency at considerably higher cost.

Staff shortages and high use of temporary staff can affect quality of care

57. Difficulties in recruiting and retaining staff and greater use of temporary staff may pose risks to patient safety and quality of care. These risks can arise from poor continuity of staff, temporary staff being unaware of local systems and processes, or a lack of staff to provide safe care. As part of its remit, Healthcare Improvement Scotland (HIS) carries out inspections of healthcare facilities, such as scrutiny of safety and cleanliness, and care of older people. Since April 2015, HIS reports have included 12 care of older people inspections, 31 safety and cleanliness inspections, one review of hospital-based clinical care in NHS Lothian and five joint inspections of health and social care conducted with the Care Inspectorate. These reports cover many different issues and the findings are largely positive. We have drawn out the concerns that specifically relate to staffing shortages and the use of temporary staff. Seven care of older people reports stated that vacancies, staff shortages or a high number of bank and agency staff affected quality of care or patient safety. Examples of concerns highlighted in the inspection reports are set out below:

- The review in NHS Lothian was carried out in response to issues highlighted in a complaint made about the care provided in hospital facilities. Failures to adequately document care requirements and care were found. The report stated that it was not possible to be clear if the record keeping or the care provided needed to improve. Examples of poor documentation included records indicating patients with pressure ulcers being left in the same position for most or the whole of a day and patients being fed by tube not receiving the appropriate oral care. The report stated that staffing shortages were affecting the time staff were able to spend with patients. This made it difficult for staff to have sufficient time to fully meet individual patient needs and treat them with dignity and respect. Bank and agency staff were used regularly and the board acknowledged that the quality and continuity of care had the potential to be compromised.

- At the Langlands Unit, part of the new Queen Elizabeth University Hospital site in NHS Greater Glasgow and Clyde, an acute stroke and rehabilitation ward was short-staffed each day of the inspection. The absence of a senior charge nurse meant there was a lack of leadership and risks for patient
safety. There were particular issues in relation to poor nutritional care of patients. Some patients on the ward said that there were not enough staff and that nurses were too busy to check up on them or answer their requests for help with toileting or bathing.47

- In the Aberdeen Royal Infirmary and Woodend Hospital in NHS Grampian, staff expressed concerns about staff shortages and patient safety. This included being unable to provide sufficient care for patients with pressure ulcers and an increasing number of patient falls.48

- In several rural areas, challenges in recruiting and retaining GPs, consultants and community mental health teams were reported to have led to a reduction in the quality of services (Argyll and Bute and Western Isles).49

There are major challenges for the future NHS workforce 58. In addition to the current workforce problems, there are a number of challenges for the future. As the general population is ageing, so is the NHS workforce:

- Around one in two community nurses were aged 50 and over, compared with one in three hospital nurses in 2015.50

- A third of all GPs and 42 per cent of GP partners were aged 50 and over in 2015.51

- At March 2016, 20 per cent of the total of hospital and community medical staff and 37 per cent of nursing and midwifery staff were aged 50 and over. Of all staff groups, support services and administrative services had the highest percentage aged 50 or over (54.6 and 43.9 per cent).52

59. We are carrying out a separate audit looking at the NHS workforce in more detail. We plan to publish a report in 2017.

NHS boards continue to struggle to meet key national performance targets

60. The Scottish Government agrees a performance contract with NHS boards through its annual LDP guidance.53 Within this guidance, the Scottish Government sets out a number of performance targets that NHS boards are required to meet. These are referred to as LDP standards. These LDP targets intend to help achieve the Scottish Government’s overall purpose and national outcomes, as well as the quality standards that NHS Scotland seeks to meet. Introducing targets has helped to improve performance within the NHS and reduce waiting times for patients. However, national targets have become more challenging at the same time as finances have been tightening. Over recent years, NHS boards have found it increasingly difficult to meet some of the key performance targets.

61. Overall at March 2016 NHS Scotland failed to meet seven out of eight key targets (Exhibit 6, page 29). The only target met nationally was the drug and alcohol treatment target. The cancer 31 days referral to treatment target was just missed by 0.1 per cent. There has been an improvement in the four-hour A&E target over the last year. At March 2016, NHS Scotland was two per cent below the interim target of 95 per cent. During 2015/16, NHS Ayrshire and Arran, Lanarkshire and Highland particularly struggled to meet performance targets (Exhibit 7, page 30).
Although none of the 14 territorial boards met all eight key targets, only three boards missed the three-week drug and alcohol treatment target (NHS Highland, Lothian and Shetland). Over half of all territorial boards failed to meet three targets (12-week first outpatient appointment, 12-week treatment time guarantee (TTG), and 62-day cancer referral to treatment). Boards’ declining performance against hospital waiting time targets is an indication of the building pressures they are facing from increasing demand.

Five out of the 14 territorial boards failed to meet the 18-week children and adolescent mental health services (CAMHS) target. Between March 2015 and 2016, performance against the CAMHS target improved (from 78.9 to 84.2 per cent) but still failed to meet the 90 per cent target. Over the same period, the total number of CAMHS patients seen has increased by four per cent, from 4,269 to 4,436 patients. We plan to carry out an audit in this area in 2017.
Exhibit 7
Comparison of key indicators by NHS territorial board at 2015/16
There is significant variation in the pressures individual boards are facing.

<table>
<thead>
<tr>
<th>Indicator/Board</th>
<th>Population aged 75+</th>
<th>Finance</th>
<th>Total savings made (£m)</th>
<th>Non-recurring savings</th>
<th>Treatment Time Guarantee</th>
<th>Treatment Time Guarantee unavailability</th>
<th>Referral to outpatient appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Core revenue outturn (£m)</td>
<td>Total savings (£m)</td>
<td>Non-recurring savings</td>
<td>NRAC: distance from parity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Territorial boards</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ayrshire and Arran</td>
<td>9.3%</td>
<td>703.6</td>
<td>19.1</td>
<td>34.5%</td>
<td>-0.5%</td>
<td>88.3%</td>
<td>14.1%</td>
</tr>
<tr>
<td>Borders</td>
<td>10.2%</td>
<td>210.2</td>
<td>6.9</td>
<td>59.3%</td>
<td>1.6%</td>
<td>99.2%</td>
<td>17.5%</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>10.8%</td>
<td>299.3</td>
<td>8.0</td>
<td>23.4%</td>
<td>3.8%</td>
<td>90.4%</td>
<td>8.9%</td>
</tr>
<tr>
<td>Fife</td>
<td>8.5%</td>
<td>637.2</td>
<td>18.0</td>
<td>60.0%</td>
<td>-1.1%</td>
<td>97.4%</td>
<td>7.2%</td>
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<tr>
<td>Forth Valley</td>
<td>7.9%</td>
<td>515.5</td>
<td>13.7</td>
<td>2.5%</td>
<td>-1.5%</td>
<td>95.8%</td>
<td>12.4%</td>
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<tr>
<td>Grampian</td>
<td>7.6%</td>
<td>927.1</td>
<td>25.1</td>
<td>34.6%</td>
<td>-2.0%</td>
<td>88.3%</td>
<td>17.3%</td>
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<tr>
<td>Greater Glasgow and Clyde</td>
<td>7.6%</td>
<td>2,197.3</td>
<td>59.6</td>
<td>19.3%</td>
<td>3.0%</td>
<td>99.9%</td>
<td>27.3%</td>
</tr>
<tr>
<td>Highland</td>
<td>9.5%</td>
<td>639.7</td>
<td>16.0</td>
<td>61.9%</td>
<td>-1.2%</td>
<td>81.0%</td>
<td>8.7%</td>
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<tr>
<td>Lanarkshire</td>
<td>7.5%</td>
<td>1,160.9</td>
<td>31.7</td>
<td>26.7%</td>
<td>-1.6%</td>
<td>83.3%</td>
<td>11.2%</td>
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<tr>
<td>Lothian</td>
<td>7.2%</td>
<td>1,392.2</td>
<td>30.5</td>
<td>32.7%</td>
<td>-1.2%</td>
<td>94.6%</td>
<td>9.8%</td>
</tr>
<tr>
<td>Orkney</td>
<td>9.7%</td>
<td>49.1</td>
<td>1.4</td>
<td>35.8%</td>
<td>-1.7%</td>
<td>96.6%</td>
<td>16.5%</td>
</tr>
<tr>
<td>Shetland</td>
<td>7.9%</td>
<td>52.8</td>
<td>2.2</td>
<td>67.2%</td>
<td>-1.9%</td>
<td>100.0%</td>
<td>53.5%</td>
</tr>
<tr>
<td>Tayside</td>
<td>9.5%</td>
<td>764.0</td>
<td>23.4</td>
<td>65.2%</td>
<td>-0.1%</td>
<td>83.8%</td>
<td>16.2%</td>
</tr>
<tr>
<td>Western Isles</td>
<td>11.0%</td>
<td>78.1</td>
<td>2.5</td>
<td>25.5%</td>
<td>7.9%</td>
<td>100.0%</td>
<td>9.0%</td>
</tr>
<tr>
<td>Scotland</td>
<td>8.1%</td>
<td>9,627.0</td>
<td>257.9</td>
<td>34.9%</td>
<td>N/A</td>
<td>92.7%</td>
<td>16.8%</td>
</tr>
</tbody>
</table>

Key
- >50%<1%<95%>20%<90%
- 20-50%-1 to 0%95-99.9%10-20%90-94.9%
- <20%>0%100%<10%≥95%

Notes:
1. Core revenue outturn and savings data is at 2015/16 financial year end. Non-recurring savings are expressed as a percentage of total savings. NRAC is the NHS Scotland Resource Allocation Committee and is expressed as the percentage distance from parity.
2. Treatment Time Guarantee (TTG) performance is expressed as the percentage of patients who waited less than 12-weeks for an inpatient/day case appointment for the quarter-ending March 2016. Treatment Time Guarantee unavailability is expressed as the percentage of patients who were unavailable for an appointment for the month-ending March 2016.
3. Referral to outpatient appointment performance is expressed as the percentage of patients waiting less than 12-weeks for the quarter-ending March 2016.

Notes continued...(page 31)
### Exhibit 7 continued

<table>
<thead>
<tr>
<th>Performance</th>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accident and emergency</strong></td>
<td><strong>Change in bed days occupied by delayed discharge patients</strong></td>
</tr>
<tr>
<td>91.2%</td>
<td>-17.8%</td>
</tr>
<tr>
<td>95.2%</td>
<td>-10.6%</td>
</tr>
<tr>
<td>94.3%</td>
<td>-21.3%</td>
</tr>
<tr>
<td>95.5%</td>
<td>5.2%</td>
</tr>
<tr>
<td>92.0%</td>
<td>-13.2%</td>
</tr>
<tr>
<td>96.1%</td>
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<tr>
<td>90.5%</td>
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<tr>
<td>97.0%</td>
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<td>91.9%</td>
<td>16.1%</td>
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<tr>
<td>92.1%</td>
<td>-10.9%</td>
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<tr>
<td>98.8%</td>
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<td>99.5%</td>
<td>-2.1%</td>
</tr>
<tr>
<td><strong>93.1%</strong></td>
<td><strong>-8.9%</strong></td>
</tr>
</tbody>
</table>

| **<90%** | **>0%** | **>5%** | **>10%** | **>50%** | **>10%** | **>50%** | **>3%** |
| 90-94.9% | 4-5% | 5-10% | 0-50% | 5-10% | 0-50% | 1-3% |

4. Accident and emergency performance is expressed as the percentage of patients who waited less than four hours to be seen in March 2016.
5. Change in the number of bed days occupied by delayed discharge patients is expressed as the annual percentage change between 2014/15 and 2015/16.
6. Sickness absence is the number of hours lost as a percentage of the total contracted hours in 2015/16. The LDP standard for this is four per cent.
7. Vacancy rates are expressed as a percentage of the establishment at March 2016.
8. Agency spending is expressed as the percentage change in spend between 2014/15 and 2015/16. *NHS Western Isles spent £0 on nursing and midwifery agency costs in 2014/15, but £158,000 in 2015/16.
9. The key is based on Audit Scotland’s assessment of the performance of boards against each indicator.

Source: Audit Scotland using financial data from the Scottish Government financial reports and consolidated accounts, performance and workforce data from ISD Scotland, and agency spend data using information provided by individual NHS boards.
64. NHS boards can record patients waiting for outpatient or inpatient treatment as being unavailable for treatment. This means that the period when a patient is unavailable for treatment or unable to attend an appointment is not included in the patient’s overall waiting time. The national average in March 2016 was 17 per cent, which is a slight improvement from 18.5 per cent in March 2015. The main reasons for patients being unavailable were personal commitments (22 per cent), other medical conditions (22 per cent), patients requesting a named consultant (23 per cent) and patients requesting to be treated within their local NHS board (14 per cent).

65. The trend in reasons for unavailability has been fairly consistent since April 2014. Patient unavailability against the TTG standard at March 2016 was highest at NHS Shetland (54 per cent), NHS Greater Glasgow and Clyde (27 per cent) and NHS Borders (17 per cent). NHS Greater Glasgow and Clyde has consistently been one of the top three boards for patient unavailability throughout the year. The board recorded the main reasons for patient unavailability as patients requesting a named consultant (44 per cent of unavailable patients), followed by patients requesting to be treated within their local NHS board (22 per cent of unavailable patients).

66. The target that no patient should wait in hospital for more than 14 days from when they are clinically ready for discharge was not met by any board throughout 2015/16. An exception was in NHS Borders, Orkney and Shetland in some months of the year. However, there have been some improvements in performance compared to 2014/15:

- At March 2016, 49 per cent of patients delayed for discharge from hospital were delayed for more than 14 days, a slight improvement from 51 per cent at March 2015 (excluding code 9 delays).

- The total number of bed days occupied by delayed discharge patients in 2015/16 reduced by nine per cent compared to 2014/15, from 623,438 to 567,853. However, this pattern masks wide variation among boards.

- In 2015/16, the overall delayed discharge bed day rate per 1,000 population aged 75 and over was 915. This is a 12.5 per cent reduction from 1,044 in 2014/15.

67. There have also been improvements in performance against some other targets. This includes more people in deprived areas stopping smoking and an increasing proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer. Performance against the target that at least 80 per cent of pregnant women will have booked for antenatal care by the twelfth week of gestation was exceeded in 2014/15, at just over 82 per cent (data for 2015/16 is still to be published). NHS boards are also trying to reduce their spending on the private sector. Boards use the private sector to increase short-term capacity and when specialist treatment is not available in the NHS. Private sector spending does not include agency staff costs. Since 2010/11, NHS spending on using the private sector increased by 18 per cent in real terms, from £69.5 million to £81.8 million in 2015/16 (0.7 per cent of total revenue expenditure). However, this reduced over the last year by four per cent from £85.3 million in 2014/15.
68. The Scottish Government has a strong focus on national targets. We have commented in previous reports about the extensive effort that NHS boards put into meeting these targets. NHS boards are under significant pressure to meet hospital waiting time targets, in particular. This does not help to support the overall strategy of moving to more community-based care. Funding is focused on meeting acute targets and it is unclear what the unmet need in the community is as this is not measured. Most boards are overspending on their acute budgets. Some NHS boards have agreed with their Boards that they face risks in continuing to achieve performance targets while remaining in financial balance and meeting financial targets (NHS Ayrshire and Arran, Lothian and Grampian).

69. The Scottish Government announced in June 2016 that it will review national NHS targets. The review’s aim is to ensure the targets deliver better outcomes for patients and make best use of NHS resources. It will also look at how targets help to deliver the national strategy for the future direction of NHS and social care services. An expert group will be set up to lead the review and work with staff, stakeholders, social care and clinical bodies. The group is due to report its findings by early 2017.
Part 2
Service reform

Key messages

1 The NHS is undergoing significant changes in how it delivers its services. This is at a time of great uncertainty about the detail and implications of many of the changes planned, and while it is facing considerable financial challenges.

2 The Scottish Government has had a policy to shift the balance of care for over a decade. It has published a number of strategies aimed at reducing the use of hospitals and supporting more people in the community. But most spending is still on hospitals and other institutional-based care.

3 New integration authorities are still developing and some progress is being made in shifting to new models of care, but it is not happening fast enough to meet the growing need. Effective leadership and a clear plan are required to manage the change.

The NHS is undergoing significant change

70. Over the last decade, there have been improvements in the way services are delivered and reductions in the time that patients wait for hospital inpatient treatment. There have also been improvements in overall health, life expectancy, patient safety and survival rates for a number of conditions, such as heart disease. However, the health of Scotland’s population is still poor compared to other developed countries and significant health inequalities still exist. A review of public health in Scotland states that ‘The population health challenge remains complex and persistent and current measures are not seen to be sufficiently accelerating improvement in the country’s public health.’ The report highlights that in Scotland there:

- is lower life expectancy than our European counterparts, with no single explanation
- are high levels of preventable death, disease and poor health in the ageing population
- are continued increases in the numbers of overweight and obese people, which could overturn life expectancy gains achieved in recent decades
- are high levels of poor health from multiple conditions, in particular of people with both physical and mental health conditions.55
71. The NHS in Scotland is undergoing major reform. A number of significant changes to the way health and social care services are delivered are under way or planned. These include:

- national policy aimed at transforming the way services are delivered, including shifting the balance of care from hospital-based services to more community-based services:
  - 2020 Vision for health and social care
  - National Clinical Strategy
- integrating health and social care services
- a new GP contract from April 2017
- a review of the current structure of NHS boards.

72. The Scottish Government has had a policy to shift the balance of care for over a decade. It has published a number of strategies aimed at reducing the use of hospitals and supporting more people in the community. In 2004, the then Scottish Executive commissioned an expert group to consider the necessary changes required to ‘build a health service for the future’. The report, published in 2005, made various recommendations and outlined a new way of delivering care to expand services in the community and deliver care as locally as possible and as specialised as necessary. It highlighted the need for a whole-system approach with partnership working and better integration of primary, secondary and social care.

73. In response, the Scottish Executive set out an action plan that aimed to shift the balance of care through Community Health Partnerships (CHPs) and expanding community services. It identified four main priority areas for investment and reform to transform the NHS:

- the NHS is as local as possible
- systematic support for people with long-term conditions
- reducing the inequalities gap
- actively managing hospital admissions.

74. In September 2011, the Scottish Government set out an ambition to enable everyone to live longer, healthier lives at home or in a homely setting by 2020. This restated many of the aims set out by the Scottish Executive in 2005. These were to have a healthcare system with integrated health and social care, and a focus on preventing and anticipating problems, and helping people to manage their conditions. Two years later, the Scottish Government set out high-level priority areas for action during 2013/14 for its 2020 Vision for health and social care.

75. In June 2015, the Cabinet Secretary for Health and Sport confirmed that the Scottish Government and NHS boards had not made sufficient progress towards delivering the 2020 Vision. The Scottish Government published a National Clinical Strategy in February 2016, including new measures for delivering the 2020 Vision and setting out its plans for health and social care in Scotland over the next ten to 15 years. It describes a number of new proposals and changes to current services. This includes the following:
• GPs to focus on care that is more complex and the wider primary care team to develop extended skills and responsibilities

• a new structure for a network of hospital services with more specialties planned and provided on a regional or national basis

• the development of up to six new centres for planned diagnostic and surgical procedures and four major trauma centres

• a strong focus on the need to reduce waste, harm and variation in treatment and to make more use of technology to support and improve care.

76. The Scottish Government has introduced several major strategies, reviews and reform since 2015 aimed at addressing the changing needs of the population and improving health (Exhibit 8, page 37).

The Scottish Government’s long-term aim to shift the balance of care has still to be realised

77. Since 2005, there have been improvements in the way services are delivered with more of a focus on developing community services. There have been reductions in the time that patients wait for hospital inpatient treatment and the length of time they stay in hospital. There has also been a shift to more day case and outpatient treatment. There have been improvements in overall health, life expectancy and survival rates for a number of conditions, such as heart disease. However, there has not been a significant shift in the balance of care.

78. The latest available figures show that in 2014/15, for health and social care combined, 56 per cent of spending was on hospital care, care homes and other accommodation-based social care, compared to 44 per cent spent on community-based care. For the NHS alone, 62 per cent of expenditure was for hospital services, compared to 38 per cent spent on community health services. These percentages have remained the same for the last five years and most spending is still on hospitals and other institutional-based care. 66

79. It is not clear what the Scottish Government’s aim of shifting the balance of care looks like and how it will be achieved. But indications of a shift would include reducing A&E attendances, emergency admissions to hospital and delayed discharges from hospital. This will require either reducing acute spending to shift resources into the community, or investing additional resources in the community while maintaining spending on acute services. The NHS cannot continue to do everything within the current resources and needs to slow the rate of growth of hospital demand. In Canterbury, New Zealand, spending was prioritised on those in greater need to reduce relying on residential care and to keep people in their own homes for longer. This had the effect of reducing demand and costs for hospital and other institutional care, and allowed for more investment in the community. We provide more information on this on page 31 of our Changing models of health and social care report and Case study 10 of the accompanying supplement.
### Overarching policy

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>The three quality ambitions – safe, patient-centred and effective – underpin all healthcare policy</td>
<td>The overall aim is to provide care closer to home or in a homely setting</td>
<td>Sets out a vision of what will be required from the workforce</td>
<td>All integration authorities were in place by April 2016. They are expected to coordinate health and care services to improve outcomes for their local population</td>
</tr>
</tbody>
</table>

#### National Clinical Strategy (February 2016)
- Includes new measures for delivering the 2020 Vision
- Sets out plans for health and social care over the next 10-15 years
- A new structure for a network of hospital services with more specialties planned and provided on a regional or national basis
- Development of up to six new centres for planned diagnostic and surgical procedures and four major trauma centres
- GPs to focus on care that is more complex and the wider primary care team to develop extended skills and responsibilities

### Consultation with the public

<table>
<thead>
<tr>
<th>Creating a healthier Scotland: What matters to you? (March 2016)</th>
<th>Our Voice (June 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation with people who use or work in health and social care services</td>
<td>To support people to get involved in planning and improving health and social care services</td>
</tr>
</tbody>
</table>

### Changes to General Practice Contract

<table>
<thead>
<tr>
<th>Removal of the quality and outcomes framework (QOF) – April 2015</th>
<th>Groups of GP practices (clusters) in local areas working together more closely and setting clear outcomes focusing on providing integrated care – during 2016/17</th>
<th>New GP contract from April 2017</th>
</tr>
</thead>
</table>

### National strategies and reports

<table>
<thead>
<tr>
<th>Realistic Medicine (January 2016)</th>
<th>Palliative Care Framework (December 2015)</th>
<th>Cancer Strategy (March 2016)</th>
<th>6 Essential Actions to Improving Unscheduled Care (May 2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Medical Officer report focusing on reducing waste, harm and variation in treatment</td>
<td>Sets out a vision for the next 5 years, with outcomes and 10 commitments to support improvements in the delivery of palliative and end-of-life care</td>
<td>Sets out ambitions and actions in 7 key areas, including prevention, improving survival, early detection and diagnosis, and improving treatment</td>
<td>A national two-year programme which aims to improve unscheduled care</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Highlights that the health of Scotland’s population is still poor and significant health inequalities still exist</td>
<td>Considers the implications of delivering a sustainable seven-day clinical service across NHS Scotland and includes proposals for working towards achieving it</td>
<td>Proposed framework and priorities for mental health for the next ten years</td>
<td>Recommends a model for out-of-hours and urgent care in the community</td>
</tr>
<tr>
<td>Makes recommendations for development of a national public health strategy</td>
<td></td>
<td>Strategy due to be published in late 2016</td>
<td>Delivery plan due to be published in late 2016, with £10 million funding</td>
</tr>
</tbody>
</table>

Source: Audit Scotland
The population is growing and ageing, and people are living longer with multiple conditions and more complex needs. This is putting increasing pressure on NHS boards’ finances, as funding is not keeping pace with the increasing needs of the population. Demand for hospital services continues to rise. This makes it difficult for NHS boards to release resources to invest in more community-based services. At the same time, demand for community services, such as GP appointments, is also rising (Exhibit 9). But there are not significant additional resources available.

New integration authorities are still developing

Integrating health and social care is central to delivering transformational change and shifting the balance of care from hospitals to more homely and community-based settings. Under new arrangements for health and social care, NHS boards and councils are required, as a minimum, to combine their budgets for adult social care, adult primary healthcare and aspects of adult secondary healthcare. This accounts for more than £8 billion of funding that NHS boards and councils previously managed separately. The new integration authorities are expected to coordinate health and care services, and to commission NHS boards and councils to deliver services in line with a local strategic plan. Over time, the intention is that this will lead to a change in how services are provided, with a greater emphasis on preventative services. This means providing care for people in their home or local community, and reducing admissions to hospital. Our recent report on progress towards integration of health and social care services sets out the structure and requirements of integration authorities in more detail.

Exhibit 9
Indicators of demand for NHS services, 2008/09 to 2015/16
Demand for NHS services in Scotland continues to increase.

<table>
<thead>
<tr>
<th></th>
<th>2008/09</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients waiting for an appointment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatients</td>
<td>145,474</td>
<td>275,517</td>
</tr>
<tr>
<td>Inpatients/day case patients</td>
<td>56,746</td>
<td>59,900</td>
</tr>
<tr>
<td>Accident and emergency attendances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008/09</td>
<td>140,189</td>
<td>144,923</td>
</tr>
<tr>
<td>2015/16</td>
<td>18,319,080</td>
<td>16,902,021</td>
</tr>
<tr>
<td>GP consultations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:
1. Outpatients waiting: the number of patients waiting for an outpatient appointment at March.
2. Inpatients waiting: the number of inpatient or day case patients waiting for an appointment at March.
3. Accident and emergency attendances: the number of patients that attended Accident and Emergency in March.
4. GP consultations: The number of GP consultations carried out in that year. Data is actual for 2008/09, but projected for 2015/16 using the same figures as the Changing models of health and social care report, Audit Scotland, March 2016.
5. 2015/16 outpatient appointment data includes referrals from all sources, but 2008/09 data only includes referrals from GPs and general dental practitioners.

Source: Audit Scotland using ISD Scotland data as at June 2016
82. All 31 integration authorities were operational by the statutory deadline of 1 April 2016. However, there have been difficulties in agreeing budgets and delays in developing comprehensive strategic plans. Councils normally set their budgets by February, whereas many NHS boards do not finalise their budgets until June. In April 2016, integrated joint boards (IJBs) in five NHS board areas had not yet finalised their budgets (Fife, Lanarkshire, Lothian, Orkney and Tayside). None of the integration authorities have set budgets for future years, although some have indicative budgets. For 2016/17, the amount that NHS boards delegated to integration authorities and the total income that NHS boards received from their integration authorities was either the same, or almost the same. This indicates there has been little change in the way services are being provided during 2016/17.

83. As at April 2016, most integration authorities were still developing performance management frameworks and establishing how progress towards delivering the national outcomes for health and well-being will be measured. Dumfries and Galloway IJB has agreed a three-year workforce plan, but workforce plans covering more than one year have still to be developed in other integration authorities. The governance arrangements for integration authorities can be complex and in several NHS board areas there are different reporting regimes in place. In some areas, local auditors of NHS boards highlighted the governance arrangements, such as roles, responsibilities and oversight, as a risk (Borders, Fife, and Lanarkshire). Local auditors also highlighted that reporting arrangements between NHS boards and the IJBs need to improve (Lanarkshire and Greater Glasgow and Clyde).

84. NHS boards in some areas have highlighted challenges they are facing owing to the way IJBs are operating in their area. These include:

- difficulties in decision-making – where IJBs have different views or priorities from each other or from the NHS board. It can also take a lot longer to reach decisions if separate discussions are being held in the NHS board and the IJBs. In Grampian, a senior leadership team, with representation from the NHS board and three IJBs, meets quarterly to review performance and make joint decisions about services

- a potential for services to become fragmented – some services are board-wide but decisions about how they are provided have to be agreed across multiple IJBs. In Ayrshire and Arran, each of the three IJBs host different specialist services on behalf of the other IJBs, such as inpatient mental health services. The board reports that this is often more practical and cost-effective than setting up separate arrangements to deliver services for individual IJBs

- clarity of operational and strategic responsibilities – accountability is not always clear, particularly when issues affect services that are not required to be delegated to the IJB. For example, delayed discharges involve a wide range of hospital specialties. In most IJBs, hospital services included in integration are those inpatient medical specialties which have the largest proportion of emergency admissions to hospital. Other hospital specialties are often not included. Argyll and Bute IJB and Dumfries and Galloway IJB are overseeing all NHS acute services, including planned and unplanned hospital services. In theory, this should allow these IJBs to better coordinate all health and care services in their area.
During 2015/16, a lot of time and effort was put into setting up the new bodies. Although integration authorities are now operational, there is still considerable work to do to ensure they are operating effectively. It is important for integration authorities to get these arrangements working, so they can focus on delivering their objectives and work towards improving outcomes for their local populations. It is therefore unlikely they will make a major impact during 2016/17. We plan to carry out further work on the progress made by integration authorities after their first year of being established and on their longer-term impact.

Some progress is being made in developing approaches to transformational change

In our report Changing models of health and social care, we highlighted that the shift to new models of care, that is transforming how care services are provided, is not happening fast enough to meet the growing need. We found that the new models of care in place were generally small-scale and were not widespread. We also recommended that the Scottish Government develops a clear framework to guide local development and consolidate evidence of what works. NHS boards and integration authorities also need to ensure that new models for how they provide care are properly planned, implemented, monitored and evaluated. This is to ensure they provide value for money and sustainability.

Although there is still limited evidence of transformational change, some progress is being made in developing approaches that aim to enable more change to happen:

- Testing new models of care in the community – in May 2016, the Scottish Government allocated £20 million of primary care transformation funding plus £10 million of mental health funding to NHS boards to test new ways of working. It is also supporting ten primary and community care ‘test sites’. The Scottish Government is providing support and advice to local areas in how to monitor and evaluate projects. It is also coordinating regional and national events to ensure learning is shared. It is still too early to see benefits or improved outcomes from these new models, but the Scottish Government is developing a framework to consolidate emerging evidence.

- Primary care teams to play a lead role – this approach is being tested in local areas. The new GP contract has still to be agreed. It needs to recognise and support the role of general practice in helping to implement the changes required to shift the balance of care. GPs are taking on more strategic roles and working with new integration authorities to help lead change. During 2016/17, a new approach is being introduced that requires groups of GP practices (clusters) in local areas to work together more closely. GP clusters are required to agree a clear set of outcomes with local partners, such as the NHS board and integration authorities, that focus on providing integrated services that benefit patients.

- Realistic medicine – the Chief Medical Officer’s annual report and the National Clinical Strategy outline the need to reduce waste, harm and variation in treatment. There is evidence of oversupply of some services or interventions, including some that are of limited value. It is estimated that up to 20 per cent of mainstream clinical practice brings no benefit to the patient. This includes increased over-investigation and treatment, prescribing multiple drugs that are of limited benefit and lead to excessive...
side-effects, surgical procedures with low benefits to patients, and clinical variation that is not reasonably explained by patient need. The Scottish Government is working with NHS boards to resolve these issues. It is also trying to ensure patients are more involved in making decisions and receive better information about potential treatments to enable them to make informed decisions.

- **Improving efficiency** – NHS boards will need to make unprecedented levels of savings in 2016/17 and identifying recurring savings is becoming increasingly difficult. However, it is recognised that there is still significant variation among boards and opportunities for further efficiencies to be made. This includes making better use of technology. A national sustainability and value programme board has been set up (paragraph 20, page 13). The Cabinet Secretary for Health and Sport has also committed to review the number, structure and roles of NHS boards. The timescales for this are not clear yet. The National Clinical Strategy sets out a case for reorganising services. This includes reducing the number of hospitals providing more specialist services and reducing the number of acute sites. These measures aim to make hospital services more efficient and will potentially release resources that could be invested into the community. However, this will take a considerable period of time to put in place. High levels of investment will also be required over the coming years to fund the proposed new diagnostic and treatment centres, due to be completed by 2021/22, and trauma centres. The Golden Jubilee National Hospital is aiming to complete the initial phase of the expansion of its diagnostic and treatment centre by the end of 2016/17. An investment in MRI scanners will provide an additional 10,000 scans per year from 2017/18. The Golden Jubilee is also testing new ways of working to roll out across Scotland, for example learning from an approach in India in treating cataracts with the potential to improve efficiency and outcomes for patients.

**A clear plan for change is needed**

88. We have previously reported that the Scottish Government is not making sufficient progress in achieving its policy aim of shifting the balance of care or keeping pace with the changing needs of the population. The 2020 Vision lacks a clear framework of how it expects NHS boards and councils to achieve this in practice, and there are no clear measures of success, such as milestones and indicators to measure progress. The cost implications of implementing the 2020 Vision are unknown and there is a lack of detail about the main principles of the policy. There is also slow progress in developing the workforce needed for new models of care and a lack of information about capital investment to support the 2020 Vision.

89. The National Clinical Strategy includes new measures for delivering the 2020 Vision and also comments on how health care in Scotland is likely to develop beyond 2020. The new strategy continues to focus on providing more care and support in the community and people being able to live longer, healthier lives at home, or in a homely setting. However, there is also a major focus on hospital services. There is currently considerable uncertainty about the implications of this strategy and other proposed changes. This includes the new GP contract, new models of care, review of NHS board structures and review of national targets. This makes capacity planning particularly challenging for NHS boards as it is not yet clear what resources are needed for the many new models
of care proposed in various strategies. Implementation of the strategy needs to incorporate the principles of the Scottish Government’s wider public service reform. This focuses on prevention and tackling inequalities, working closely with the public to help improve services and meet the needs of communities, and effective partnership working across the public, third and private sectors. Integration authorities in particular will have an important role to play in helping to deliver public service reform.

90. The Scottish Government carried out a consultation with people who use or work in health and social care services during 2015/16 and published a summary of the findings in March 2016. The Scottish Government has committed to consider the findings when developing existing and future policy. In June 2016, the Cabinet Secretary for Health and Sport launched ‘Our Voice’, an approach to support people to get involved in planning and improving health and social care services at an individual, community and national level.

91. The Scottish Government has set up a transformational change programme board with the aim of accelerating progress towards the 2020 Vision. It has membership from across the Scottish Government health directorate, NHS boards, integration authorities, councils, the third sector (such as charities and voluntary groups), and people who use health and social care services. In addition to the National Clinical Strategy, the programme board has identified a number of areas that it will focus on to help to make change happen. It is reviewing the current position with each of these strands and then plans to identify priorities for implementing change. These are:

- public health reform
- health and social care integration
- supporting the wellbeing of children and young people.

92. Many elements of the National Clinical Strategy remain uncertain and a clear plan has yet to be put in place:

- There are no measures or milestones in place that will allow progress to be measured against the strategy.
- The financial implications of implementing the strategy are unknown and it is unclear what funding will be available for it.
- The implications for the workforce have still to be identified. This includes the numbers of various professions, training and skills required for the new ways of working outlined in the strategy.

93. Evidence is still emerging about new models of care, including the impact and outcomes of proposed new ways of working. It is important that the new models of care being tested are properly evaluated and the cost implications fully understood. New ways of working need to be sustainable and affordable within current financial constraints. The Scottish Government, in partnership with NHS boards and integration authorities, should use financial modelling to estimate the cost of implementing its national strategy and how this will be funded. It is challenging for boards to make significant changes to services while continuing to react to immediate pressures. But this makes it more important than ever
to find more efficient ways of working. There also needs to be a real focus on implementing more preventative measures to reduce admissions to hospital. Increasing demand for hospitals is putting more pressure on NHS boards’ acute budgets each year. It is also better for patients to be treated in the community in a more homely setting where possible.

94. The workforce is critical to delivering new models of care. The right staff, with the right skills, need to be available to provide the new ways of working. However, it is not clear yet what number and levels of staff will be required until further work is done on testing new models and a clearer plan is in place. The Scottish Government has published a workforce implementation plan for 2016/17. It states that activity will focus on identifying workforce actions to help tackle health inequalities across Scotland; and developing a workforce to deliver integrated health and social care services across NHS boards, councils and third party providers. However, the plan is high level and does not outline the workforce requirements to deliver the 2020 Vision and the National Clinical Strategy.

95. Each NHS board is required to produce its own workforce plan. Many of these acknowledge the changes that will be required to deliver the national strategies, but they are still working on more detailed plans. There is a lack of long-term workforce planning (more than five years) and many boards’ plans do not sufficiently address problems with recruitment and retention or succession planning. A clear plan for the workforce must be a priority for the programme board. The time to train new staff varies, but it takes several years (at least seven years to train a junior doctor), and this needs to be built into workforce plans. In their manifesto, Scottish ministers have committed to introduce a national and regional workforce planning system across the NHS in Scotland.

96. The King’s Fund, drawing on learning from high-performing healthcare organisations across the world, has identified key areas for reforming the NHS in England. However, the principles identified about what needs to be done to implement new models of care in the medium and longer term are applicable to NHS organisations across the UK. These include:

- engaging doctors, nurses and other staff in improvement programmes
- investing in staff to enable them to achieve continuous quality improvement in the long term so improvement is based on commitment rather than compliance
- recognising the importance of leadership continuity, organisational stability, a clear vision and goals for improvement, and the use of an explicit improvement methodology
- the need for leadership in NHS organisations to be collective and distributed, with skilled clinical leaders working alongside experienced managers
- NHS organisations prioritising leadership development and training (preferably in-house) in quality-improvement methods
Endnotes

2. Real terms figures have been calculated using GDP deflators at market prices, and money GDP: June 2016 (Quarterly National Accounts), National Statistics, July 2016.
6. Inpatient, Day case and Outpatient Stage of Treatment Waiting Times - Monthly and quarterly data to 31 March 2016, ISD Scotland, June 2016. 2015/16 outpatient appointment data includes referrals from all sources, but 2008/09 data only includes referrals from GPs and general dental practitioners.
7. These figures exclude non-core funding which is provided to boards for unpredictable costs such as capital and pension accounting adjustments.
12. The increase of £101 million in the maintenance backlog includes an adjustment for inflation (this was not applied in previous years). It also includes a real-terms reduction of around £40 million in most NHS boards’ backlog position in 2015. NHS Greater Glasgow and Clyde has identified around £50 million of new maintenance from recent surveys.
13. Investment planned for new hospitals: completion of the Queen Elizabeth University Hospital, Royal Edinburgh Hospital, Royal Hospital for Sick Children in NHS Lothian, East Lothian Community Hospital, new hospitals in NHS Dumfries and Galloway, Highland and Orkney.
15. Thirteen out of the 14 territorial NHS boards in Scotland included drug costs as a financial risk in their LDPs.
16. 2015/16 data on total spending by the NHS in Scotland on drugs in hospitals and the community is not available until November 2016. However, 2015/16 data is available on the cost of NHS prescriptions dispensed in the community (£1.1 billion). Also, ISD provided Audit Scotland with data on the top ten drugs used in hospitals for 2015/16.
18. This statistic relates to items reimbursed. ISD data provided to Audit Scotland, August 2016.
20 A generic, or unbranded, drug is comparable to the equivalent branded drug in dosage, strength and quality but is usually cheaper. Prescribing by generic name ensures that when a product comes out of patent, generic drugs/devices can be dispensed against the prescriptions, allowing savings to be realised without any change having to be made to the prescription.


23 Information provided to Audit Scotland from ISD Scotland, July 2016.


26 The cost of all patented drugs is regulated at a UK level to reduce the cost to the taxpayer. The NHS does not cap the price of generic drugs because they are meant to be widely available with prices driven down through competition.

27 ISD data provided to Audit Scotland, August 2016.

28 Health Service Medical Supplies (Costs) Bill Factsheet, Department of Health, 2016.

29 Access to newly licensed medicines progress update, Health Improvement Scotland, HS/S4/16/12/1, Health and Sport Committee, Scottish Parliament, 1 March 2016.

30 ISD data provided to Audit Scotland, August 2016. This figure relates to drugs dispensed in the community.

31 ISD analysis for the Scottish Government, provided to Audit Scotland, August 2016. This relates to drugs dispensed in the community and in hospitals.


33 The New Medicines Fund is funded from rebate payments from the UK Pharmaceutical Price Regulation Scheme (PPRS). The receipts for Scotland from this scheme have not yet been finalised for 2016/17.

34 NHS Scotland Workforce Information - as at 31 March 2016, ISD Scotland, June 2016. For March 2016, there was a coding issue which excluded a small number of staff (approximately 200 WTE) on fixed term secondments within NHS boards. NHS Tayside figures were affected by this the most.


37 The future of general practice - survey results, British Medical Association (BMA), February 2015.

38 Vacancies – NHS Scotland Workforce Information - as at 31 March 2016, ISD, June 2016.

39 ISD consultant vacancy data shows advertised vacancies only. It does not include vacant posts that are not advertised and being covered by other staff such as temporary agency or bank staff.

40 Primary Care Workforce Survey Scotland 2015, ISD Scotland, June 2016.

41 Information provided by NHS boards to auditors, June 2016.

42 NHS Scotland Workforce Information - as at 31 March 2016, ISD Scotland, June 2016.


44 NHS Scotland Workforce Information - as at 31 March 2016, ISD Scotland, 2016; and information provided by NHS boards to auditors, June 2016.

45 Scottish Health Service Costs year ended 31 March 2015, and NHS Scotland Workforce Information - as at 31 March 2016, ISD Scotland.

1. **Unannounced Inspection Report – Care for Older People in Acute Hospitals: Queen Elizabeth University Hospital, NHS Greater Glasgow and Clyde, HIS, December 2015.**

2. **Unannounced Inspection Report – Care for Older People in Acute Hospitals: Aberdeen Royal Infirmary and Woodend Hospital, NHS Grampian, HIS, November 2015.**

3. **Services for older people in Argyll and Bute; Services for older people in the Shetland Islands; Services for older people in the Western Isles: Reports of a joint inspection of health and social work services for older people, The Care Inspectorate and HIS, February 2016, November 2015 and March 2016.**

4. **Community nursing staff in post and vacancies, ISD Scotland, June 2015; Nursing and midwifery staff in post, ISD Scotland, September 2015.**

5. **Number of GPs in Scotland by age, designation and gender, ISD Scotland, December 2015.**

6. **Overall NHS Scotland workforce summary by staff grouping, ISD Scotland, June 2016.**

7. **Local Delivery Plan Guidance 2016/17, Scottish Government, January 2016.**

8. **Patients recorded under ‘code 9’ are those with complex needs. This includes patients delayed due to waiting for a place in a high-level needs specialist facility where no facilities exist or where an adult may lack capacity under adults with incapacity legislation.**


10. **A National Framework for Service Change in the NHS in Scotland, Scottish Executive, May 2005.**


12. **Route map to the 2020 Vision for health and social care, Scottish Government, May 2013.**


15. **Health and social care integration: Progress update, Audit Scotland, December 2015.**

16. **All areas, apart from Highland, are following the body corporate model, creating an Integration Joint Board to plan and commission integrated health and social care services in their areas. Highland is following the lead agency model, continuing arrangements established in earlier years for integrated services. In this model, the NHS board and the council delegate some of their functions to each other.**

17. **The national health and wellbeing outcomes are high-level statements of what health and social care partners are attempting to achieve through integration and improving quality across health and social care. [http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes](http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes)**


19. **Chief Medical Officer’s Annual Report 2014-15: Realistic Medicine, Scottish Government, January 2016.**

20. **Changing models of health and social care, Audit Scotland, March 2016.**


22. **https://ourvoice.scot/**

23. **Reforming the NHS from within: Beyond hierarchy, inspection and markets, The King’s Fund, June 2014.**
# Appendix

## NHS financial performance 2015/16

<table>
<thead>
<tr>
<th>NHS board</th>
<th>£(000) Revenue Resource Limit</th>
<th>£(000) Outturn</th>
<th>£(000) Variance</th>
<th>£(000) Capital Resource Limit</th>
<th>£(000) Outturn</th>
<th>£(000) Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>725,762</td>
<td>725,697</td>
<td>66</td>
<td>43,409</td>
<td>43,408</td>
<td>1</td>
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<tr>
<td>Borders</td>
<td>214,209</td>
<td>214,119</td>
<td>90</td>
<td>2,375</td>
<td>2,369</td>
<td>6</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>306,487</td>
<td>306,427</td>
<td>60</td>
<td>60,075</td>
<td>60,058</td>
<td>17</td>
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<tr>
<td>Fife</td>
<td>665,244</td>
<td>665,010</td>
<td>234</td>
<td>12,562</td>
<td>12,550</td>
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</tr>
<tr>
<td>Forth Valley</td>
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<td>533,772</td>
<td>201</td>
<td>3,894</td>
<td>3,894</td>
<td>0</td>
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<tr>
<td>Grampian</td>
<td>963,459</td>
<td>963,316</td>
<td>143</td>
<td>11,249</td>
<td>11,249</td>
<td>0</td>
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<tr>
<td>Greater Glasgow and Clyde</td>
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<td>2,310,894</td>
<td>240</td>
<td>81,370</td>
<td>81,344</td>
<td>26</td>
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<tr>
<td>Highland</td>
<td>662,779</td>
<td>662,680</td>
<td>99</td>
<td>10,925</td>
<td>10,925</td>
<td>0</td>
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<tr>
<td>Lanarkshire</td>
<td>1,187,796</td>
<td>1,187,515</td>
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Note: Figures include core and non-core revenue and capital funding (resource limit) and expenditure (outturn).

Source: Scottish Government consolidated accounts, June 2016
NHS in Scotland 2016

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1. **Purpose of Report**
   1.1. The purpose of the report is to:-
   
   ♦ summarise the key findings contained in the report by the Accounts Commission
   ♦ identify areas for further consideration by the Council and the Integration Joint Board for Health and Social Care
   ♦ provide the information on how these issues are being addressed

2. **Recommendation(s)**
   2.1. The Integration Joint Board is asked to approve the following recommendation(s):-
   
   (1) that the key recommendations made by the Account Commission, detailed at Appendix 1 of this report, are noted; and
   (2) that the development of an action plan by the Director, Health and Social Care to address the recommendations be noted.

3. **Background**
   3.1. The overall aim of the audit was to examine how effectively councils are planning to address the financial and demographic pressures facing social work. The objectives were to assess:-
   
   ♦ the scale of the financial and demand pressures facing social work
   ♦ the strategies councils are adopting to meet these challenges
   ♦ the effectiveness of governance arrangements, including how elected members lead and oversee social work services
   ♦ the impact of financial and demand pressures on people who use services and on carers, and how councils involve them in planning how services are provided

3.2. The report has three parts:
   
   ♦ part one challenges facing social work services
   ♦ part two strategies to address the challenges
   ♦ part three social work governance and scrutiny arrangements
3.3. Current approaches will not be sustainable given the scale of the challenge, and there are risks that reducing costs further could affect the quality of services. Fundamental decisions are required on long-term funding and social work service model for the future.

4. National perspective
4.1. Since 2010/2011, councils’ total revenue funding has reduced by 11% in real terms. Social work spending increased by 3% in real terms over the same period, and now accounts for a third of overall council spending. Further reductions in councils’ budgets are an additional pressure on social work services, particularly as their financial commitments continue to increase.

4.2. Council’s Social Work Resources provide important services to some of the most vulnerable people across Scotland. But they are facing significant challenges. These include financial pressures caused by a real-terms reduction in overall council spending, demographic changes, and the cost of implementing new legislation and policies. The Accounts Commission have estimated that these changes require councils’ social work spending to increase by between £510 and £667 million by 2020 (16–21% increase), if councils and Integration Joint Boards (IJBs) continue to provide services in the same way.

4.3. Councils are implementing a wide range of legislation and policy changes aimed at improving services, better supporting carers, improving outcomes for people and increasing the wages paid to adult care workers. This has significant financial implications.

4.4. Key policy initiatives reflect:
- increased personalisation of services
- an increased focus on prevention
- an increased focus on joint working
- supporting carers
- duties on public bodies to coordinate the planning, design and delivery of services for children and young people with a focus on improving wellbeing outcomes

4.5. The Accounts Commission notes the impact of demographic change on Health and Social Care spending particularly people living longer with health and care needs.

4.6. Between 2012 and 2037, Scotland’s population is projected to increase by 9%. All parts of the population are projected to increase, but by different amounts:
- the number of children by 5%
- the working age population by 4%
- the number of people of pensionable age by 27%

4.7. Although life expectancy continues to increase, Healthy Life Expectancy (HLE), that is the number of years people can expect to live in good health, has not changed significantly since 2008. This means that a larger number of older people may require support for longer, unless HLE increases.

4.8. The Scottish Government has estimated that over the period 2012-32, spending on social care for older people will need to increase by between 1.5 per cent and 3.3 per cent a year, depending on changes to HLE.
4.9. As at July 2015, 17,357 children in Scotland, around 1.8% of the total, were looked after or on the Child Protection Register. Of these 15,404 were looked after, 2,751 were on the child protection register and 798 were both looked after and on the register. The number of children on the Child Protection Register increased by 34% between 2000 and 2015, with three in every 1,000 children under 16 now on the Register.

5. Local perspective
5.1. Social work in South Lanarkshire has a number of challenges, which require strategic and operational responses. Many of these challenges arise from the socio-economic ‘make-up’ of the local authority area. The following information describes some of these challenges:

- The population of South Lanarkshire is projected to rise by 14,611 by 2021, with the most significant increase being in the older people population, which for the 65+ age group will rise by over 2% per annum and a 1.5% for the 85+ age group. Putting this in context in 2011 there were 12,700 people who were 85+ and in 2021 there will be 18,258
- South Lanarkshire has a significant deprivation issue, with the most recent Scottish Multiple Deprivation Index (SIMD) showing that 58 areas in South Lanarkshire are in the 15% most deprived areas in Scotland
- South Lanarkshire also has the fifth largest number of income deprived people and for this reason tackling disadvantage and deprivation is one of the Council’s priority objectives in the Council Plan

5.2. The health of the people of South Lanarkshire is not as good as the average for Scotland as a whole. South Lanarkshire residents have lower life expectancy and they do not enjoy as many years of good health. This is particularly evident within communities identified as economically, socially and environmentally deprived. In the most deprived areas, poor health is a significant problem with one in four of all people saying they have a long-term health condition. Death rates for some conditions such as cancer and strokes are below the Scottish average, but for others including heart disease, they are above the national average.

5.3. South Lanarkshire had 548 children who were being looked after in the period covered by this report. South Lanarkshire had 187 children on the Child Protection Register as at 31 July 2015.

6. Key Roles
6.1. Chief Social Work Officer
6.1.1. The Commission comments on the key role of the Chief Social Work Officer (CSWO) which has changed significantly in recent years and there are risks that CSWOs may have too many roles and have insufficient status to enable them to fulfil their statutory responsibilities effectively.

6.1.2. Scottish Ministers issued revised guidance on the role of the CSWO in July 2016 to reflect the introduction of Health and Social Care Integration. This summarises the minimum scope of the CSWO role, recognising the diversity of the structures and partnerships that deliver social work services. The CSWO’s responsibilities apply to social work functions whether delivered by the Council or by other bodies under integration or partnership arrangements.
6.1.3. CSWOs have strategic and professional responsibility for social work, including monitoring service quality and professional standards. Integration does not change the CSWO’s responsibility to provide professional leadership. This role is also critical in supporting the clinical and professional governance agenda within the Integrated Partnership.

6.1.4. Reporting lines for CSWOs always lie within the Council and the establishment of IJBs does not change this. However, CSWOs now have an additional statutory, non-voting place as adviser to the IJB.

6.2. Elected Members
6.2.1. Councils have a statutory duty to assess people’s social care needs. If they assess a person as needing support and eligible to receive services, they must provide or pay for services to meet these needs.

6.2.2. The integration of health and social care has resulted in complex and varied governance arrangements for social work services. Elected members have important leadership and scrutiny roles, but there are risks that increased complexity could lead to members not having an overall view of social work. It is essential that elected members assure themselves that the quality of social work services is being maintained and that councils are managing risks effectively.

6.2.3. It is important that elected members receive training and guidance on the operation of the new governance arrangements and that elected members not involved in the IJB are fully informed about its operation.

6.2.4. There is scope for councils and their community planning partners to do more to promote and empower communities. This includes working with them to design, commission, deliver and evaluate services to achieve better outcomes, and to build capacity to allow communities to do more to support themselves. Elected members need to play a key role engaging with communities in a wider dialogue about council priorities.

6.2.5. Elected members may find that their role changes, but they remain the key decision-makers for social work services on behalf of their constituents and they ensure effective scrutiny, governance and strategic oversight of the new arrangements. It is essential that elected members assure themselves of the quality of social work services and ensure councils manage risks effectively at a time of great change. With increasing financial pressures, councillors may face a difficult challenge in managing people’s expectations, but they have a crucial role in doing so and providing leadership for their communities.

6.3. Integration Joint Board (IJB)
6.3.1. Under the Public Bodies (Joint Working) (Scotland) Act 2014, councils and NHS boards are required to create integration authorities. These are responsible for the governance, planning and resourcing of adult social care services, adult primary care and community health services and some hospital services. The Act also allows councils and NHS boards to integrate other areas of activity, such as children’s health and social care services and criminal justice social work.
6.3.2. This means that councils delegate to the integration authority their responsibility for strategic planning for adult social services and for any other services they decide to include. Councils still carry the ultimate responsibility for the delivery of social work services in their area. The Public Bodies (Joint Working) (Scotland) Act 2014 aimed to achieve greater integration between health and social care services to improve outcomes for individuals and improve efficiency by ‘shifting the balance of care’ from the acute sector to community settings. The Accounts Commission have previously highlighted the risk that ultimate responsibility might lie with IJBs, which plan and direct councils and NHS boards in how services are to be delivered. All parties need to recognise this risk and set out clearly an agreed understanding of each other’s roles and responsibilities.

6.3.3. Accountability arrangements for the IJB Chief Officer are complex. The Chief Officer has a dual role. They are accountable to the IJB for the responsibilities placed on the IJB under the Act and the integration scheme. They are accountable to the Council and NHS board for any operational responsibility for integrated services, as set out in the integration scheme.

6.3.4. Councils and IJBs need to develop longer-term financial strategies and plans for social work services, taking into consideration the financial pressures. For example, they need to assess the affordability of options for changing the way they deliver services, so that elected members can consult the public and make informed decisions.

6.3.5. In terms of health and social care integration it is important that there are clear linkages between the planning of those services that are integrated and those that are not, for example the transition from children’s services to adult services or between children’s services and criminal justice. Planning for these transitions needs to be well coordinated to ensure a seamless service without overlaps or gaps in services, particularly where responsibility is split between the IJB and the Council.

6.4. Strategic Commissioning Plan

6.4.1. Each IJB is required to produce a strategic plan that includes strategies for all the services delegated to it.

6.4.2. Councils have a statutory duty to assess people’s social care needs. If they assess a person as needing support and eligible to receive services, they must provide or pay for services to meet these needs. Social Work Resources has a lead partnership role in commissioning services for people who require support. The Resource recognises that positive outcomes can be achieved through partnership work with a range of agencies. Services need to be innovative and build on the assets and strengths of individuals and communities.

6.4.3. Councils have achieved significant financial savings through outsourcing services such as homecare to the private and third sectors through competitive tendering and re-tendering contracts. The percentage of homecare provided directly by council staff has fallen steadily, both in terms of the number of clients served and the number of hours provided.
6.5. Carers

6.5.1. In 2010, the Scottish Government reported that unpaid carers saved health and social services an estimated £7.68 billion a year. More recently, Carers UK estimated the value of unpaid care in Scotland to be £10.8 billion, more than three times current Social Work net spending.

6.5.2. The Carers (Scotland) Act 2016 became law in March 2016 and will be implemented on 1 April 2018. It provides for the planning and provision of support, information and advice for unpaid carers and encourages councils to become involved in carers’ services. It also means councils are required to prepare a carer support plan for carers, including young carers, who want one.

6.5.3. There will be further cost implications arising from the new duties.

7. Addressing the Challenges

7.1. Councils, IJBs and other stakeholders all believe that prevention is the key to meeting the growing demands for social work services within finite resources. The report recognises that there has been a limited shift to more prevention and different models of care. Many councils have taken an opportunistic or piecemeal approach to changing how they deliver services, often to meet financial challenges or as the result of initiative funding by the Scottish Government.

7.2. Councils cite various challenges to shifting service models towards prevention:

- a lack of funding because resources are locked into current service models to meet existing demands and savings may not materialise for several years after implementation
- a lack of social worker time – a concern that social work has become crisis based
- managing relatives’ expectations
- community resistance – for example, opposition to closing a local hospital or care facility to free up funding for more accessible community-based care
- cultural differences between councils and the NHS

7.3. Councils have commonly adopted some prevention initiatives, most of which are effective in the short term, but examples of long-term initiatives are more limited. Common prevention activities included:

- re-ablement
- using technology early intervention for children and families
- restricting out of area service for looked-after children

7.4. Within South Lanarkshire, we will develop as part of the Strategic Commissioning Plan a strategy to move towards more distinctive preventative approach whilst recognising the need to maintain a balance with long term care and support obligations. This will include refreshing and refocusing key supporting elements including:

- a telehealth/telecare strategy
- a revised carers strategy
- service redesign and building on an assets based approach
7.5. The report identifies that councils have adopted a number of strategies to achieve savings. They have tightened eligibility criteria so that fewer people receive services and targeted funding to people in greatest need. They have also achieved significant savings in the cost of homecare and care homes through competitive tendering and the national care home contract.

7.6. Councils have discretion on the thresholds for care they use locally. The level set in each council will depend on the resources available and on the Council’s policies and priorities.

7.7. This national standard for eligibility criteria and waiting times for the personal and nursing care of older people was introduced in 2009. The Council’s position on eligibility has not changed since then. It is considered prudent to now review our position in terms of eligibility criteria given the current and emerging pressures.

7.8. The homecare review has identified a range of efficiencies to improve the internal service and provide a rebalancing of the activities between the Councils own service and external providers.

7.9. Councils have a challenging task to manage the market for providing services in their local area. There are potential tensions around making savings while ensuring high-quality services at a fair cost in an environment of increasing demand and financial pressures. There are risks to the quality of services if councils continue to drive down costs at the rate they have in the past without changing how they provide services.

7.10. The Council has demonstrated its support for social care in a number of positive ways. Some examples include:
- investment of £1 million for demographic growth and £1 million to address service financial uplifts in 2016/2017
- recruitment of more home carers to provide the Supporting Your Independence (SYI) approach, which focuses on the capacity of individuals as opposed to a deficit model
- continuing to increase the number of foster carers and prospective adopters to support permanency planning/stability for young people

8. Employee Implications
8.1. There are no employee implications associated with this report.

9. Financial Implications
9.1. The Scottish Government has estimated that over the period 2012-2032, spending on social care for older people will need to increase by between 1.5% and 3.3% a year, depending on changes to HLE. This implies an increases in social work spending of between £510 and £667 million (a 16 – 21% increase) by 2019/2020.

9.2. In 2016/2017, councils’ total revenue funding, that is the funding used for day-to-day spending, will be five per cent lower than in 2015/2016. This is a reduction of 11 per cent in real terms since 2010/2011. This is a significant pressure on all council services, including social work.
9.3. Against the trend of falling council spending, councils’ total social work net spending increased in real terms from £3.2 billion to £3.3 billion between 2010/2011 and 2014/2015, an average increase of 0.8% a year. As a result, spending on social work increased from 28.9% to 32% of council spending.

10. Other Implications

10.1. Risk

10.1.1. The Council’s, IJB’s and resource risk register all reflect the risk associated with diminishing financial resources and the impact of increased demand for services.

10.1.2. The Scottish Government’s Living Wage commitment provides clear benefits for low-paid workers. However, increases in employee costs and contract costs will put pressure on councils’ and service providers’ finances.

10.1.3. Insufficient funding to social work could seriously compromise the authority’s statutory obligations and increases the risk of judicial challenge.

10.1.4. It is important that the scrutiny arrangements reflect the risks associated with managing transitions. Councils and elected members will need to ensure they have a strategic overview of the whole of social work service and ensure that strategy, budget arrangements; commissioning, procurement and workforce planning are coordinated at a council-wide level.

10.2. Sustainability

10.2.1. There are no sustainability issues associated with this report.

11. Equality Impact Assessment and Consultation Arrangements

11.1. This report does not introduce a new policy, function or strategy, or recommend a change to an existing policy, function or strategy and, therefore no impact assessment is required.

11.2. Customer and community consultation is not required as a result of this report.

Val de Souza
Director, Health and Social Care

Date created: 08 November 2016

Previous References

- none

List of Background Papers
Accounts Commission: Social Work in Scotland (September 2016)
Contact for Further Information
If you would like to inspect the background papers or want further information, please contact:-
Pat McCormack, Service Development Manager
Ext: 3708 (Phone: 01698 453708)
Email: pat.mccormack@southlanarkshire.gcsx.gov.uk
Appendix 1: Key recommendations

Social Work Strategy and Service Planning
Councils and IJBs should:
- instigate a frank and wide-ranging debate with their communities about the long-term future for social work and social care in their area to meet statutory responsibilities, given the funding available and the future challenges (paragraph 111)
- work with the Scottish Government, their representative organisation (COSLA or the Scottish Local Government Partnership (SLGP), Social Work Scotland and other stakeholders to review how to provide social work services for the future and future funding arrangements (paragraphs 35–41)
- develop long-term strategies for the services funded by social work by:
  - carrying out a detailed analysis of demographic change and the contribution preventative approaches can make to reduce demand for services (paragraph 52)
  - developing long-term financial and workforce plans (paragraph 81)
  - working with people who use services, carers and service providers to design and provide services around the needs of individuals (paragraphs 69–72)
- working more closely with local communities to build their capacity so they can better support local people who may be at risk of needing to use services (paragraph 112)
- considering examples of innovative practice from across Scotland and beyond (paragraphs 54, 67–68)
- working with the NHS and Scottish Government to review how to better synchronise partners’ budget-setting arrangements to support these strategies (paragraph 36)

Governance and Scrutiny Arrangements
Councils and IJBs should:
- ensure that the governance and scrutiny of social work services are appropriate and comprehensive across the whole of social work services, and review these arrangements regularly as partnerships develop and services change (paragraphs 87–93)
- improve accountability by having processes in place to:
  - measure the outcomes of services, for example in criminal justice services, and their success rates in supporting individuals’ efforts to desist from offending through their social inclusion
  - monitor the efficiency and effectiveness of services
- allow elected members to assure themselves that the quality of social work services is being maintained and that councils are managing risks effectively measure people’s satisfaction with those services
- report the findings to elected members and the IJB (paragraph 90, 108–109)

Councils should:
- demonstrate clear access for, and reporting to, the council by the Chief Social Work Officer (CSWO), in line with guidance (paragraphs 104–106)
- ensure the CSWO has sufficient time and authority to enable them to fulfil the role effectively (paragraphs 102–107)
- ensure that CSWO annual reports provide an annual summary of the performance of the social work service, highlighting achievements and weaker areas of service delivery, setting out the Council’s response and plans to improve weaker areas and that these are actively scrutinised by elected members (paragraphs 108–110)
Workforce
Councils should:
♦ work with their representative organisation (COSLA or the SLGP), the Scottish Government and private and third sector employers to put in place a coordinated approach to resolve workforce issues in social care (paragraphs 21–23)
♦ as part of their contract monitoring arrangements, ensure that providers who use zero hours contracts allow staff to accept or turn down work without being penalised (paragraph 24)

Service Efficiency and Effectiveness
Councils and IJBs should:
♦ when planning an initiative, include evaluation criteria and extend or halt initiatives depending on the success of new approaches in improving outcomes and value for money (paragraphs 53–53)
♦ work with COSLA to review the eligibility framework to ensure that it is still fit for purpose in the light of recent policy and legislative changes (paragraphs 46–47)

Councils should:
♦ benchmark their services against those provided by other councils and providers within the UK and overseas to encourage innovation and improve services (paragraphs 54, 67–68)
1. Purpose of Report
1.1. The purpose of the report is to:-

- provide an update on the consultation process associated with Achieving Excellence: the NHS Lanarkshire Healthcare Strategy
- highlight the close linkage between the Strategic Commissioning Plan of the H&SCP and the Healthcare Strategy
- identify the next steps in the process for the development and execution of the Healthcare Strategy

2. Recommendation(s)
2.1. The Integration Joint Board (IJB) is asked to approve the following recommendation(s):-

(1) that the update on the consultation process associated with the Healthcare Strategy be noted;
(2) that the complementary role of the H&SCP in the preparation and implementation of the healthcare strategy is noted;
(3) that a copy of the outcome of the consultation process be shared at a future meeting of the IJB; and
(4) that regular updates are provided at future meetings of the IJB to share progress in achievement of the respective strategies.

3. Background
3.1. The draft Healthcare Strategy was previously shared with the IJB in June 2016, at which time there was a requirement that the Chair, Chief Executive, NHS Lanarkshire, and other NHS Lanarkshire Directors attend a briefing session with South Lanarkshire Council to provide detail of the content of the Strategy.

3.2. On 5 October 2016, Dr Jane Burns, Medical Director of NHS Lanarkshire Acute Services presented the main aims of the Strategy to the Council and, thereafter, there was a full Q&A session involving the Chief Executive of NHSL and the Chief Officer of the Health and Social Care Partnership.
3.3. This session was part of a full consultation process led by NHS Lanarkshire that involved a series of events across all the main townships as well as some specific requests for special interest groups.

3.4. A report of the consultation process, complete with the main issues arising, is currently being collated and will be brought to the next meeting of the IJB.

3.5. Throughout the consultation process, the linkage between the Healthcare Strategy and the respective Strategic Commissioning Plans of North and South Health and Social Care Partnerships was outlined.

3.6. In taking forward the Healthcare Strategy, the Chief Officer of the H&SCP is a co-chair of the Healthcare Strategy implementation group and there is similarly representation of the Director of Planning from NHSL on the Strategic Commissioning Group of the H&SCP.

3.7. It is recognised that the IJB has a lead role in either providing directly or commissioning a range of ‘in scope’ services which is instrumental to the delivery of the Healthcare Strategy. In some instances, the South H&SCP has the lead role in providing these services on behalf of NHSL and both H&SCPs, for example hosting primary care services.

3.8. The attached schematic outlines the proposed way forward in the planning and delivery of services associated with the Healthcare Strategy.

3.9. A key part of the Healthcare Strategy locally and the 2020 National Healthcare Strategy is to support an increased level of care being provided at home/in homely settings and a reduced reliance on inpatient care. Accordingly, being able to demonstrate revised models of care with a demonstrable shift of resources – both people and finance – will be crucial if the respective strategies are to be delivered effectively.

4. Reporting Arrangements
4.1. Regular reports from the Strategic Commissioning Planning group – which will be responsible for ensuring consistency between the IJB’s agreed priorities and the implementation of the Healthcare Strategy, will be provided to both the IJB and the Performance and Audit Sub Committee.

5. Employee Implications
5.1. There are no employee implications associated with this report.

6. Financial Implications
6.1. There are no financial implications associated with this report.

7. Other Implications
7.1. Being able to demonstrate an effective message which supports increased care at home will be required. Consequently the risks and sustainability issues will be related to the ability of the Partnership to provide strong community based services and a reducing reliance on hospital and residential care. This will need to be supported through a consistent communication strategy involving practitioners at all levels and across all agencies.
8. **Equality Impact Assessment and Consultation Arrangements**

8.1. The Equality Impact Assessment will be undertaken as part of Healthcare Strategy development.

8.2. Whilst many aspects of the ambitions and outcomes described in the draft Strategy will be recognised from other work (for example the 2020 vision, the National Clinical Strategy and local Strategies for cancer, palliative care etc), there are elements of major service change included in the proposals which require mandatory consultation: this includes the preparation of a business case for the redevelopment/replacement of Monklands District General Hospital and the creation of a major trauma unit for Lanarkshire.

8.3. Therefore, the draft Strategy as a whole will be subject to a three month consultation which will assist the NHS Board (and IJBs) to assess the nature and content of the final Healthcare Strategy from 2017 onward.

8.4. The report on the consultation process will include assessment on its conduct from the Scottish Health Council, and their report will be considered by the Cabinet Secretary for Health and Wellbeing.

Val de Souza  
Director, Health and Social Care

**Previous References**  
♦ none

**List of Background Papers**  
♦ none

**Contact for Further Information**  
If you would like to inspect the background papers or want further information, please contact:-  
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Appendix 1

SOUTH IJB

NHS BOARD

NORTH IJB

STRATEGIC DELIVERY BOARD

STRATEGIC DELIVERY TEAM

WORKSTREAM 1

WORKSTREAM 2

WORKSTREAM 3

WORKSTREAM 4

WORKSTREAM 5

WORKSTREAM 6
1. **Purpose of Report**

1.1. The purpose of the report is to:-

- present to the Integration Joint Board (IJB) an update on the work which has been progressed to date by the Strategic Commissioning Group and a summary of feedback on Strategic Commissioning Plans (SCP) by the Scottish Government.

2. **Recommendation(s)**

2.1. The Integration Joint Board is asked to approve the following recommendation(s):-

(1) that it note the work and progress of the Strategic Commissioning Group in assuring that there is good governance and strategic oversight in place to monitor the implementation of the ambitions set out in the Strategic Commissioning Plan 2016-2019; and

(2) that it note the key messages emanating from the Scottish Government’s feedback on Strategic Commissioning Plans across Scotland and the South Partnership position with regards to this.

3. **Background**

3.1. The Public Bodies (Joint Working) (Scotland) Bill passed through the Scottish Parliament on 25 February 2014 and received Royal Assent on 1 April 2014. This Act supports and directs the Scottish Government’s vision of integrated adult health and social care.

3.2. As part of finalising the Regulations and Orders to support the Act, the Government has also issued guidance to partnerships on Strategic Commissioning Plans (SCP).

3.3. Similar to other areas of service delivery, for example Children’s Services whereby a Children’s Services Plan is a statutory requirement under the Children (Scotland) Act 1995, the Public Bodies (Joint Working) (Scotland) Act places a similar duty on Integration Joint Boards, from April 2016 onwards.

3.4. On 29 March 2016, the Integration Joint Board approved its SCP 2016-2019, thus ensuring the final aspect of governance and planning was in place to allow integration to ‘go live’ by the 1 April 2016 target date.
4. **The Work of the Strategic Commissioning Group**

4.1. As part of the approval of the Integration Scheme, the IJB as a legal entity is required to establish a Strategic Commissioning Group (SCG) with a prescribed membership as detailed within the Act.

4.2. Since June 2015, a shadow SCG has met and much of the early work centred around developing the Strategic Commissioning Plan. As referred to above, and with this piece of work now complete, the attention of the SCG has moved to ensuring that there is the necessary governance and accountability in place to oversee the implementation of the strategic intentions.

4.3. Given that the SCP commits to 80 strategic commissioning intentions and 77 associated key performance measures, a piece of work was undertaken which assimilated this into three thematic areas as follows:

- early intervention, prevention and health improvement
- Intermediate Care and Reducing Reliance on Hospital and Residential Care
- mental health

4.4. A thematic group has now been established for each of these areas, with consistent Terms of Reference in place and a schedule of planned meetings. The role and purpose of these groups will be to deliver on the strategic intentions aligned to their theme, whilst ensuring that there is overall consistency across the four localities for priority areas.

4.5. In tandem with this, has been the establishment of four Locality Planning Groups (LPGs), each chaired by a voting member of the IJB as follows:

- Hamilton/Blantyre – Tom Steele (Non-Executive Director)
- Rutherglen/Cambuslang – Councillor Jim McGuigan
- East Kilbride – Councillor Lynsey Hamilton
- Clydesdale – Councillor Allan Falconer

4.6. Each of the four LPGs have now met on a number of occasions and the main areas of their activity has been analysing the strategic needs data and early work to prepare a locality plan for their area which takes account of local issues and priorities within the SCP.

4.7. The SCG has also shaped and directed the work of the strategic needs assessment information to support robust strategic planning. There is now an electronic portal (NEXUS) which has been developed and rolled out which allows locality planning groups to access the following from the one landing page:

- locality and data zone profiles related to population, poverty, health, social care, employment and crime based information
- performance information for the Partnership linked to the key performance indicators
- detailed health information and costs related to acute services and General Practice information
- comparator data between the South Partnership and national trends

4.8. In light of wider recognition by the SCG that health economics expertise and the need to establish a more robust process for prioritisation were elements that should feature in future strategic planning and commissioning decisions, the SCG has secured support from NHS Health Scotland and the Health Economic Department of Glasgow Caledonian University. The ambition from this will be to build capacity and
expertise within the Partnership to ensure this is a feature of any work undertaken within the Commissioning Cycle (analyse, plan, do and review).

5. **Scottish Government Feedback on Strategic Commissioning Plans**

5.1. Related to the above is the recent feedback from the Scottish Government on the structure and content of SCP across Scotland. The Partnership will use this information in conjunction with other planned activity to assist the Partnership to further develop and mature its approach to strategic commissioning. A full copy of the Scottish Government paper is attached within Appendix 1.

5.2. By way of summary, some of the more important key messages with regards to SCPs across Scotland can be summarised as follows:

<table>
<thead>
<tr>
<th>Scottish Government Key Messages</th>
<th>South Lanarkshire Partnership Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Partnerships had an SCP in place by 01 April 2016, although some are less well developed with regards to ambition and pace of change.</td>
<td>South Lanarkshire Partnership SCP was approved on 29 March 2016 and further work requires to confirm the detail of the high level ambitions.</td>
</tr>
<tr>
<td>All plans include the list of delegated functions.</td>
<td>South Lanarkshire plan has list of Council, NHS and NHS hosted functions which will form part of the Partnership.</td>
</tr>
<tr>
<td>Some plans explain how the Partnership will work with the wider Community Planning Partnership agenda to maximise opportunities for joint working.</td>
<td>Health and Care is one of the four Community Planning themes and the Partnership Improvement Plan (PIP) for Health and Care details the contribution of the Partnership to the CPP process. The key elements of the Health and Care PIP directly emanate from the SCP.</td>
</tr>
<tr>
<td>Strategic Planning Groups have been established in each Partnership but this is not well covered in the context of the plan.</td>
<td>Appendix 1 details information on the South Strategic Planning Group.</td>
</tr>
<tr>
<td>Accessibility of the plans was generally good.</td>
<td>The South Lanarkshire Partnership SCP is located within the integration section of the website and copies have been distributed to all locality bases, hospitals and GP practices.</td>
</tr>
<tr>
<td>All Partnerships have undertaken a strategic needs assessment.</td>
<td>This has been one of the major achievements of the Partnership so far, in that there is an integrated electronic tool which details needs and performance data. The linked ISD analytical support is also providing a good return for the Partnership.</td>
</tr>
<tr>
<td>Some plans include Market Facilitation Plans and it is essential that all of these are completed.</td>
<td>This is an area of development that the South Partnership requires to take forward, given the commitments made within the plan to for example intermediate care, care home provision, care at home, Anticipatory Care Plans, health improvement and emergency care demand.</td>
</tr>
<tr>
<td>SCPs do not deal with procurement arrangements.</td>
<td>This is a key aspect of the commissioning process and although procurement exists within both of the parties, a more integrated model of procurement to underpin the SCP commissioning intentions requires to be considered and linked to other aspects such as Market Facilitation Planning.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>There is little evidence that data from the Third and Independent Sectors is included in the strategic needs assessment.</td>
<td>Whilst the Partnership has made good progress in this area, with developments such as the LOCATOR Tool and measuring demand and supply within the independent sector, further work is required and in particular this will be picked up through the Market Facilitation Planning.</td>
</tr>
<tr>
<td>A brief analysis of deprivation in the Partnership was a feature of some plans and is a serious consideration, particularly with regards to tackling inequality.</td>
<td>High level information is contained within the South Lanarkshire Partnership SCP. That said, the Partnership is confident that the detail with regards to deprivation is more than adequately referenced within the electronic needs assessment tool that localities are currently working with. This allows localities to analyse information down to data zone level and includes a host of information regarding the factors influencing inequalities.</td>
</tr>
<tr>
<td>A number of plans include Equality Impact Assessments which outline what the Partnership is doing to develop and publish equality outcomes. All Partnerships must publish equality outcomes to meet their statutory obligations.</td>
<td>The South Lanarkshire Partnership has drafted its Equality Outcomes Statement and this has been submitted to the Equalities and Human Rights Commission (EHRC). Feedback is awaited on this.</td>
</tr>
<tr>
<td>All plans identify strategic priorities and there are a number that are broadly consistent across Partnerships. Where Partnerships have children’s services delegated, specific priorities relating to those services are included.</td>
<td>The South Lanarkshire Partnership Plan has 70+ commissioning intentions which have been aligned to the 10 consultation themes identified and the 9 health and wellbeing outcomes. Children’s services are in the Partnership from a health perspective but remain within the Council from a children’s social care viewpoint. That said, the South Lanarkshire children’s services plan provides strategic oversight for the inter – agency agenda relating to children and young people.</td>
</tr>
<tr>
<td>Plans contain varying levels of financial information. The Scottish Government will support further work on through advice notes and with COSLA.</td>
<td>The South Lanarkshire Partnership SCP has a section which outlines a total health and social care delegated budget and how this is derived from the parties.</td>
</tr>
<tr>
<td>The impact of financial re-modelling of services was not considered in many plans nor the method made clear of how</td>
<td>The Partnership has signed up to building capacity and knowledge with regards to a prioritisation model which</td>
</tr>
</tbody>
</table>
these decisions will be reached with regards to the allocation of resources. includes consideration of techniques such as Programme Budgeting Marginal Analysis and Cost Benefit Analysis. This work is at an early stage of development.

An area requiring specific attention is the financial sum set aside for hospital services. The Scottish Government is working with Partnerships, Health Boards and local authorities to draft good guidance for budget setting to ensure better alignment of processes.

Within the South Lanarkshire Partnership budget a sum of £55.154m has been set aside. The future discussions regarding how this budget will be utilised will be linked to the Healthcare Strategy and IJB Commissioning Intentions. Issues such as future bed modelling and bed configuration across acute sides have been a key facet of these discussions and considerations to date.

The number of localities in each Partnership area ranges from two to none. The size and scope also ranges from the smallest at 1,294 people to 219,422. Further work is required across Partnerships to fully develop their locality arrangements and maximise the potential involvement of communities and local professionals is planning and decision making.

The South Lanarkshire Partnership has agreed four localities with a population size as follows:
- Hamilton/Blantyre – 107,464
- East Kilbride – 88,877
- Clydesdale – 61,616
- Ruther Glen/Cambuslang – 57,872

All four areas have locality planning groups and further work is being undertaken to develop integrated locality operational structures.

Some plans contain a high level summary of workforce issues. It is imperative that integrated workforce plans consider issues for Health and Social Care staff and the independent sectors.

The issue of workforce planning has been considered by both parties and this work now needs to evolve into an integrated workforce plan.

Many plans emphasise the key role of primary care services and GPs as key to local service delivery and locality planning.

Primary Care is a hosted service detailed with the South Partnership SCP. It is acknowledged that there are particular pressures on GP services in particular across Lanarkshire. The Primary Care Transformation Programme which has ring fenced funding of £6.1m will explore new ways of working for Primary Care in Lanarkshire with a view to addressing some of the known challenges in this sector.

In some plans the relationship between the Partnership and acute services is low key and not well covered.

This is an area where it is acknowledged that the relationship between the South SCP Commissioning intentions and the aspirations of the Health Care Strategy need to be strong and complementary. Also, and of equal importance is the relationship between the Chief Officer and Director of Acute Services. In both instances from a South Lanarkshire perspective, there is a clear understanding of the direction of travel.
It is important that hosting arrangements are not used in multi-partnership Health Board areas to maintain existing NHS arrangements, particularly where there is scope through partnerships for greater local ownership.

In total, there are 21 hosted services across both North and South Lanarkshire Partnership, with nine being lead by South and 12 by North. Although at this stage, arrangements have been on maintaining stability and current service provision, both Partnerships are committed to locality at these arrangements moving forwards.

Housing is recognised as a key component of effectively shifting the balance of care. Just over half of the plans contain a Housing Contribution Statement.

The South Lanarkshire SCP has a detailed Housing Contribution Statement that is integral to the plan. In terms of developing the next Local Housing Strategy, the Partnership has and will continue to be a key contributor to shaping the future direction of travel, particularly in relation to intermediate models of care and future housing options within the market place.

All partnerships have developed a performance framework which includes local and national outcomes and measures.

The South Lanarkshire Partnership has developed a comprehensive performance framework which is organised around the nine Health and Wellbeing Outcomes and 10 Commissioning themes which were developed as part of the consultation and engagement process for the SCP. This framework meets a number of requirements, in that it caters for all reporting requirements through a single integrated performance report.

5.3. In terms of delegated functions, the report provides information across the 31 partnerships as to the areas that have been delegated. A total of 30 of the 31 partnerships have a Body Corporate Model of integration with an IJB. Highland is the exception to this and has adopted a Lead Agency Model, whereby NHS Highland leads adult health and social care services and Highland Councils leads children’s health and social care.

5.4. In addition to the minimum requirement to delegate adult health and social care services, the following analysis provides an overview of the number and percentage of other areas which the Council and NHS Board within a partnership area have elected to delegate.

<table>
<thead>
<tr>
<th>Functions</th>
<th>Number of Partnerships who have delegated the functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Health Services</td>
<td>19 or 63% have delegated and 11 or 37% have opted not to delegate</td>
</tr>
<tr>
<td>Children’s Social Care Services</td>
<td>11 or 37% have delegated and 19 or 63% have opted not to delegate</td>
</tr>
<tr>
<td>Criminal Justice Services</td>
<td>16 or 53% have delegated and 14 or 47% have opted not to delegate</td>
</tr>
<tr>
<td>All Acute Services</td>
<td>2 or 7% have delegated and 28 or 93% have opted not to delegate</td>
</tr>
</tbody>
</table>
5.5. From a South Lanarkshire perspective, the Council and NHS Board through the Integration Scheme have delegated all adult health and social care and children’s health services.

6. **Next Steps**

6.1. There are a number of key areas of focus that the Strategic Planning Group will lead and retain oversight of which directly connects to the both the South Lanarkshire SCP and the Scottish Government report on SCPs. In no particular order, the priorities and next steps moving forwards will be:

- further development of the locality planning model involving a phased implementation of an agreed operational management structure
- developing and implementing a transformational change programme which considers the modernisation of services regarding care homes/intermediate care provision, home care, primary care transformation, delayed discharges, Self-directed Support and Asset Based Community Development
- realising the potential from health and social care data linkage to further develop our intelligence and needs assessment profiling to support decision making regard future commissioning intentions
- ensuring close linkage between the SCP and ‘Achieving Excellence’, the NHS Lanarkshire Healthcare Strategy and South Lanarkshire Council Plan Connect

7. **Employee Implications**

7.1. There are no employee implications associated with this report.

8. **Financial Implications**

8.1. There are no financial implications associated with this report.

9. **Other Implications**

9.1. There are no additional risks associated with this report.

9.2. There are no sustainable development issues associated with this report.

9.3. There are no other issues associated with this report.

10. **Equality Impact Assessment and Consultation Arrangements**

10.1. This report does not introduce a new policy, function or strategy, or recommend a change to existing policy, function or strategy and, therefore, no impact assessment is required.

10.2. Customer and community consultation has been intrinsic to the development of this draft SCP as outlined in the above sections.

Val de Souza  
Director, Health and Social Care

Date created: 03 November 2016

**Previous References**

- none
Contact for Further Information
If you would like to inspect the background papers or want further information, please contact:-
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Health and Social Care Integration

Strategic Commissioning Plans

An overview of strategic commissioning plans produced by Integration Authorities for 2016 - 2019

October 2016
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Key messages

Strategic commissioning is more than the publication of a plan, it is an approach to making sure people have access to the right care at the right time, and in the right place. It involves a range of activities, centred around a continuous cycle of **analyse, plan, do and review** and is iterative and dynamic to support collaborative system change across health and social care. Those Partnerships established in April 2015 have already reviewed and refreshed their plans, through this approach.

Functions of strategic commissioning plans include setting the vision and direction of travel, providing a means of communication, promoting effective and on-going engagement, building consensus, making linkages across a range of plans, services, different parts of the system, sectors and people, and determining strategic priorities.

- All Partnerships completed strategic commissioning plans by 1st April 2016 and these are high level and strategic. Further work is needed in a few plans and in supporting implementation plans to raise the scale of ambition and the pace at which it will be achieved, but most are aiming high.

- All plans include a list of functions that have been delegated by the Local Authority and by the NHS Board. A number of plans use tables and graphics to good effect in order to communicate this information.

- The reach and quality of engagement in the development of strategic commissioning plans is comprehensive and generally of good quality across Scotland. Strong engagement and working on a co-production basis needs to become the norm, not just in agreeing the vision and setting direction. This is emerging in a number of the Partnerships.

- Some plans describe how the Partnership is working with the Community Planning Partnership (CPP). This will ensure a common approach between key public sector agencies and optimise opportunities for joint work on shared priorities.

- Strategic Planning Groups have been established in each Partnership but this is not well covered in many of the strategic commissioning plans and should be given more prominence in subsequent iterations.

- Accessibility of plans and accompanying documents was generally good but there were sometimes difficulties in locating these. Scottish Government is currently working with a small number of Partnerships to identify good practice in engagement strategies, including publishing documents and improving accessibility.

- All Partnerships have undertaken a strategic needs assessment that considers needs, population dynamics and projections, service activity, supply and demand and gaps in provision to inform their strategic commissioning plan. Some are being further developed.
Some plans include Market Facilitation Plans, and it is essential that these are completed in all Partnerships. Third and independent sector partners and procurement staff should actively participate in the development of these plans.

Strategic commissioning plans do not deal with procurement arrangements. Effective procurement of care and support services is a crucial aspect of strategic commissioning and Partnerships must plan for how this will developed and improved, using best available evidence and guidance for implementing new approaches.

There is little evidence that data from the third and independent sectors is included in strategic needs assessments. This is an area for development and work is underway through Source and in some Partnerships to address this.

A brief analysis of deprivation in the Partnership’s population is a particular feature of some plans. Deprivation constitutes a serious issue for many parts of Scotland and its impact should be considered in plans. Tackling health inequality is a strategic priority in almost all plans. This needs further development in some plans in order to move beyond identifying the issues to what action will be taken, often acting in collaboration with others such as community planning partners.

A number of plans include equality impact assessments and outline the work the Partnership is doing to develop and publish equality outcomes. All Partnerships must publish robust Equality Outcomes and undertake an Equality Impact Assessment to ensure they are meeting their statutory obligations.

All plans identify strategic priorities and there are a number that are broadly consistent across Partnerships. Where Partnerships have children’s services and community justice social work services delegated, specific strategic priorities relating to these services are included.

Plans contain varying levels of financial information. To assist with the production of Annual Financial Statements in future years, the Scottish Government has published an advice note on the scope of these and what they should contain ([http://www.gov.scot/Publications/2016/09/1985](http://www.gov.scot/Publications/2016/09/1985)). We will also work with COSLA to produce a suggested pro-forma that will be issued in late Autumn of 2016.

The financial impact of re-modelling services is not considered in many plans nor is the method made clear for how decisions will be made about the allocation of resources. This has been challenging for Partnerships to do ahead of finalising budgets and is an area for development across plans. To assist Partnerships with work required on prioritisation, the Scottish Government has published an advice note on the key characteristics that should be incorporated in this process ([http://www.gov.scot/Publications/2016/09/9980](http://www.gov.scot/Publications/2016/09/9980)).

An area requiring specific attention is the financial planning for the sum set aside for hospital services. The Scottish Government is working with Partnerships, Health Boards and Local Authorities to draft guidance on good practice for budget setting, so that the processes will be better aligned for 2017/18.
The number of localities in each Partnership ranges from two to nine. The size of localities ranges from a large urban population of 219,422 to a small island population of just 1,264. In all, 128 localities have been established in Partnerships to take forward work on a local basis. Further work is required across Partnerships to fully develop their locality arrangements and maximise the potential of the structured involvement of communities, and local professionals in planning and decision making.

Some plans contain a high level summary of workforce issues. It is imperative that emergent integrated workforce plans carefully consider and seek to address the panoply of issues for staff in health and social care services, including in the third and independent sectors.

Many plans emphasise the key role of primary care services in health and social care integration. Some explore the need to develop stronger and more innovative links with primary care, where most patient contact takes place. All plans identify GPs and primary care as a key component of local service delivery and locality planning.

A number of plans clearly outline the relationship between the Partnership and acute care and identify the Partnerships’ statutory role in strategic planning for emergency care services delivered in acute hospitals. In some plans, responsibility for planning for the emergency care pathway is low key and not well covered. Future iterations must pay more attention to this.

While there may be opportunities for efficiency in some instances through establishing hosting arrangements, it is important that hosting is not used in multi-partnership Health Board areas to maintain existing NHS arrangements where there is scope through the Partnerships for greater local ownership and improvement.

Housing is recognised in most plans as a key component of effectively shifting the balance of care from institutional care to community based services and supports. Some plans contained information on the local Housing Plan and its fit with health and social care delivery. Just over half of plans contain a housing contribution statement.

All partnerships have developed a performance framework that includes national and local outcomes and measures. Where appropriate, performance frameworks include children’s outcomes and criminal justice outcomes as well as the National Health and Wellbeing Outcomes. Although not a requirement, first iterations of performance reports have been published by Partnerships established last year.
Introduction and background

1. The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) put in place the framework for integrating health and social care. The Act places a duty on Integration Authorities (referred to throughout this document as Partnerships) – either Integration Joint Boards or Health Boards and Local Authorities acting as lead agencies – to create a strategic plan for the integrated functions and budgets that they control.

2. Scottish Government published statutory guidance on Strategic Commissioning Plans in December 2014. The strategic plan is the output of what is more commonly referred to as the strategic commissioning process. The statutory guidance provides the following definition of strategic commissioning: it is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place. The guidance also explains that where we refer to the strategic commissioning plan, we are referring to the strategic plan described in the Act. These are not separate or different plans, they are one and the same.

The importance of effective strategic commissioning for the success of integrated health and social care provision cannot be over-stated. It is the mechanism via which the new integration partnerships will deliver better care for people, and better use of the significant resources we invest in health and social care provision.

Strategic Commissioning Plan, Statutory Guidance, December 2014

3. By developing strategic commissioning plans for, as a minimum, all adult care groups, and taking a population approach to planning, Partnerships are focusing on designing, commissioning and delivering services in new and sustainable ways, in collaboration with their partners.

4. All Partnerships completed their strategic commissioning plans by 1st April 2016, as required. Generally, these set out the vision, aims, ambitions and outcomes that each Partnership will seek to deliver, over the life of the plan. Some Partnerships have, or are in the process of, developing further iterations, clearly demonstrating that the plans are dynamic and being actively used. In addition, all Partnerships have developed or are developing detailed, costed implementation or operational plans for the delivery of strategic priorities identified through the strategic commissioning process.

5. This report provides an overview of the content and approach of these first iterations, and identifies common themes and key areas for further development. It is intended to assist local systems to accelerate the transformational potential of their plans, and deliver sustainable new models of care and support that are focused on improving outcomes.
Overall Content and Approach

6. Most Partnerships have produced plans that are easy to read and provide a clear, high-level direction for health and social care services and supports in the coming years. All articulate a clear vision, and many include principles, mission statements and values to support this.

7. The plans are high level and strategic. They do not cover anything in great detail but often provide links or appendices to supplementary material. These do offer more detail, but do not routinely include information about how plans will be delivered, with timescales and costs. A number of plans have a whole range of accompanying documents, which have both informed the plan or been developed as a result of it.

8. Some plans give commitments with timescales for when other plans will be produced and some provide obvious hooks and levers for the development of more detailed plans leading to transformational change. For example, for specific care groups, service redesign or new service delivery, each of which requires to be consistent with the direction established in the strategic commissioning plan, and deliver the intended change on a sustainable basis.

9. All plans draw on relevant extant plans and strategies, and some explain how the strategic commissioning plan relates to these in the immediate and longer-term. Some plans use good graphics to illustrate how various plans and strategies relate to the strategic commissioning plan. However, the strategic commissioning plan is not a summation of other strategies but provides the means for coherence across a range of inter-related plans.

10. All plans include an explanation of why change is necessary, emphasising increasing demand and rising public expectations combined with limited finance. Some make a particularly cogent case by drawing on key data that are specific to their Partnership and which highlight the enormity of what needs to change, and why, in that Partnership area.

11. The scale of ambition expressed varies amongst plans, but most are aiming high. Some plans contain clear statements about their aspirations and ambitions, whilst others describe their ambitions in a more oblique way through the plans they have for delivering new models of care that are sustainable and focused on improving outcomes.

12. Further work is needed in a few plans and in supporting implementation plans to raise the scale of ambition and the pace at which it will be achieved. An increased focus on how transformational and sustainable change will be achieved at pace and scale, using the resources available to the Partnership must be a key aspect of planning and implementation.

13. Innovation and relentless pursuit of established strategic priorities to deliver improved outcomes is vital, as is seizing opportunities, while responding flexibly to the rapidly changing landscape within which Partnerships operate.


number of plans highlight the opportunities integration presents and how they plan to use these.

14. The need to do things differently and to support innovation, particularly through more extensive and imaginative use of technology, is a feature of a number of plans. Telehealth is generally not well covered in plans.

15. Working in close partnership with staff, people who use services, carers and the third and independent sectors, as well as local communities, is also recognised throughout plans as a key aspect of working differently and supporting innovation.

Scope of plans

16. The scope of plans is determined by the functions delegated to Partnerships. All plans include a list of functions that have been delegated by the Local Authority and by the NHS Board. A number of plans use tables and graphics to good effect in order to communicate this information.

17. Some plans explicitly cover public protection and all Partnerships, as a minimum, have delegated responsibility for adult protection. Interagency procedures are already in place for child, adult and public protection, however integration offers an opportunity to refresh these and to strengthen public protection.

18. Some plans, where children’s services are not within scope refer to the need to build strong and meaningful collaboration with integrated children’s services. A list of delegated functions to each partnership beyond the statutory minimum is appended at Annex 1.

19. Plans have been prepared in a variety of formats and styles with length varying between 18 pages to over 250 pages. The lengthier plans tend to include a range of planning material, such as detailed needs assessments and equality impact assessments, as appendices, while shorter plans are usually supported by a suite of associated documents that are separately published.

20. Explanations about what Integration Joint Boards (IJBs) are, who is on them, the number of voting members and other members, including advisors, have helpfully been included in the majority of plans.

21. Some of the clearest and most accessible plans have included light touch information about the Act and other key policy objectives, often by using graphics and charts to good effect. This includes vignettes of what will change for people in new integrated health and social care arrangements and what the overall approach is to delivering change.

Reach and quality of engagement

22. A range of stakeholders including staff, people using services, carers, the third and independent sectors must be fully engaged in the preparation, publication and review of the strategic commissioning plan. This is to establish a meaningful
co-productive approach, to enable Partnerships to deliver the national outcomes for health and wellbeing, and achieve the core aims of integration.

23. The reach and quality of engagement in the development of strategic commissioning plans is comprehensive and generally of good quality across Scotland. All Partnerships have rolled out extensive programmes of meetings with staff, people using services, carers, providers, third and independent sectors, local communities and the wider public to gauge opinion on what's important to them, to inform strategic priorities. A large number of Partnerships also ran formal consultations on their plans and many made significant alterations as a result.

24. Although not all planning will require this level of engagement on such a broad scale, it must be recognised as being a key part of an on-going strategic commissioning process. Strong engagement needs to become the norm, not just in agreeing the vision and setting direction. This co-productive way of working and engaging is emerging in a number of the Partnerships. Locality planning (discussed below) is an additional helpful vehicle for this.

25. Strategic Planning Groups (SPGs) have a formal statutory role in preparing and monitoring strategic commissioning plans. SPGs have been established in each Partnership and form an important cornerstone for effective stakeholder engagement and involvement, with a link directly to the IJB. The role of the SPG is not well covered in many of the strategic commissioning plans and should be given more prominence in subsequent iterations.

26. The model for SPGs varies slightly across Scotland but the majority are meeting regularly, and have developed a programme of work focused on monitoring the implementation of the plans and reviewing and refreshing existing plans. Locality planning leads are now playing into a number of SPGs, providing real opportunities for local community engagement on matters affecting people living and working in localities.

27. Within SPGs and across an extensive range of other stakeholder groups, key relationships and engagement with people using services, carers, professionals and clinicians, along with the third and independent and housing sectors, and with the wider public are being developed and deepened. Many Partnerships have developed engagement strategies and are focusing on developing effective communications with their local stakeholders and beyond.

28. Some plans describe how the Partnership is working with the Community Planning Partnership (CPP) to extend and co-ordinate reach into local communities and neighbourhoods. This link to CPPs ensures that health and social care is not isolated from wider and highly relevant agendas that include transport, leisure and recreation, education, economic development, housing, policing, and fire and rescue services.

29. An array of web platforms have been developed for Partnerships, with the majority being hosted by the Local Authority and/or Health Board. A few Partnerships have developed their own web sites. Many have social media
accounts and are regularly publishing updates and information bulletins, increasing the visibility of their Partnership.

30. One issue we noted, however, was occasional difficulty in locating plans (and more often linked documents) on websites. In response, the Scottish Government is currently working with a small number of Partnerships to identify good practice in engagement strategies, including publishing documents and improving accessibility.

31. With a requirement under the Act to publish strategic commissioning plans and other documents, it is imperative that they are made more readily accessible. This has implications not only for the accessibility of the plans and other information the public may wish to access about Partnerships, but for the general visibility of Partnerships, what they do and what they are setting out to achieve, and requires attention.

**Strategic needs assessment**

32. All Partnerships have undertaken a strategic needs assessment that considers needs, population dynamics and projections, service activity, supply and demand and gaps in provision to inform their strategic commissioning plan, and shape services and support to deliver better outcomes. A few Partnerships intend to undertake a more in depth analysis to better inform future iterations of their plans.

33. Most plans use information from strategic needs assessment to highlight the challenges faced by the Partnership. This is most effectively described in plans where the challenges are put in simple and fairly stark terms that demonstrate the scale of what needs to be done and provide clear justification for major change across the existing health and social care system.

34. As well as good use of population health and well-being data, many plans provide a range of high level needs assessment information on particular care groups and draw on a range of available data. There are some areas (notably community health services and social care services) where information is historically light, as is not routinely collected nor joined up across data sets.

35. In order to improve the data available to Partnerships, the Scottish Government commissioned NHS National Services Scotland (Information Services Division - ISD) to develop a health and social care dataset, and to develop analytical capacity and skills in Partnerships. This work was known as the Health and Social Care Data Integration and Intelligence Project, now known as Source, and is a development of our longstanding work on the Integrated Resources Framework.

36. The IT platform to support Source has been available since April 2015 and provides a secure data collection, storage, linkage and reporting facility – a “datamart” - for each Partnership. The initial phase of this work has so far focussed on linking a range of existing health datasets with Local Authority social care data. Once Local Authorities have submitted their data, every Partnership will be able to access pseudonymised, individual level longitudinal data for about
70% of the resources used by their populations. Over time, our objective is to capture 100% of partnership resources at this level.

37. In addition, the Local Intelligence Support Team (LIST) has allocated its analytical staff directly to work within each of the 31 partnerships. This resource provides additional capacity and capability in Partnerships for data analysis, to underpin the strategic commissioning process. Feedback on LIST support and the Partnership embedded method of delivering it is very positive across the country.

38. The data now available has been put to effective use by many of the Partnerships in their plans. Improved data availability has encouraged a system-wide focus on how data can help inform future planning by improved understanding of what the current state of play is, and to identify what needs to change to better meet outcomes and build a more sustainable health and social care system.

39. Many plans indicate that the Partnership is adopting an assets-based approach. This is critical in order to fully recognise, develop and make best use of wider assets and resources available in local communities and to facilitate partnership working with local communities.

40. There is little evidence that data from the third and independent sectors is included in strategic needs assessments. This is an area for development as Partnerships develop their data sets, strategic analysis and locality profiling and work is underway through Source and by some Partnerships in this regard. Locality planning and market facilitation work will necessitate a better understanding of the contribution made by the third and independent sectors, sharing and using data across sectors is at an early stage of development in most Partnerships.

41. Some plans include some basic market intelligence and data on service configuration. Some have Market Facilitation Plans as appendices, or available as separate documents. A few plans commit the Partnership to developing a Market Facilitation Plan. It is essential that third and independent sector partners actively participate in the development of such plans (and in any refresh of pre-existing plans), including in the provision of locally collected data about needs, outcomes, service configuration and costs.

42. It is also important that procurement staff are involved in the development of market facilitation plans, drawing on their expertise and knowledge as well as involving them directly in changing relationships with providers. Strategic commissioning plans do not deal with procurement arrangements, implying that this will require to be dealt with elsewhere. Effective procurement of care and support services is a crucial aspect of strategic commissioning and Partnerships must plan for how this will developed and improved, using best available evidence and guidance for implementing new approaches.

43. Data on high resource individuals is used in a few plans to highlight the significant level of resource being directed to the care and treatment of a relatively small number of people. This data is being used to plan improved and
clearer routes for people through the local health and social care system, and potentially for the redirection of resources.

44. A brief analysis of deprivation in the Partnership’s population is a particular feature of some plans. Deprivation constitutes a serious issue for many parts of Scotland. Poverty and deprivation can have a devastating effect on health and well-being, none more starkly represented than in death rates in affluent areas compared to those in areas of deprivation, where people can die 15 years earlier due their economic and social circumstances. Deprivation and its impact needs to be part of the work on tackling inequalities, and should be more prominent in plans.

45. A few plans briefly explore equalities issues, describe the diversity of their populations, and highlight some of the difficulties equalities groups may experience in accessing and using health and social care services. A number of plans include equality impact assessments and outline the work the Partnership is doing to develop and publish equality outcomes, which the Partnership considers will enable it to better perform the equality duty set out in the Equality Act 2010 and accompanying regulations.

46. Having published their equality outcomes, Partnerships are required to publish reports on progress on mainstreaming the equality duty. These duties should be considered during the development of the strategic commissioning plan. All Partnerships must also carry out an Equality Impact Assessment when preparing their strategic commissioning plan to ensure they are meeting their statutory obligations.

Strategic priorities

47. All plans identify strategic priorities and many identify commissioning intentions for delivering on these priorities. Where commissioning intentions and action plans are not contained in the plan, local additional work is underway or completed.

48. Many plans map strategic priorities onto national outcomes for health and wellbeing, and indeed a few Partnerships have simply adopted the national outcomes as their strategic priorities and outlined what they intend to do to deliver on these.

49. A number of broadly consistent strategic priorities have been identified by Partnerships, partly as these relate closely to the nine national outcomes. Strengthening and working in partnership with local communities, reducing avoidable admissions to hospital, support for carers, prevention and early intervention, promoting healthy lifestyles, promoting self-management and independence, developing primary care and community responses, delivering integrated care models and single points of entry to services are frequently identified as strategic priorities.

50. Optimising efficiency and effectiveness, and achieving best value are also commonly identified as strategic priorities, as is valuing and developing the
workforce. Delivering personalised care and support alongside giving people
more choice and control featured as a priority in a number of plans.

51. Tackling health inequality together with the wider equality agenda and adopting a
human rights approach is explored and identified as a strategic priority in almost
all plans. This needs further development in some plans in order to move beyond
identifying the issues to what action will be taken, often acting in collaboration
with others, such as community planning partners.

52. Improving mental health and well-being is identified a strategic priority in a small
number of plans, and is recognised as an issue in a number of others.

53. Establishing health and social care systems that keep people safe from harm,
usually linked to protecting vulnerable people or wider public protection activity,
was a strategic priority in a number of plans. Dignity at end of life and improved
care was also prioritised in a few plans.

54. Where Partnerships have children’s services and community justice social work
services delegated, specific strategic priorities relating to these services are
included, such as giving children and young people the best possible start in life
and reducing reoffending. Many strategic priorities are applicable to all sections
of the population.

Financial planning

55. Robust financial planning to support strategic commissioning plans is essential.
Plans contained varying levels of financial information ranging from the overall
estimated sum available across the Partnership to details of indicative allocations
for each service delegated.

56. Partnerships are required to publish an Annual Financial Statement on resources
that it plans to spend in implementing the strategic commissioning plan. This is a
summary of the financial plan that underpins the strategic commissioning plan.
To assist with the production of Annual Financial Statements in future years, the
Scottish Government has drafted an advice note on the scope of these and what
they should contain. We will also work with COSLA to produce a suggested pro-
forma that will be issued in late Autumn of 2016.

57. We recognise that reporting financial information in the way expected has been a
challenge for Partnerships (and Health Boards and Local Authorities) and that
approximations may need to be made during initial planning and reporting cycles,
while information systems are developed and bedded in.

58. The allocation of resources to improve outcomes is a key task of Partnerships,
particularly in view of the key challenges of increasing demand and constrained
resources. How sustainability will be achieved was generally not well detailed in
plans although many referred to the need to develop sustainable services and
that new, affordable models of care are needed that better meet people’s
outcomes.
59. The financial impact of re-modelling services is not considered in many plans nor is the method made clear for how decisions will be made about the allocation of resources in terms of investment and disinvestment to achieve identified strategic priorities. Such decisions must be based on the basis of clear criteria, a robust process and application of relevant and focused information, and must take account of the Partnership's duty to achieve best value.

60. This has been challenging for Partnerships to do ahead of finalising budgets and is an area for development across plans. To assist Partnerships with work required on prioritisation, the Scottish Government has published an advice note on the key characteristics that should be incorporated in this process.

61. The process for agreeing the initial allocations from Health Boards and Local Authorities and the associated due diligence was set out in Integration Schemes and supported by statutory guidance. Nevertheless, the process has been difficult and protracted in many partnerships and this has had an impact on financial planning.

62. One area requiring specific attention is the financial planning for the sum set aside for hospital services. It is evident from strategic commissioning plans that many partnerships haven't been provided with sufficient information on their population's use of hospital services to incorporate hospital capacity in their plans. This has been reinforced by the responses to recent surveys of Partnerships, where only thirteen were able to provide a figure for the bed capacity used by their populations.

63. The Scottish Government is working with Health Board and Local Authority Directors of Finance and IJB Chief Finance officers to draft guidance on good practice for budget setting, so that the processes will be better aligned for 2017/18, with the intention to move to a position of providing as much certainty as possible over a three year period.

64. Statutory guidance stipulates that budget setting for year 2 onwards should be a process based on negotiation about the level of funding, performance and associated risks, rather than a roll forward of individual service budgets used for the initial allocations. Together with early engagement between partners in looking forward to 2017/18, we expect that these developments will allow the process for agreeing future budgets to be more straightforward and to provide a framework for improved financial planning.

Outcomes

65. A number of plans refer explicitly to the integration principles set out in the Act and all include detailed references to achieving the national health and well-being outcomes, and to locally determined outcomes. Helpful charts and graphics have been used in some plans to make links between national health and well-being outcomes, strategic priorities and commissioning intentions.

66. The whole purpose of integrating adult health and social care services is to improve health and wellbeing outcomes for people in Scotland. As referred to
above, delivering personalised care and support was identified as a strategic priority of many plans.

67. Self-directed Support (SDS) is identified in some plans as an approach that supports the delivery of joined up, flexible, person-centred care and support with the express intention of providing people with greater choice and more control over how they live their lives. This was occasionally linked to, for example, people being able to choose to die at home, as well as a wider range of options for meeting personal outcomes.

68. Preventative, early intervention and self-management approaches are identified as important to achieving better outcomes in many plans. As is supporting people and communities to take greater responsibility for their own outcomes, reducing the need for services. Well targeted anticipatory care planning is also highlighted as an area for development in a number of plans.

69. In some plans, outcomes are identified at a wholly strategic level with little attention paid to personal outcomes, and how these are linked to and drive service and strategic level outcomes.

Localities

70. As expected, locality arrangements vary significantly across the country and some are at early stages of development. Some locality arrangements are focused on both an organisational unit for operational delivery and for locality planning, while others are entirely focused on one or the other with the intention of developing localities further over time.

"... effective services must be designed with and for people and communities – not delivered top down for administrative convenience"

The Christie Commission Report
Commission on the future delivery of public services, June 2011

71. The statutory guidance on localities states that localities provide one route, under integration to ensure strong community, clinical and professional leadership of strategic commissioning of services. Essentially, it is the route whereby local communities and local clinicians and professionals can play an active role in service planning for their local population, in order to improve outcomes. This approach fits well with community empowerment. It ensures that people who live and work in a locality have a forum to inform redesign and improvement in that locality.

72. All plans (except two, where this is detailed separately) include details of the localities proposed or in place in each of the Partnerships. The number of localities in each Partnership ranges from two to nine. The size of localities ranges from a large urban population of 217,422 to a small island population of just 1,264.
73. In all, 128 localities have been established in Partnerships to take forward work on a local basis. A table of localities mapped to Partnerships and Health Boards is appended at Annex 2.

74. Many plans highlight the need to shift to more preventive approaches and to build community capacity. Working closely with local communities and building their on their assets is also widely recognised, especially in locality planning and delivery. In this regard, many Partnerships have used positive learning and evidence from tests of change undertaken at locality levels to inform broader system changes prioritised within their plans.

75. Many localities are based on existing Community Planning Partnership areas to retain or develop a strong connection to community planning. This will ensure a common approach between key public sector agencies and optimise opportunities for joint work on shared priorities.

76. A small number are based on long-standing locality arrangements between health and social care, which have been refreshed and enhanced to meet the requirements of the Act. Most have taken clear account of emerging GP cluster arrangements.

77. Some Partnerships have begun to develop locality plans and a few strategic commissioning plans include initial or outline priorities for localities, in addition to the strategic priorities for the Partnership. Many are developing locality profiles, using partnership wide data and disaggregating this to the locality area. This will be an important aspect of equipping localities to plan for their populations. Similarly, disaggregation of budgets to locality levels will be crucial for place based planning and is not yet complete in most Partnerships.

78. A number of Partnerships have established locality managers’ posts, which have the combined responsibility for managing service delivery and locality planning in their patch. Some Partnerships have established locality leads who will work closely with GP locality leads, and others to establish and lead locality planning.

79. Further work is required across Partnerships to fully develop their locality arrangements and maximise the potential of the structured involvement of communities, and local professionals in planning and decision making. Overtime, it is intended that proportionate resources, responsibility and accountability will shift to localities. A level of infrastructure is required to support these arrangements and make them operate effectively, this is at early stages in some Partnerships.

**Workforce and multi-disciplinary teams**

80. Many Partnerships have either created or are planning the development of multi-disciplinary teams, flowing from priorities identified in strategic commissioning plans. These are intended to bring different professionals across health and social care together to make sure people receive seamless care or support from the right professional. Some of these teams will include input from the third sector.
81. Hubs have been established or are planned in many Partnerships, often focused around GP or primary care practices. These are designed to better meet people’s changing and diverse needs, including improved understanding and use of community based supports. The development of multi-disciplinary teams will be a crucial aspect of transforming primary care services in integrated settings, which envisages GPs becoming expert-generalist in complex care and focusing more on quality and leadership.

82. The Scottish Government recently published a National Clinical Strategy for Scotland. It wholly supports the aims and intended outcomes of integration. The strategy sets out the intention to build capacity in primary care, with a broader mix of professionals involved, who will be working collaboratively in clusters and working with social care and the third sector.

83. In secondary care, the strategy is to consider the potential for developing fewer inpatient sites, that will provide more highly specialised services, linked to local hospitals. The Chief Medical Officer’s annual report for 2014-15 introduced the adoption of an approach called “realistic medicine” in order to reduce harm and over treatment, and to ensure that treatment is tailored to patient preferences.

“Doctors generally choose less treatment for themselves than they provide for their patients.”
Chief Medical Officer’s Annual Report 2014-15

84. Some plans contain a high level summary of workforce issues and some indicate wider work is being undertaken on developing an integrated workforce strategy. A few contain outline workforce strategies. It will be imperative that these integrated workforce plans carefully consider and seek to address the panoply of issues for staff in health and social care services, including in the third and independent sectors.

85. Partnerships fully recognise the health and social care workforce as a major asset. Achieving the right skill mix, and having the right staff in the right places is a priority to better meet people’s needs and achieve sustainability. Some highlight concern about the age profile of the workforce, while a few note recruitment and retention issues affecting a range of staff from GPs to social care assistants. Growing the social care workforce is jointly on the agenda with some CPPs.

86. Many plans highlight that organisational development resources have been deployed to support and bring different parts of the health and social care workforce together, as well as to support new senior management teams and IJBs. The development of cross sector or intra-professional integrated education and training opportunities is at an early stage in most Partnerships. Leadership development programmes are in place in some Partnerships.
Primary care

87. Many plans emphasise the key role of primary care services in health and social care integration. Some explore the need to develop stronger and more innovative links with primary care, where most patient contact takes place.

88. Some plans identify how the Partnership will support the development of improved primary care services, including improving links with the acute sector, introducing step up and step down beds as alternatives to hospital admission, developing better community links and improving access to a wide range of community services and supports.

89. A few plans also refer to the potential of promoting and enhancing primary care involvement in tackling inequalities.

90. Linking primary care to social care and community services features in a number of plans and as described above many Partnerships are building service hubs around GP or primary care practices. Similarly, improved working and communication between primary and secondary care is also covered in a number of plans.

91. All plans identify GPs and primary care as a key component of local service delivery and locality planning.

Links to acute care and cross partnership working

92. A number of plans clearly outline the relationship between the Partnership and acute care and identify the Partnerships’ statutory role in strategic planning for emergency care services delivered in acute hospitals. In some plans, responsibility for planning for the emergency care pathway is low key and not well covered.

93. A number of Partnerships have developed close working relationship with the acute sector, and with neighbouring Partnerships where they share a common boundary within a Health Board. This has assisted with winter planning, which increasingly is described by Partnerships as year round, whole system capacity planning.

94. Many plans outline the arrangements that have been put in place to support services that cannot be easily disaggregated to individual Partnerships, within a Health Board area. To this end, what are variously described as lead partnership or more regularly as hosting arrangements have been established across a number of neighbouring partnerships. This has led to some close working between Chief Officers and their senior teams to address issues of common concern, including linking with acute care senior staff, and the development of new and sustainable models of care.

95. While there may be opportunities for efficiency in some instances through establishing hosting arrangements, it is important that hosting is not used in multi-partnership Health Board areas to maintain existing NHS arrangements where
there is scope through the Partnerships for greater local ownership and improvement.

96. Partnerships are required to have regard to one another’s strategic commissioning plans, across neighbouring partnerships. Some plans explicitly mention this and what they have considered in this regard, but most do not.

97. A few plans provide good coverage of the need to improve the interface between communities and hospital, to focus hospital care on those who need it most and can gain most from it. Some plans set out clearly that reductions in bed days lost to delayed discharge and reductions in Accident and Emergency presentations and emergency admissions are needed. What this might imply in terms of disinvestment and reinvestment is not often as well covered.

98. Preventing unnecessary hospital admissions and expediting timely discharge from hospital is a priority of many Partnerships, as outlined above in the strategic priorities section. A decisive move to prevention and early intervention, along with investment in intermediate care are key aspects of the wider approach required to tackling these issues. This was emphasised in many plans but frequently it was not costed.

Housing

99. The housing sector is represented on all SPGs and on some Integration Joint Boards and is or will be involved in locality planning, as this develops.

100. Housing is recognised in most plans as a key component of effectively shifting the balance of care from institutional care to community based services and supports. It also seen as providing and promoting preventive approaches.

101. Some plans contained information on the local Housing Plan and its fit with health and social care delivery. 17 of the 31 plans contain a housing contribution statement. The housing contribution is strongest where the statement is not confined to an appendix in the plan, but where housing and its contribution are also reflected throughout the plan.

102. A lack of affordable housing is noted as a concern in a number of plans as well as the implications this has for local populations and for staff working in health and social care. The need to develop housing options as an alternative to residential care is also mentioned in a few plans. There is an opportunity to deepen and broaden the contribution of housing in future iterations of strategic commissioning plans.

Performance reporting

103. Each Partnership is required to publish an annual performance report setting out progress against the statutory outcomes for health and wellbeing, using the integrated budget. Annual performance reports will report on a core set of indicators as well as additional measures agreed locally.
104. All partnerships have developed a performance framework that includes national and local outcomes and measures. Where appropriate, performance frameworks include children’s outcomes and criminal justice outcomes as well as the National Health and Wellbeing Outcomes.

105. Most included the framework in their strategic commissioning plans. Performance reports will be provided on a regular and routine basis to Integration Authorities, as well as to senior management teams, as part of ongoing performance management responsibilities, in addition to annual reporting.

106. Although not a requirement, Partnerships that were established prior to April 2016 have begun to publish their performance reports. These outline what has been achieved by the Partnerships and include a mix of national and local measures.

107. Performance reports will provide a means for shared learning across Partnerships, although we fully recognise that what works well in one area may not wholly work in others, due to a number of factors, including how services are configured. That said, there are a number of consistent themes and priorities for Partnerships and there are opportunities for collaboration and learning, which will help inform decisions about transforming services while being mindful of the local circumstances and context of individual Partnerships.
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1. **Purpose of Report**
   1.1. The purpose of the report is to:
       - provide an update on the review of NHS Lanarkshire’s interim Primary Care Out of Hours (OOHs) service model, implemented from 1 July 2015
       - provide the Integration Joint Board (IJB) with information on the performance of the OOHs service from 1 July 2015
       - advise the IJB of feedback from patients, carers and staff members on their experience of the interim service arrangements
       - provide an update in relation to how the NHSL interim arrangements link with the recommendations contained within Professor Sir Lewis Ritchie’s national review of OOH services
       - note the feedback from the External Peer Review process undertaken on 24 August 2016
       - note the recommendation from NHSL to the IJB that the interim two site model introduced as a BCP arrangement now be adopted on a substantive basis.
       - note that a similar paper has been shared with and agreed by the North Lanarkshire IJB.

2. **Recommendation(s)**
   2.1. The Integration Joint Board is asked to approve the following recommendation(s):
       1. that it note the feedback from the external peer review that the evidence presented on service delivery is demonstrating some significant improvements for staff in respect of safety, the environment, support and training and team working; and in immediate patient outcomes since the introduction of the interim model in 2015;
       2. that the advice from the external review that the current two centre model be adopted as providing an equitable urgent care service – a service that is fair and accessible to all, according to need, be accepted;
       3. that it support and approve the request from NHSL that the current arrangements now be introduced on a permanent basis; and
       4. that a further action plan be produced to develop the further actions highlighted in the feedback from the external review attached.
3. **Background**

3.1. NHS Lanarkshire commenced a review of its Out of Hours General Medical Services in 2014. This service is to provide urgent OOH GP appointments for people who are unable to wait until their own GP is open, that is, 8am to 6pm Monday - Friday. Prior to the conclusion of that process, a National review of OOH Services was announced. Thereafter, since the interim moves were introduced, Professor Sir Lewis Ritchie has published his report, ‘Pulling Together: transforming urgent care for the people of Scotland’.

3.1.1. The full report is available by following the link provided below.

http://www.gov.scot/topics/health/services/nrpcooh

3.2. Accordingly, the local review of services has sought to demonstrate compatibility with the national report and the respective comparisons/areas of development are as per highlighted quotes.

3.3. The local review of services was undertaken in keeping with the guidance contained in CEL 4 (2010) “Informing, Engaging and Consulting People in Developing Health and Community Care Services”.

3.4. In May 2015, NHS Lanarkshire Board, in recognition of the patient safety issues which had arisen as a result of staffing difficulties in the OOH service, agreed to an interim move to a two site primary care emergency centre (PCEC) model within existing community centres; Douglas Street, Hamilton and Airdrie Community Health Centre, Airdrie. The two centre model reflected the preferred option as described in the NHS Lanarkshire review.

3.5. The interim arrangements, which commenced on 1 July 2015, also supported the development of a new multi-disciplinary team based approach and improved innovative ways of working with increased skill mix opportunities provided to meet the growing OOH demand against a diminishing medical workforce.

3.6. The preferred model and configuration - agreed through two option appraisal events, provided solutions to the previous service delivery difficulties with accommodation that replicated in-hours GP facilities; increased uptake in sessions by GPs; both sites being easily accessible; adequate parking spaces for patients; consulting and waiting areas fit for purpose; and appropriate IT systems to support the service. The revised arrangements were also able to support and enhance team working; reduced clinical isolation at particular times of the day/night and introduced improved training opportunities for a range of clinical staff.

3.7. The service has further developed its infrastructure to support clinicians by introducing Health Care Support Workers, with particular emphasis in the overnight period.

3.8. NHS Lanarkshire requested an External Peer Review of the Out of Hours Service and this was completed by members of the group who conducted the National review. The report of the External Review is attached at Appendix 1.

3.9. The report concludes that the two centre model should be adopted and developed further in pursuit of the wider aims of the national review.
4. **Reporting Arrangements**  
4.1. Weekly and monthly reports are currently provided to the NHS Corporate Management Team and NHS Lanarkshire Health Board respectively.

5. **Employee Implications**  
5.1. Since the move to the new arrangements, there has been an increase in the number of GPs prepared to work in the service. Additionally a range of additional nursing staff have also been working in the service.

6. **Financial Implications**  
6.1. There are no financial implications associated with this report.

7. **Other Implications**  
7.1. Since the move to the new arrangements, the level of risk has reduced, meaning that the service is no longer graded as a High Risk on the Corporate Risk Register.

7.2. There are no sustainable development implications associated with this report

7.3. There are no other issues associated with this report

8. **Equality Impact Assessment and Consultation Arrangements**  
8.1. A full EIA and consultation process were undertaken as part of the initial review. These are available if required.

8.2. There was no requirement to undertake any consultation in terms of the information contained in this report.

Val de Souza  
**Director, Health and Social Care**

Date created: 02 November 2016

**Previous References**

♦ none

**Contact for Further Information**
If you would like to inspect the background papers or want further information, please contact:-  
Craig Cunningham, Head of Commissioning and Performance  
Ext: 3704 (Phone: 01698 453704)  
Email: craig.cunningham@lanarkshire.scot.nhs.uk
Out of Hours Urgent Care Transformation: Peer Review Report Lanarkshire

1. Background

In the interests of patient safety and in response to significant challenges in filling General Practitioner (GP) Out of Hours (OOHs) shifts, the NHS Lanarkshire Board approved a move, from 1 July 2015, to an interim two centre model for GP out of hours services based in the community centre, Douglas Street Hamilton and Airdrie Community Health Centre (there had previously been five centres, although in practice for a year before the interim arrangements were introduced it had not always been possible to open the part-time centres in either Clydesdale (Lanark) or Cumbernauld). The move followed an extensive public consultation process carried out in line with Scottish Health Council guidance and good practice.

The Cabinet Secretary for Health and Wellbeing endorsed the move on the basis that these interim proposals would enable NHS Lanarkshire to develop a broader range of OOHs solutions, which must be in-line with the outcome of the National Review of GP OOHs Services which was underway at that time, led by Professor Sir Lewis Ritchie (announced on 30 January 2015, reported on 30 November 2015). Annex A provides details of how Lanarkshire’s review of services and interim arrangement align with the principles in Sir Lewis’s report.

Richard Foggo, Head of Scottish Government Primary Care Division wrote to Integrated Joint Boards (IJBs) in June 2016 inviting self-assessment of their respective urgent care out of hours services along with an action plan for 2016-2017.

A peer review process led by Sir Lewis Ritchie has been established to provide views and assess the proposals and progress against the recommendations in Sir Lewis’s Report Pulling together: transforming urgent care for the people of Scotland. Full membership of the Peer Review Group is attached at Annex B.

On 17 June Lanarkshire asked Sir Lewis Ritchie as Chair of the National OOHs Review to undertake a Rapid External Review of the proposed new model of OOH services in Lanarkshire. This approach was supported by DG Health and Social Care and has been incorporated into the peer review process with Lanarkshire being the first Board assessed under this process.

The group considered Lanarkshire’s self-assessment and proposals at a meeting on 17 August 2016. This was followed up by a visit to Lanarkshire by a peer review group on 24 August 2016. The membership of the visit team is provided in Annex C.

The Peer Review team represented the four key workstreams considered as part of the review: Workforce and Training; Quality and Safety; Models of Care; and Data and Technology.

2. Review process

The broad principles against which the Review team considered the plans are also set out in Annex C. During the visit the team were able to meet a wide range of professionals, administrative staff and other stakeholders who are working with the HSCP and NHS Board as part of the Primary Care Transformation Programme, including: GPs working both In hours and Out of Hours, mental health and paediatrics professionals, SAS, NHS 24 and importantly patient partners. The team also took the opportunity to visit the OOH centre in Hamilton and speak to staff (GPs, Nurses, Receptionists, Planners and Drivers).
3. Evidence, Evaluation and Progress

A wide range of evidence was made available to the review team both before and during the visit including:

- options appraisal
- full public consultation report
- demographic mapping process (including drive time for the two models consulted on)
- patient flow and outcomes data
- monthly performance data (one, two and four hour home visits)
- NHS Health Scotland OOH Study
- Scottish Health Council Report on NHS Lanarkshire’s consultation process
- Scottish Health Council Report of Patient Focus Group, Lanarkshire (as part of the OOH Review).

Since the introduction of the interim model in 2015 the evidence shows that Lanarkshire has made some significant improvements in key performance measures. These are demonstrated in the graphs at Appendix 1 (see below). For example, before implementation of the interim model, the service saw examples of less than 40% of patients assessed as needing to be seen within one hour being seen on time. This is now consistently over 80%. The service has made significant improvements in performance against one and two hour assessments at both Urgent Care Primary Care Emergency Centres (PCECs) and in home visits.

Evidence from staff feedback also demonstrated that since the move to a two centre model, staff morale has improved significantly. Benefits and improvements included a team based approach rather than lone working; greater opportunities for learning and mentoring closer, multi-disciplinary working; better and safer working environment. These improvements are aligned to the recommendations in Sir Lewis’s the report. It is also worth noting that this evidence was borne out in the discussions the review team had with on-site staff on the day of the visit.

Statement of support from a wide range of staff are included at Annex E.

Lanarkshire was also able to demonstrate that since the interim model had been introduced, it had adapted its service in response to patient feedback. For example, infrastructure improvements had been instigated: seating in the centre had been adjusted; a drink machine was installed for patients in Hamilton; a saving from the provision of a minibus (that evidence showed was not being effectively used) was re-invested in an administrative medicines management post (freeing up a nurse to work with patients); there was an issue with the timely provision of taxis which was resolved by changing taxi supplier.

The patient representatives present during the visit were positive about the service and confirmed that they had been involved and contributed positively to the development of the consultation process that led to the introduction of the interim model; and have been involved in the development and improvements to the service since its introduction.

The 2015-2016 patient experience survey shows that overall 70% of those who responded who had used out of hours services had a positive experience of the service with a further 20% rating the service as fair. It is noted however, that the responses, although demonstrating that patient satisfaction with the service has not changed significantly - many of the results remain slightly below the Scottish average.

In advance of the visit the peer review team had provided a list of questions. The responses are set out in Annex D, along with some further areas explored at the meeting.
4. **Good Practice and Innovation**

**Nursing:** In 2015 the organisation introduced a nurse development programme for general nurses with five year post registration experience within an A&E or ERC department. Six nurses were supported to attend university one day per week with the remaining hours spent in a primary care centre with ongoing support. Within the service, GP and Nurse mentors were identified and supported the nurses throughout the study period. Of the four who completed the course, three have secured promoted posts at band 7 and one remains in service. Retention of the staff continues to be a challenge as the knowledge and skills gained make the staff an attractive asset for other areas of service provision. The service is currently recruiting to a further six development posts and is working with the Nurse Director to identify how the nursing model fits in-line with the national direction for the nursing workforce, in particular the role of the advance Nurse Practitioner.

**Health Care Support Workers:** Lanarkshire has introduced Health Care Support Workers (HCSW's) in the urgent care centres. This has been welcomed by all practitioners working in the service. HCSW's carry out routine observations for all patients presenting at the centre and enter the results within the Adastra case records to allow clinicians access prior to and during the consultation.

**Learning ST1/3:** Evidence demonstrated a supportive, learning environment where some GPs in the OOH service act as mentors and undertake supervisory role for registrars working OOH.

Part of the training programme for ST1’s and ST3’s includes working in the OOH’s period. Many of the GP’s who have qualified this year had experience of working in the original model across five centres - often in environments which were not as they would have expected. On interviewing this group to join the service as a sessional GP they have stated that the service has been greatly improved, citing not only the environment but also the infrastructure that supports the service.

The service recognised the important contribution of the learning experience for ST3’s working in the OOH’s and following discussion with NES, the lead for GP education recognised the importance of making the OOH’s learning experience as beneficial as possible. Since late June of this year, GP supervisors working in the service identified that some of the ST3’s had completed all their academic work and had passed all exams and only required to complete the compulsory OOH’s work experience. Following discussion with the ST3’s, Clinical Director and management team, arrangements were put in place to have ST3’s carry out home visits on their own supported by the GP supervisor via telephone from one of the centres. It was also agreed at the end of the session the GP supervisors would review the cases with the ST3. This was very well accepted by all and the ST3’s have stated that this was an excellent learning experience prior to them continuing with their career. This practice will be embedded for future ST3’s working in the service.

This has also led to the trainees signing up to work in the OOH service in a way which they previously did not do.

**Paediatric pathways:** As part of the OOH urgent care initial testing programme Lanarkshire is supporting increased paediatric Nursing and Community Health staff in the OOH period.

These are both key special groups where specific recommendations are made in Sir Lewis’s report.
The current pathway for children accessing primary care services in the out of hour's period will be extended to test the introduction of Advanced Nurse Practitioners with expertise in the provision of care to children. The model being tested is using this resource to observe, monitor and treat children within an urgent care setting with the aim of reducing admission to acute services as well as creating a clearer pathway for follow up either in Primary care or within acute specialisms. The model will cover four common areas of illness; Gastroenteritis, Fevered child, Asthma and Bronchiolitis. The test started recently and early indications of impact are positive.

**Mental health pathways:** Mental Health services currently provide professional advice and guidance to the NHS Lanarkshire local OOH hub after calls being triaged by NHS 24. Calls from the hub are forwarded for a one to four hour response to the patient/caller from the psychiatric liaison nursing service during the OOHs period. The nurses provide this service in their day to day role, which can impact on response times and accessibility to respond timely to OOHs hub.

There are a number of patients who have mental health needs seen by the OOH GP (often in a distressed state) who would benefit from specialist mental health care. However, OOH services have been unable to access this due to a mismatch between demand and capacity both within primary and secondary care. Data provided highlight the busiest time between 6pm and 2am, consistent with additional data provided from NHS 24.

Providing a dedicated mental health input to the Urgent Care Centre is the focus of this test of service change, building on the role played in winter planning provision. The availability of expert nurses in mental health to efficiently respond to mental health calls in the OOH centres will ultimately benefit patient and carer outcomes.

Both “Tests of change” programmes will operate over a three month period with fortnightly reporting to the local urgent care implementation group. The urgent care implementation group will monitor, review and act on any changes required. It is recognised that, for both programmes, there are further areas of development which both fields would wish to take forward, however, this will include the further development of the workforce and the use of IT.

**Improvement:** As part of its primary care improvement programme, Lanarkshire had developed an improvement support team to support sustainable improvements in primary care across Lanarkshire. The team provide guidance to front line staff looking for advice on improvement methodology, tools, data management and coaching in order to make improvement. A continuous improvement approach has been adopted to ensure ongoing evaluation of the two centre model for GP OOHs services and regular measurement against the key performance indicators to identify and address any problems.

5. **Areas for Further Development**
The following areas were identified by the Review Team for further development and exploration:
♦ access to NHS Lanarkshire clinical portal in the out of hours period would enhance the information available to clinicians with a direct impact on the management and provision of care. The Review Team were supportive of this. National support as part of the national prioritisation of e-health systems should be considered further
♦ fundamental improvements to the Adastra system, recording of clinical information and sharing of clinical records for all members of the team are required. These recommendations have been identified in the main OOHs review and will be progressed by the new National OOHs group which will include representation from Lanarkshire
further consideration of career pathways for GPs, nurse practitioners and advanced nurse practitioners working in an out of hours urgent care environment and the associated education and training; including professionalising those in a supervisory role (NES, Faculty, Development Alliance course)

consideration of how some of the evidence collected and presented might be applied as the multi-disciplinary out of hours urgent care hub model is developed going forward for example, the future role of SAS in one hour home visits?

consideration of how the role of other professionals and services in the areas outwith the two centres for example, the role of community pharmacy.

collection of how further to build on the engagement with the third sector; developing the role they might play in supporting out of hours urgent care.

greater clarity on aspects of the recommendations that might be tested further in the current year (2016-2017). The Group were particularly keen that Lanarkshire build on the current arrangements and consider how Douglas Street, Hamilton might be developed as a multi-disciplinary, multi-agency Urgent Care Resource Hub as envisaged in Sir Lewis’s Report supported by the service in Airdrie operating as a local Urgent Care Centre. By ensuring co-location of those managing and dispatching calls to the Urgent Care Resource Hub, this has the potential to further increase and enhance the efficiency and effectiveness of access for patients and support a wider range of partnership working.

further evidence of how evaluation will be built into the tests of change.

6. Conclusions and Recommendations
The Review team has concluded that the previous multi-centre model was neither safe nor sustainable; and supports the development of the current two centre model as key for business continuity and service resilience at this time, while ensuring an equitable service – a service that is fair and accessible to all, according to need (a key guiding principle of the OOH Review Report).

It has noted that the evidence supporting the reconfiguration of urgent out of care service (and the interim model adopted by NHS Lanarkshire) was robust and that Lanarkshire has demonstrated a range of innovative solutions in response to the issues identified as part of its review of services.

The evidence presented on service delivery is demonstrating some significant improvements for staff in respect of safety, the environment, support and training and team working; and in immediate patient outcomes since the introduction of the interim model in 2015.

However, it will be important that Lanarkshire continues to develop the service and the review team has made a number of recommendations in that regard. These recommendations require support and endorsement at IJB level. These are set out above.

The recommendations should be incorporated into a detailed action plan for 2016-2017 which should be kept under continuous internal scrutiny by Lanarkshire. It is proposed that a further external peer review visit, through the IJB, to determine progress will be carried out in mid-2017.

Professor Sir Lewis Ritchie
Chair, Out of Hours Urgent Care Peer Review Group
31 August 2016
## Peer Review Group: Membership

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Positional Information</th>
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<tbody>
<tr>
<td>Prof. Lewis Ritchie (Chair)</td>
<td>Academic GP, University of Aberdeen</td>
</tr>
<tr>
<td>Prof. Kate O'Donnell</td>
<td>Professor of Primary Care Research &amp; Development, University of Glasgow</td>
</tr>
<tr>
<td>Kate Bell</td>
<td>Senior Manager Change &amp; Innovation, NHS Lanarkshire (declared interest and did not attend meetings or visit)</td>
</tr>
<tr>
<td>Prof. David Bruce</td>
<td>Director of Postgraduate GP Education, NHS Education Scotland</td>
</tr>
<tr>
<td>Dr Norrie Gaw</td>
<td>Joint Chair National Out of Hours Operations Group</td>
</tr>
<tr>
<td>Dr Sian Tucker</td>
<td>Joint Chair National Out of Hours Operations Group; Clinical Director, Lothian Unscheduled Care Service</td>
</tr>
<tr>
<td>Christine Johnstone</td>
<td>Community Engagement and Improvement Support Manager, Scottish Health Council</td>
</tr>
<tr>
<td>Dr Brian Robson</td>
<td>Executive Clinical Director, Healthcare Improvement Scotland</td>
</tr>
<tr>
<td>Dr John Gillies</td>
<td>Retired GP, Chair, RCGP Scotland (2010-2014)</td>
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<tr>
<td>Ellen Hudson</td>
<td>Associate Director, Royal College of Nursing, Scotland</td>
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<tr>
<td>Katy Lewis</td>
<td>Director of Finance, Dumfries &amp; Galloway</td>
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<tr>
<td>Fiona MacKenzie</td>
<td>NHS National Services Scotland, Information Services Division</td>
</tr>
<tr>
<td>Linda Harper</td>
<td>Associate Nurse Director of Practice Nursing and Unscheduled Care Workforce Development, NHS Grampian</td>
</tr>
<tr>
<td>Prof. Andrew Russell</td>
<td>Medical Director, NHS Tayside</td>
</tr>
<tr>
<td>Dr Libby Morris</td>
<td>Clinical Advisor in Primary Care for e-health, SG and GP, NHS Lothian</td>
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Principles

- How population and demographics will be used to predict demand;
- How the service will take account of patients with special needs as identified in the Review Report that is, palliative care; frail and elderly; mental health and children;
- How it will address inequalities;
- How the service will work in partnership with stakeholders as set out in the Report including NHS 24, the Scottish Ambulance Service, the third sector, social work and social care services, pharmacy and allied health professionals;
- How the workforce and service will be recruited, retained, configured to meet and manage the demand based on the individual needs of patients;
- The education and training of all urgent care staff;
- The arrangements that will be put in place to govern the relationship within and between the partner organisations that make up the urgent care service;
- The appropriate and safe flow of information between partners;
- Clinical governance mechanisms and reporting systems;
- Use of data to assess service capabilities/identify areas for improvement;
- Quality, improvement and performance management arrangements; and
- Evaluation and Continuous Improvement/Sustainability Plans

Peer Review Visit Team:

- Professor Sir Lewis Ritchie, Academic GP, University of Aberdeen & Scottish Government
- Professor Andrew Russell, Medical Director, NHS Tayside
- Ellen Hudson, Associate Director of Professional Practice, Royal College of Nursing Scotland
- Professor David Bruce, Director, Postgraduate General Education & Associate Postgraduate Dean (Foundation), NHS Education for Scotland
- Steven Wilson, Senior Programme Manager, Healthcare Improvement Scotland
- Dr Libby Morris, Clinical Lead, eHealth, Scottish Government
- Dr Sian Tucker, Clinical Director, Lothian Unscheduled Care Service, NHS Lothian
- Linda Gregson, Scottish Government, Primary Care Division

Lanarkshire Team

- Calum Campbell, Chief Executive
- Iain Wallace, NHS Board Medical Director
- Chris Mackintosh, South Lanarkshire HSCP Medical Director
- Craig Cunningham, Head of Commissioning, South Lanarkshire HSCP
- Kate Bell, Senior Manager Change & Innovation
- Maria Docherty, South Lanarkshire HSCP Director of Nursing
- Lorraine Smith, Service Manager East Kilbride locality/OOHs
- Steve Conroy, Clinical Director OOHs
- Jim Murray, Service Manager, Paediatrics
- Lorna Bruce, Senior Nurse Mental Health
- Carol Lambe, Senior Change Nurse OOH
- Frances Moore, Co-ordinator OOH Service
- Calvin Brown, Primary Care Comms Manager
- Margaret Moncrieff, Chair South Lanarkshire Patient Public Forum (PPF)
- Colin Angus, Vice Chair, South Lanarkshire PPF
Data and technology:

♦ It would be helpful to see the data and understand improved outcomes and performance immediately before and after introduction of the interim model

A: From the attached graphs, in Appendix 1, it is clear to see that since the introduction of the interim model performance in the service has significantly improved. Of particular note is the reduction in the unfilled GP sessions and marked improvement in the one and two hour home visiting and PCC performance. We do acknowledge that our current performance against our four hour targets are not at the standard that we would want to see, this is an area of work which we will concentrate on in the future. Please see performance charts Appendix 1

♦ Reasons for increased presentations of children?

A: To date there has been no scientific analysis of why there has been an increase in presentation of children however it would appear that parents find it easier and more pleasant to access Out of Hours (OOHs) rather than visit the ED. It may be that access during day time periods is difficult, for a variety of reasons including socioeconomic issues, and therefore rather than take time off work families find it easier to choose to access urgent care OOHs.

♦ Actual number of GPs now working in the service (that is, have the numbers increased or are the same number doing more shifts?); relationship to pay rates; GP recruitment and retention; filling shifts; Use of agency workers

A: The service currently employees the same number of salaried GP’s as we did prior to the service change in 2015. There are currently 112 independent practitioners registered to work in the OOH service, this is similar to the number recorded in the service 2014/15; whilst there are similar numbers the profile of the GP’s has changed. Of the GP’s registered to work in the service some have increased the number of sessional hours they work (partly due to changes in their other employment for example, retirement). It should be noted that since the move in July 15 that there has been an increase in the number of newly qualified GP’s who carried out their training in Lanarkshire who have registered to work in the service and have indeed taken sessions. During interview it’s apparent that ST1’s and ST3’s are sharing their experience in regards to the environment, peer supervision and support and have indicated that these have influenced their decision to register to work in the service. The organisation reviewed and implemented yearly pay rates to cover all sessions, including public holidays and seasonal hard to cover periods in 2014 and this has remained the same.

Although there had been an increase in the number of GPs, Lanarkshire was still employing agency staff. Shifts were issued six weeks in advance of any approach to fill through agencies.

NHS Lanarkshire also confirmed that the pay rates offered were the same now as before introduction of the interim model.
What if anything would make it easier to use existing data (for example, winter demand/plans) to inform provision; and what/where are the gaps

A: There are a number of IT systems used in a variety of settings by Health and partner agencies however their ability to connect and share information is not optimal. What we require is the connectivity across a range of systems to allow practitioners/professionals/agencies working in urgent care settings to have access to, and the ability to share, information in the provision of care to patients. To help shape the development of services, including workforce, we need easily accessible data via the existing software system in OOH.

Access to NHSL clinical portal in the OOHs period would enhance the information available to clinicians therefore having a direct impact on the management and provision of care.

Interested in hearing more about the Telehealth linkages to care homes

A: Each of the care homes in NHSL has an aligned GP practice and the provision of Telehealth links will support ‘professional to professional’ video conferencing and being able to ‘put eyes on’ patients remotely when required. Additionally, in the future, this will also facilitate nurse visits in the OOH period where they could get remote support from GP/A&E as required. It is anticipated that the linkages will be established within the next few months, this following some contractual difficulties with the initial proposed supplier. It is anticipated that there will be similar linkages to the GP hospitals and also from OOH to A&E departments

Relationship between the interim model and other provision (for example, A&E presentations; under provision in-hours and cross border presentation)

A: There was a concern expressed prior to the interim move that there would be an increased presentation at A&E following the relocation of OOH services to community health centres. Ongoing monitoring of A&E activity has shown this not to be the case with the exception of Hairmyres. The increase in presentation has been attributed to boundary changes and a change in clinical service provision in GG&C.

Whilst we have no evidence to show that under provision in hours has had an impact on OOH we would acknowledge that general practice is extremely challenged on a day to day basis.

We have robust cross boundary arrangements in place at this time and since the implementation of the interim model the service has been able to see all patients referred.
Workforce

The role of Nurses in the model, including recruitment and retention. At what level of training/competencies are the OOH Nurses working to for example, are they minor illness Nurses or advanced Nurse practitioners? If advanced Nurse practitioners are they completing a recognised ANP MSc supported by an ‘in house’ workplace based assessment.

A: All the nurses currently employed are working at nursing practitioner level (band 6 A4C) some see all ages other see only adults. In 2015 the organisation introduced a Nurse development programme for general nurses with five year post registration experience within an A&E or ERC department. They were employed under an ANNEXU contract (A4C) receiving 75% of a band 6 salary, all were employed on a 30hr contract and supported to attend university one day per week with the remaining hours spent in a primary care centre with ongoing support. The organisation secured six places at Glasgow Caledonian University to study “advance assessment” and “non medical prescribing, level 9”. Within the service, GP and Nurse mentors were identified and supported the nurses throughout the study period.

Six nurses were recruited to the development post, four completed the course, three have secured promoted posts at band 7 and one remains in service. We acknowledged before recruitment that retention of the staff would be a challenge due to the fact that the knowledge and skills gained would make the staff an attractive asset for other areas of service provision. Moving into year two the service is currently recruiting to a further six ANNEXU posts whilst working with the Nurse Director to identify how the nursing model fits in line with the national direction for the nursing workforce, in particular the role of the advance Nurse practitioner.

Workforce planning; how is the workforce plan for the service and beyond being developed;

A: As part of the NHS Lanarkshire local review there was a detailed analysis of demographics, patient flow by day and time of the week and requirement by professional group such that this determined the service required a 60/40 ratio of medical to practitioner (such as nursing, mental health, pharmacy, Paeds). Please see section around Nurse development above. The role of pharmacy in the provision of urgent care is being considered in Lanarkshire’s action plan for 2016-17.

Having established a primary care transformation board, one of the key areas that we are focusing on is around GP recruitment and retention and promoting general practice and urgent care in Lanarkshire as a positive career choice. We intend to take a holistic approach to deal with what is a complex problem and takes into account the full spectrum of the GP career path, from medical student through qualifying and specialised training, pre retirement and post retirement.
What if anything has been changed/adapted in response to patient feedback on interim arrangements;

A: Further to two patient satisfaction questionnaires and patients accessing the service we have responded to patient feedback by:
- Reviewing transport companies which has resulted in improved responsiveness to returning patients to their home.
- Improving the directional information on the internet and improving the signage at street level.
- Providing access to drinking water on both sites.

Impact of the reduction to two centres on patients including volume of house calls

A: Ongoing monitoring of urgent care activity has demonstrated that there has been little variation on overall activity. On looking at specific geographical areas for example, Clydesdale and Cumbernauld, we can see that there has been no reduction in patient activity in the OHHs period. There was no change to home visiting arrangements at the time of the interim move and this arrangement remains the same.

Financial implications (for example, extra vehicles for increased distances/demand?; taxi, patient transport costs);

A: Given that there was no change to home visiting arrangements, there were no financial implications for the service. Whilst there has been a slight increase in the number of requests for patient transport, there has only been a slight increase in costs due to new contractual arrangements with transport providers.

Adverse Events

A: Although there had been a couple of SEARs, it was confirmed that these would have happened regardless of the reconfiguration of services. Before the move to two centres, there had been regular reporting of clinical risks by staff through the Datix system. This had improved significantly since the change

Proposals and timescales for engaging with wider stakeholder groups in the development of the urgent care resource hub model (for example, 3rd sector, NHS 24, SAS, Health and Social Care workforce)

A: Our next step in developing the care resource HUB is to relocate the OOHs HUB from Hairmyres Hospital into the primary care centre in Hamilton alongside the other elements of the service. This will increase efficiency and our effectiveness to respond to clinical need.
Since the transition, we have improved and enhanced our Partnership forum with NHS24, SAS and ourselves. The forum has proved pivotal in enhancing the relationship between the partners resulting in us sharing and learning from each other’s experience. This culminated in a Partnership workshop with A&E, NHS24, SAS, Mental Health and Paediatrics in April 2016, the outcome of the workshop has resulted in two tests of change for Mental Health and Paediatrics and the establishment of a local transforming urgent care group to monitor and evaluate the impact of the change.

With the establishment of HSCP, our intention is to scope the art of the possible to further develop our resource HUB with regards to the third sector, ICST and social care services such as Alert and Home Care.

One of the developments associated with Health and Social Care Partnerships in recent years has been the development of Locator Tool. This allows people to follow the undernoted link and thereafter post a service in which they would be interested. In turn, this provides the person/carer access to all relevant voluntary groups in their respective area.

http://www.vaslan.org.uk/locator/ Additionally, through eLament - NHS Lanarkshire has led a range of initiatives aimed at providing self help/supported help to assist people in managing mental health issues. Again, this is supported through an electronic platform and provides an accessible alternative to hands on care where appropriate http://www.elament.org.uk/. Both of these services can be accessed 24/7.

♦ Relationship with SAS

A: The changes had resulted in an initial increased demand for Scottish Ambulance Services urgent tier vehicles (particularly in relation to patient transfers), with a knock on effect on A&E vehicles (less urgent tier are available overnight). Working together, analysing and using the data has resulted in additional urgent tier capacity in the area. A paramedic is now working as part of the Douglas Street, Hamilton team
Views from Clinicians in the Lanarkshire Re-Modelled Out of Hours Service

1. Medical Director (Primary Care) – Dr Chris Mackintosh

Dr Mackintosh has been involved in the redesign process since its launch.

“Clinicians working in the OOH service, and not working in the OOH service, have developed their views both during the consultation period and during the implementation so far. I have heard only positive comments about the current service both in terms of delivery of service and in terms of working within the service. There is also a recognition that further development is both healthy and desirable within the learning environment which now exists”

2. Clinical Director (Out of Hours) – Dr Steve Conroy

Dr S Conroy, Clinical Director for OOH’s was appointed in July 2015 and previously worked in the service. He has commented on the general feeling from those working in the service.

“Whenever I have been on duty I have asked colleagues about their opinion on the new working arrangements. I think, because I have worked in the service for years, I get honest answers and nothing intended just to placate me. I have had nothing but positive comments back, some from surprising sources. The main positive has been around an increased feeling of team working because of the presence of more colleagues. People feel safer and much more supported. On occasion people have sought me out to tell me. I haven’t come across anybody who would want to move away from this way of working now.”

3. Lorraine Byrne – Trainee Nurse Practitioner

‘I am pleased to advise that I have passed advanced assessment and non medical prescribing modules. I would like it to be acknowledged that I contribute a large proportion of my success to my GP mentor Dr David Tollan. The time, enthusiasm and support I received from Dr Tollan was invaluable and had a direct impact on my successful completion of both modules. I would also like to thank NHS Lanarkshire for the opportunity.’

4. General Practitioner

Sessional OOH’s GP Dr Dianne Campbell

“The Lanarkshire GP Out of Hours service has felt quite different to work in since the switch to the two primary care centres. There is much more of a team approach, with the extension of nurse practitioner, clinical support worker and medicines management roles. I have far less of a feeling of being a lone wolf, in a room. The security of the buildings has also been excellent. The medicines management team have made home visiting shifts go much more smoothly, as I can trust that the home visiting bags are well maintained, despite being handled by so many clinicians during the course of the month.”

Salaried OOH’s GP Dr David Tollan

I am a salaried out of hours GP with NHS Lanarkshire. I have been in post for eight
years. I have worked through some turbulent times.

Since we moved to Hamilton and Airdrie I am enjoying my job much more. The key to this is team work. As we are now working in an environment that supports team work, the changes have been substantial. Out has gone lone working and in has come real quality teamwork.

Out has gone unacceptable accommodation in the hospitals and in has come appropriate facilities to look after our patients. Shifts are being filled by enthusiastic GPs. NHS Lanarkshire have excelled in making a poor place to work into being a good place to work. I am appreciative of the changes that have been made.

5. OOH’s Pharmacy Advisor Ms Jacqueline Kelland

“The introduction of Medicine management staff allows a particular focus on medicines within the OOH’s period. This ensures that we have medicine stock at all times, we don’t order to excess and we are mindful of expiry dates ensuring we don’t run the risk of issuing expired stock.

From a management perspective we have been able to undertake review audits on particular medicines for example, prednisolone and have implemented new processes and improved prescribing habits.
Appendix 2

NHS Lanarkshire Out of Hours Monthly Performance Report (Jan ‘15 - Sept ‘16)

Home visit – 1 Hour

Home visit – 2 Hours
Report to: South Lanarkshire Integration Joint Board  
Date of Meeting: 06 December 2016  
Report by: Director, Health and Social Care

Subject: Medicines Management for People who require a Care at Home Service

1. Purpose of Report
   1.1. The purpose of the report is to:-

   - note the progress on the roll-out and implementation of a procedure within home care that supports people at home to manage their medication safely and effectively, while working within the current guidelines of the Care Inspectorate
   - consider proposals for ratification and full implementation of the procedure

2. Recommendation(s)
   2.1. The Integration Joint Board is asked to approve the following recommendation(s):

   (1) that it note the evaluation of the Medicines Management Procedures that has been implemented within East Kilbride and Hamilton localities to date;
   (2) that it consider proposals for ratification and full mainstreaming of the service across South Lanarkshire Health and Social Care Partnership (HSCP); and
   (3) that it note the success to date of this work, and continue to support the programme.

3. Background
   3.1. Under the direction of Reshaping Care for Older People, and now the Integrated Care Fund, two Medicines Management Pharmacists were tasked to work alongside both South and North Lanarkshire Councils to create a pan-Lanarkshire Medicines Management Procedure for Care at Home.

   3.2. The new medication arrangements, currently being rolled out within South Lanarkshire HSCP, enable home carers to prompt service users' medication, or to administer the medication if that level of service is required and appropriate. These arrangements are operational in East Kilbride and Hamilton localities, with Clydesdale locality staff currently being trained prior to implementation.

   3.3. Until this work commenced, it has been custom and practice to provide vulnerable people with their medication presented in Multi Compliance Aids (MCAs) which are often referred to as blister packs or dosette boxes. While this particular practice has become common place within Home Care Services, there has been a growing concern about the safety and appropriateness of this type of care, particularly as 40% of all medicines are not suitable to be housed within such a device due to concerns of safety and/or efficacy.'
3.4. The Care Inspectorate has a requirement for Home Care Services to provide both a prompt and an administration service. Accompanying the requirement for these services is the need for appropriate training, documentation and audit. All of these are provided within the new Medicines Management Procedure. Further, the Medicines Management Procedure definitions of ‘prompt’ and ‘administration’ completely align with the definitions of the Care Inspectorate (published Sept 2015) and support the service user’s independence where at all possible.

3.5. The Home Carer grading matrix currently reflects the requirement for home carers to both prompt and administer medication. Trade Unions have been fully involved in the developments. There is a comprehensive training programme in place for all carers and the roll out of the medicines management procedures is being implemented on an incremental basis across localities.

4. Progress

4.1. The Medicines Management Procedure has been operational in Strathaven since October 2013, when the initial pilot commenced, with East Kilbride locality following in May 2015 and Hamilton in May 2016. A comprehensive training programme was designed and delivered to ensure home carers:

- have an awareness of medicines and their risks
- are empowered to identify and query medicines-related problems
- have the ability to signpost appropriately for any medication concerns they identify, while documenting the next steps for resolving problems, providing an audit tool
- have a confidence to undertake the tasks associated with safe and effective medication use by their service users

4.2. Medicines Management training is provided to Home Carers, Home Care Managers and out of hours personnel. A total of 635 individuals have received the one day training session which is delivered by the Pharmacists from NHS Lanarkshire, with support from a home care co-ordinator.

4.3. To cover the volume of people who require an awareness of the Medicines Management Procedure, Community Pharmacy champions have also been trained within the last 10 months. These Pharmacy champions offer awareness and support to Community Pharmacies within the HSCP, enabling the Community Pharmacy to have a greater understanding of the requirements of a Care at Home Service in relation to medicines use, and to provide Medication Administration Records (MAR charts) for those patients who require administration of medication, when requested to do so.

4.4. Service users require to be assessed for their level of need in order to determine the level of support required with their medication from home care staff. A Medicines Management Assessment Tool was developed to identify this need. This patient-centred assessment of each individual maximises their independence and facilitates their re-ablement. The Medicines Management assessment may be undertaken by a range of Health and Social Care staff. There have been 225 assessments completed to date with almost 50% assessed as managing their medication independently, 35% requiring basic assistance and 15% requiring administration support.
4.5. The Medicines Management Assessment Tool is a non-clinical document, which is used by multiple disciplines and can be used at any point in the service user’s journey. Assessor training was developed, which is now delivered on a multi-agency within the community and across the hospital interface. Approximately 145 assessors have participated in this training programme.

4.6. In addition, it is especially important to realise that people’s needs change, often as the result of a change in their health status, resulting sometimes in a hospital admission. For this reason, we hope to achieve a single system of working with a 360° process with Medicines Management established in the community and the opportunity to maintain that service when service users rotate through the hospital.

5. Evaluation of Pilot

5.1. Feedback from the pilot work has been positive. Service users who have transferred onto the new model of care, along with their family/unpaid carers have expressed support for this practice, stating to staff that they would not like to return to the previous method of working. Management and staff are in agreement with this opinion.

5.2. Home Carers have responded positively to the change in practice and with sufficient training and support have welcomed the opportunity to manage medicines more appropriately and feel confident in directing enquiries to Community Pharmacists and other appropriate personnel.

5.3. The roll-out of the Medicines Management Procedure delivers improved systems for medicines reconciliation for the most vulnerable people living in their own homes. Additionally, earlier identification of medicines-related problems are communicated to an appropriate healthcare professional allowing earlier clinical intervention, reduction of harm and in some instances avoiding admission to hospital.

5.4. It has also been critical to map the complexity of the multiagency, multidisciplinary systems which combine to provide care for vulnerable people living at home in the community; and to realise how all of the different stakeholders must be engaged to influence, agree and then implement new models of care.

6. Next Steps

6.1. It is proposed to fully mainstream the use of the Medicines Management Procedure in the localities that have been trained.

6.2. Training dates have been planned until February 2017 for the Home Carers and assessors within the Clydesdale locality and dates will be scheduled in the Rutherglen locality. The Medicines Management Assessment Tool will then be used by assessors of multiple disciplines, allowing all service users to have an assessment of their potential requirement for medicines support, using the minimal intervention approach in which they are trained.

6.3. Communication is ongoing with community pharmacists across the East Kilbride, Hamilton and Clydesdale localities to ensure their continued support of Home Carers and all patients who receive a home care service and, in particular, those who require a MAR chart in order to facilitate an administration service.
6.4. The Medicines Management Procedure is currently being updated following the learning from the pilots and subsequent roll-out phases described above. The presentation of the Medicines Management Procedure to the Care and Clinical Risk Governance Group will follow, with a view to achieving its ratification and full implementation of the policy across Lanarkshire.

6.5. Support will continue to be available to staff in all localities with Medicines Management. Additionally, the pharmacists will provide more in-depth assistance in the management of complex cases, including those with high risk drugs for example, warfarin, or those with medical/social complexities for example, Huntington’s Disease.

6.6. It is anticipated that implementation of the Procedure would be extended to all localities.

6.7. At a national level links are in place with the Royal Pharmaceutical Society, the Care Inspectorate and the Association of Directors of Social Work to look at forming a National Assessment Tool.

7. Conclusion
7.1. A single, patient-centred Medicines Management Procedure, integrated within Health and Social Care, where the Assessment Tool can be used within hospital and community settings to determine the appropriate level of patient support. This provides a system of audit, medicines reconciliation, trained staff and empowered patients able to live safely in their own home – an effective end-to-end solution.

7.2. The Medicines Management Procedure gives the following benefits to people who receive a home care service;
   ♦ reduces the 5-17% of hospitals admissions that are medicines-related (Scottish Patient Safety Programme)
   ♦ alignment with the Care Inspectorate requirements around prompt and administration services, audit, training and documentation
   ♦ supports the independence of those who require minimal support to self-administer medication, and aligns with Supporting Your Independence (SYI)
   ♦ allows the South Lanarkshire HSCP to offer an administration service to those who are most in need of support with medication
   ♦ person-centred assessment which can be undertaken by clinical or non-clinical staff at any point on the patient journey, which identifies support needs for each individual
   ♦ ensures standards of work which protect and promote the safety and wellbeing of people receiving support, and provides safeguards for staff
   ♦ early identifying and treating patients in the community, prior to the need for hospital admission, so reduces hospital admissions
   ♦ increases capacity of Care at Home and other services by stabilising patients in the community

7.3. The Medicines Management Procedure aligns with the nine National Health and Wellbeing Outcomes, supporting them to live well in their own home by delivering the most appropriate level of medication assistance according to a person-centred needs-based assessment and a culture of supporting people’s independence while providing quality improvement for those who require a medication service.
8. Employee Implications
8.1. Consideration must be given to the ongoing training requirements for the Home Care workforce and staff associated with the service such as Emergency Social Work Service and community health staff. This includes consideration of ongoing medicines training for new employees, for people returning after absence, and as refresher training. We anticipate that medication training may become part of the service's core training in the future.

8.2. The current home care training has been offered to the in-house service alone. Consideration should be given to the independent care providers in relation to medication, and the understanding that use of a new Medicines Management Procedure within the HSCP will have a relevance to independent care providers, particularly those who have a contract with South Lanarkshire HSCP and would therefore require to work to the same Medicines Management Procedure. Both Medicines Management and Assessor training would be relevant for independent care providers in order to support service delivery to their service users, many of whom have split care packages between the in-house and independent providers.

8.2. Additionally, consideration must be given to the involvement of independent providers of home care, particularly as some people receiving home care have split packages of care and therefore a requirement for a consistency of service delivery.

9. Financial Implications
9.1. Training programme for above staff. Whilst additional home care time has been given to support individuals on the pilot it is anticipated that through the review process and the Medicines Management Assessment Tool, there may also be reductions in service.

10. Other Implications
10.1. Risk assessment is conducted for each service user in advance of policy implementation.

10.2. There are no sustainable development issues associated with this report.

10.3. There are no other issues associated with this report

11. Equality Impact Assessment and Consultation Arrangements
11.1. An Equality Impact Assessment will be undertaken as part of the pilot.

11.2. Consultation has been undertaken with service users, families, GPs, Community Pharmacists and Social Work employees.

Val de Souza
Director, Health and Social Care

Date created: 18 November 2016

Previous References
♦ none
Contact for Further Information
If you would like to inspect the background papers or want further information, please
contact:- Deborah Mackle, Service Manager, Home Care
Ext: 3744 (Phone: 01698 453744)
Email: deborah.mackle@southlanarkshire.gcsx.gov.uk
1. Purpose of Report
1.1. The purpose of the report is to:-

- provide an update on the current position in relation to GP staffing in Lanarkshire
- provide the Integrated Joint Board (IJB) with information on the various strands of work in place to help mitigate the position

2. Recommendation(s)
2.1. The Integration Joint Board is asked to approve the following recommendation(s):-

(1) that the current position in relation to GP staffing in Lanarkshire is noted; and
(2) that updates on progress against the various actions be submitted to future meetings of the Board.

3. Background
3.1. Over the past several months a growing number of practices have approached NHS Lanarkshire to discuss a variety of issues that are impacting on their ability to sustain services and can be summarised as follows.

3.2. Moffat Practice
3.2.1. Although in NHS Dumfries and Galloway (NHS D&G), this practice has branch premises in Lanarkshire (Crawford and Leadhills) and as a result of recruitment difficulties following the retirement of the GPs in the Moffat practice, NHS D&G has had to take over the running of the practice. To maintain services, NHS D&G is considering withdrawing General Medical Services (GMS) from the Crawford and Wanlockhead branches, the former of which will affect patients in a rural area of South Lanarkshire.

3.3. Lanarkshire Position
3.3.1. There are four practices in Lanarkshire with closed lists and a number of other practices looking to review their position. Also, a number of practices have sought to review/revise their practice boundary in an attempt to stabilise their workload.
3.4. Property Issues
3.4.1. Practices which own their own premises have a further complication in attracting new GP partners in that they are usually required to ‘buy into’ the practice in that when a partner retires, they take a proportion of the value of the building with them. This also needs careful consideration going forward.

3.5. The general recruitment/retention issues, the lack of GP locums, rising workload and declining morale, not only in Lanarkshire but across Scotland and the UK, are all leading to a deteriorating situation which is beginning to impact on the sustainability of GMS services locally. As noted in the figures below from the Primary Care Workforce Survey Scotland 2015, all of this is set against a backdrop of NHS Lanarkshire having the fewest number of GPs per head of population of all mainland boards.

4. Assessment of Current Position
4.1. Recognising that the traditional model of general practice is no longer sustainable, discussions between SGPC and the Scottish Government on the future of the GMS contract in Scotland have been ongoing for some time. It is anticipated that the recently announced revisions to the existing contract will remain in place throughout 2017 with a new contract for GPs in Scotland anticipated for April 2018 onwards.

4.2. The Primary Care Workforce Survey Scotland 2015, published by Information Services Division, highlights some key issues:

- the estimated Whole Time Equivalent (WTE) of GPs declined by 2% between 2013 and 2015 (from 3735 to 3645)
- the proportion of GPs working eight or more sessions, considered to be a ‘full time’ commitment, has decreased with a resulting decrease in the number of WTE GPs across Scotland. This decrease is occurring against a backdrop of increasing demand on GP services, with a continuing drive to shift from hospital to primary care and an ageing population
- an increase in the number of GP vacancies since the last survey in 2013. The survey has found that a large proportion of the vacancies reported in the survey that were still unfilled had been vacant for over six months
over a third of GPs working in Scottish general practice are aged 50 years old or over. Among male GPs, this proportion is higher, with nearly half (47%) aged 50 years old or over.

4.3. To ensure general practice in Lanarkshire is sustainable during the current recruitment/retention challenges, which are predicated to get worse over the next several years and in the absence of sufficient numbers of additional GPs, substantial and sustained service transformation and greater collaboration between practices will be required to ensure patients continue to access quality general medical services.

4.4. Whilst recognising that the main role of ‘GP clusters’ is not to work together to develop sustainable models of care, this would seem an ideal vehicle to support more collaborative ways of working. As practice clusters develop and evolve across Lanarkshire, the opportunity this brings for practices coming together to collaborate and develop economies of scale – both in terms of clinical expertise/resources and management and administration – needs to be encouraged and supported to ensure the transformation that is required can be achieved.

4.5. It has to be recognised, however, that such change tends to take significant periods of time and much of it is reliant on the availability of other staff groups being able to prescribe, for example, Advanced Nurse Practitioners (ANPs) and pharmacists who are also in short supply and take time to grow.

4.6. NHS Lanarkshire has secured £6.1m of funding as part of a Primary Care and Mental Health Transformation Programme over a number of work streams and this programme should be reviewed and adapted and in the most challenging areas, accelerated, to deal with the current emerging difficulties being seen in general practice across Lanarkshire.

5. Employee Implications
5.1. There are no employee implications associated with this report.

6. Financial Implications
6.1. Significant depending on potential solutions. Further work is required in quantifying the same.

7. Other Implications
7.1. This issue has now been included on the NHSL Corporate Risk Register as ‘very high’.

7.2. There are no sustainable development implications associated with this report.

7.3. There are no other issues associated with this report.

8. Equality Impact Assessment and Consultation Arrangements
8.1. EQIA may be required depending on the solutions adopted.

8.2. There was no requirement to undertake any consultation in terms of the information contained in this report.

Val de Souza
Director, Health and Social Care
Previous References

- none

Contact for Further Information
If you would like to inspect the background papers or want further information, please contact:
Craig Cunningham, Head of Commissioning and Performance
Ext: 3704 (Phone: 01698 453704)
Email: craig.cunningham@southlanarkshire.gcsx.gov.uk
1. **Purpose of Report**  
1.1. The purpose of the report is to:-

- to support the further development of the agreed Vision for the Integration Joint Board and develop agreed values, behaviours and ways of working.

2. **Recommendation(s)**  
2.1. The Integration Joint Board is asked to approve the following recommendation(s):-

(1) that a development session with the Integration Joint Board (IJB) members is held in January to build on the vision statement, to explore and agree joint values and behaviours for the Board and how these translate to ways of working that will support the delivery of the Partnership Outcomes; and

(2) that a programme of master classes be delivered throughout the year informed by the output from the IJB development session.

3. **Background**  
3.1. The focus on the IJB development to date has been on the legislative requirements of the Board and the development of the Strategic Commissioning Plan.

3.2. New members have been appointed to the Board and this is the right opportunity to develop the next steps for the Board and individual members to support the partnership in developing its shared vision, values and new ways of working.

3.3. Changing Models in Health and Social Care, Audit Scotland (March 2016) highlighted that NHS Boards and councils could do more to address barriers and facilitate change.

4. **Development**  
4.1. A development session should be delivered:

- to support the board members and senior officers to explore and agree their vision for how the board will operate
- to agree joint values and behaviours for the Board and how these translate to ways of working collaboratively that will support the delivery of the Partnership Outcomes
- to support the transformational change required for system delivery to asset based community delivery.
4.2. The Organisational Development Manager will work with the Chairs of the Locality Planning Groups to support further development on specific support required for this role in relation to locality planning and engagement.

5. Employee Implications
5.1. There are no employee implications associated with this report.

6. Financial Implications
6.1. The costs of any sessions associated with this report will be met through the partnership Organisational Development Fund.

7. Other Implications
7.1. There are no risk implications associated with this report.
7.2. There are no sustainability development implications associated with this report.
7.3. There are no other implications associated with this report.

8. Equality Impact Assessment and Consultation Arrangements
8.1. There is no requirement to carry out an impact assessment in terms of the proposal contained in this report.
8.2. There were no requirement to undertaken any consultation arrangements.

Val de Souza
Director, Health and Social Care

Date created: 11 November 2016

Previous References
♦ none

List of Background Papers
♦ none

Contact for Further Information
If you would like to inspect the background papers or want further information, please contact:-
Yvonne Cannon, Organisational Development Manager
Ext: 4249 (Phone: 01698 454249)
Email: yvonne.cannon@southlanarkshire.gcsx.gov.uk
1. Purpose of Report
   1.1. The purpose of the report is to:-

   ♦ to provide an update in relation to the planning arrangements put in place to ensure services are prepared for the coming winter months and that mitigating actions have been identified to assist in supporting any increases in activity and/or supporting adverse weather conditions. These arrangements have been informed by national guidance to meet the needs of the local population during the winter period.

2. Recommendation(s)
   2.1. The Integration Joint Board is asked to approve the following recommendation(s):-

   (1) that the winter planning actions, set out in the attached Winter Plan, which are being undertaken to provide a comprehensive approach to ensure robust plans are in place to manage additional service pressure associated with winter be supported.

3. Background
   3.1. Each year, NHS Lanarkshire, in conjunction with other planning partners, (as listed at 3.2 below) develops a Winter Plan in order to prepare for an increase in unscheduled demand across a range of services during the winter months. The plan is informed by local past experience and national guidance.

   3.2. A winter planning group has been established with involvement of acute services; North and South Lanarkshire Health and Social Care Partnerships; NHS Resilience Officer; Salus; NHSL infection control; North and South Lanarkshire Council Resilience officers; Scottish Ambulance Service and NHS24. The communications team is also represented on the group to ensure consistent and organised communication plans with all other parts of the public sector in the lead up to winter.

   3.3. Over the last few years, the Scottish Government has provided a self assessment checklist for boards to utilise in order to assess their readiness for winter. The detailed self assessment checklist is provided as Appendix 1 to the attached plan.
3.4. In addition to the self assessment, we have introduced a range of local indicators and these are similarly provided as Appendix 2 in the attached plan.

3.5. Work is continuing in indentifying any additional resources, surge capacity and other contingencies which may be required such that the respective performance measures referred to above can be achieved. In this respect, much of the work already undertaken and funded via the local unscheduled care action plan, integrated care funds and other service improvement work supported throughout the year will assist in ensuring maintenance of performance.

3.6. The IJB and NHS Lanarkshire Health Board were also represented at the National Integrated Winter Planning event on 8 September 2016 and the associated learning from that event has been included in the respective areas of the action plan.

4. Employee Implications
4.1. Additional staffing will be deployed based on predicted levels of high demand.

5. Financial Implications
5.1. The HSCP and NHSL have directed funding to support the plan. Some further funding was also received from Scottish Government and this will be used to support a range of initiatives to increase the flow through the hospitals over the winter period. This includes extended ambulatory care, frailty assessment, enhanced social work provision, outpatient antibiotic therapy provision, extended nursing and AHP roles and enhanced medical cover particularly over the weekend. In addition to the measures to enhance patient flow we will also ensure that in the event of surges in demand we have the ability to flex inpatient provision. This will result in a minimum of £1,777k being available to support specific winter planning work.

6. Other Implications
6.1. Filling of staffing rotas over the peak winter period has been identified as a risk, however, work is ongoing in filling the respective rotas.

7. Equality Impact Assessment and Consultation Arrangements
7.1. This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy and, therefore, no impact assessment is required.

7.2. There was also no requirement to undertake any consultation in terms of the information contained in this report.

Val de Souza
Director, Health and Social Care

Date created: 01 November 2016

Previous References
♦ none

Contact for Further Information
If you would like to inspect the background papers or want further information, please contact:-
Craig Cunningham, Head of Commissioning and Performance, South Lanarkshire Health and Social Care Partnership
Ext: 3704 (Phone: 01698 453704)
Email: craig.cunningham@southlanarkshire.gcsx.gov.uk
Winter Planning

NHS Lanarkshire, North Lanarkshire H&SCP, South Lanarkshire H&SCP

1. Background
   Each year, the Health Board, in conjunction with the Health and Social Care Partnerships and other planning partners, (as listed below) develops a Winter Plan in order to prepare for an increase in unscheduled demand across a range of services during the winter months. This plan is informed by local past experience and National guidance.

   A winter planning group has been established with involvement of Acute Services; North & South Lanarkshire H&SCP’s; NHS Resilience Officer; Salus; NHSL Infection Control; North & South Lanarkshire Council Resilience officers; Scottish Ambulance Service and NHS24. The Communications Team is also represented on the group to ensure consistent and organised communication plans with all other parts of the public sector in the lead up to winter.

   Scottish Government have provided a self assessment checklist for boards to utilise to assess their readiness for winter and this has been populated to provide assurance that the respective planning arrangements are in place. This is attached at Appendix 1.

2. Key Elements of the Winter Plan
   Appendix 1 provides a detailed breakdown of the actions put in place as per the assessment checklist. This is supported by detailed action plans in relation to the respective hospital sites and H&SCPs to meet the needs of the population during the winter period.

   Undernoted is a summary of the main areas covered by the respective individual plans.

a. Primary Care/General Practice
   - provision of General Medical Services on the Public Holiday Mondays and Tuesdays post Christmas and New Year
   - delivery of the flu vaccination programme to the population at risk, over 65s, and children. Reminder to patients to ensure they have adequate supplies of medication during public holiday periods
   - proactive visits to vulnerable groups using the SPARRA data, and specifically those patients identified as being part of Care Management, including assessment of carer needs
   - locality specific plans which set out staffing levels, escalation plans, access to home loan equipment and availability of local services during the peak periods
   - guidance issued to all nursing/care homes alerting them to the steps they should take to minimise the impact of winter – including what to do in the event of suspected Norovirus

b. Primary Care Out of Hours/NHS24
   A number of measures have been put in place to increase capacity and ensure that patients are seen and treated by the most appropriate service, in the most appropriate environment. Additionally, Tests of Change are currently being undertaken in support of ‘transforming urgent care’ and these will support greater numbers of patients being seen outwith a hospital environment. Additionally, specific work is also being undertaken in relation to COPD patients and how they can be supported in the OOH period without recourse to hospital admission.
Direct access to NHS 24 is also going to be made available from the 3 x A&E departments. It is envisaged this will assist in supporting redirection of inappropriate A&E attenders.

c. **Acute Hospital Service**
   The detail contained within Annex 1 has been informed by lessons learnt from past experience as well as the national guidance and the initiatives set up in response to the Reshaping Care and subsequent Integrated Care Fund initiatives; the Lanarkshire Unscheduled Care Action Plan; and Delayed Discharge Action plan. The plans describe a range of initiatives aimed at maximising senior decision making at the front door, services to support early diagnosis and discharge and wider coverage over weekends to ensure 7 day flow.
   Significant work has also been undertaken in assessing the balance between elective and unscheduled care over the peak winter period with an increase in day cases being factored into the period post first week in January. Surge capacity has been identified and will only be utilised in extremis recognising the current prioritisation process linked to the availability of funding.

d. **Vulnerable Patients**
   Action is being taken to identify patients that for clinical reasons must attend hospital for treatment. An example of this would be a renal patient. Contingency plans have been prepared to respond to any difficulties experienced by those patients in travelling to hospital during the winter period. This will involve close liaison between SAS and the respective Roads Departments of North and South Lanarkshire Councils. Similarly, care plans for patients who are ‘regular’ attendees across a range of services are also being prepared/updated with a view to ensuring a shared understanding of preferred care arrangements.

e. **Health and Social Care Partnerships**
   Work has been undertaken to identify the additional capacity that should be available to acute sites as a result of the additional investment which has taken place in community based services to expedite safe discharge and thereby reduce the number of beds occupied by delayed patients.

   This shows that if both Partnerships meet their respective trajectories, there will be an additional 22 beds available across Lanarkshire (8 in North and 14 in South). Close working arrangements with the respective Discharge Hubs in each of the 3 x DGHs will be a constant feature as part of the Winter Plan. Plans are also in place to ensure rapid access to both assessment and home care staff over the winter period. Similarly, external home care providers have confirmed they are confident they will have sufficient staffing to meet additional demand.
   A range of intermediate care beds will also be introduced in South Lanarkshire to assist in managing demand over the winter period. These resources are already available in North Lanarkshire.
   An escalation plan covering NHSL and both Partnerships, linked to the existing ‘barometers’ has also been agreed and is being tested as part of the build up to the peak winter period.

f. **Scottish Ambulance Service**
   The Scottish Ambulance Service has indicated their preparedness to respond to requests for additional ambulance transport provided advance notification is given of the nature and extent of that additional demand. It is intended to again utilise the Predictive Data Analysis Tool to predict demand implications for the Scottish Ambulance Service. Plans are also in place to have a dedicated discharge vehicle at each of the 3 x DGH sites.
g. **Communication Plan**
A communication plan will be directed at both the staff across all agencies and the public. This will be undertaken in consultation with NHS24, national communications and Councils.

Information for the public on early preparedness for winter will be available and displayed in A&E Departments, as well as wider circulation to the general public in the form of social media and coverage in national campaigns. Specific reference will be given to flu vaccine and management of Norovirus and the respective advice for patients, visitors and the public alike.

A dedicated web page has been included on NHS Lanarkshire Intranet site with all associated folders in relation to providing fast access to respective information.

3. **Monitoring Performance**
A performance framework has been developed specifically to collate performance information into a report for the winter planning group, the respective Admission and Discharge groups in North and South Lanarkshire and the Unscheduled Care Group. This is attached as Appendix 2.

This is beyond the routine reporting of performance as part of the national arrangements.

4. **Risk Assessment**
Identifying sufficient staff and funding to support all the areas identified within the winter planning process has been identified as a significant risk.

The Health Board and the respective H&SCPs have directed levels of budget to the value of £937,673 to be made available to support the winter plan. Following the receipt of some further national funding, this will be used to support a range of initiatives to increase the flow through the hospitals over the winter period. This includes extended ambulatory care, frailty assessment, enhanced social work provision, outpatient antibiotic therapy provision, extended nursing and AHP roles and enhanced medical cover particularly over the weekend. In addition to the measures to enhance patient flow we will also ensure that in the event of surges in demand we have the ability to flex inpatient provision.

Filling of staffing rotas over the peak winter period has progressed well, however, work is ongoing in filling the gaps, recognising that the respective rotas are not all covered in full in-year.

Both Councils conducted winter resilience events to test their respective arrangements and the Lanarkshire Local Resilience Partnership held their annual winter event, 'Winter Breach 5' on 27 October in Ravenscraig Regional Sports Facility, Motherwell. The focus will be on power loss and in particular the effect of that on communication.

All areas have been directed to update Business Continuity Plans and confirm that they are robust and accessible. A number of these have also been/are being tested.
**Winter Preparedness: Self-Assessment Guidance**

- Local governance groups should use the attached checklists to self-assess the quality of overall winter preparations and to ascertain where further action is required to ensure that winter preparedness priorities are met.

- There is no requirement for these checklists to be submitted to the Scottish Government.

- Draft winter plan(s) on local winter planning arrangements should be lodged with the Scottish Government by the end of August, and final plans by the end of October. Draft plans should cover the actions being taken around the critical areas and outcomes outlined in this guidance and include details of local governance arrangements. Final plans should have senior joint sign-off reflecting local governance arrangements and should be published online. Plans / links to plan(s) should be sent to Winter_Planning_Team_Mailbox@gov.scot.

- Winter Plans should consider the critical areas highlighted in the Preparing for Winter 2016/17 Guidance and demonstrate effective integration of key partners and services.

- The following RAG status definition table is offered as a guide to help you evaluate the status of your overall winter preparedness against each action.

<table>
<thead>
<tr>
<th>RAG Status</th>
<th>Definition</th>
<th>Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>Systems / Processes fully in place &amp; tested where appropriate.</td>
<td>Routine Monitoring</td>
</tr>
<tr>
<td>Amber</td>
<td>Systems / Processes are in development and will be fully in place by the end of October.</td>
<td>Active Monitoring &amp; Review</td>
</tr>
<tr>
<td>Red</td>
<td>Systems/Processes are not in place and there is no development plan.</td>
<td>Urgent Action Required</td>
</tr>
</tbody>
</table>
|   | Resilience Preparedness  
    (Assessment of overall winter preparations and further actions required) | RAG | Lead | Completion Date | Comments |
<table>
<thead>
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<tbody>
<tr>
<td>1</td>
<td>The partnership has robust business continuity management arrangements and plans in place to manage and mitigate all key disruptive risks including the impact of severe weather. These arrangements have built on the lessons learned from previous periods of severe weather, and are regularly tested to ensure they remain relevant and fit for purpose.</td>
<td>GM’s , Site Directors, PSSD</td>
<td>Completed</td>
<td>Acute and primary care services have been reviewing arrangements which will be complete by September</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Resilience officers are fully involved in all aspects of winter planning to ensure that business continuity management principles are embedded in winter plans. The <em>Preparing For Emergencies: Guidance For Health Boards in Scotland (2013)</em> sets out the expectations in relation to BCM and the training and exercising of incident plans – see Sections 4 and 5, and Appendix 2 of Preparing for Emergencies for details. The <em>NHSScotland Standards for Organisational Resilience (2016)</em> sets out the minimum standard of preparedness expected of Health Boards – see Standard 18.</td>
<td>Resilience Officers</td>
<td>Ongoing</td>
<td>NHS, SLC + NLC resilience officers are members of the winter planning group</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Business continuity (BC) plans take into account the organisations critical activities; the analysis of the effects of disruption and the actual risks of disruption; and plans are based on risk-assessed worst case scenarios.</td>
<td>GM’s , Site Directors, PSSD</td>
<td>Completed</td>
<td>Acute and primary care services have been reviewing arrangements which will be complete by September</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Risk assessments take into account staff absences and a business impact analysis so that essential staffing requirements are available to maintain key services. The critical activities and how they are being addressed are included on the corporate risk register and are regularly monitored by the risk owner.</td>
<td>GM’s , Site Directors, PSSD</td>
<td>November 2016</td>
<td>A ‘desk-top’ exercise will be undertaken in MDG.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The partnership has negotiated arrangements in place for mutual aid with local partners, which cover all potential requirements in respect of various risk scenarios.</td>
<td>A Robertson, K Wratten, AMcMann</td>
<td>Completed</td>
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</table>
3. The NHS Board and Local Authority have HR policies in place that cover:
   - what staff should do in the event of severe weather hindering access to work, and
   - how the appropriate travel advice will be communicated to staff and patients

   Resilience officers and HR departments will need to develop a staff travel advice and communications protocol to ensure that travel advice and messages to the public are consistent with those issued by Local /Regional Resilience Partnerships to avoid confusion. This should be communicated to all staff.

   R Hibbert  | Completed

4. The NHS Board’s website will be used to advise on travel to hospital appointments during severe weather and prospective cancellation of clinics.

   C Brown  | Completed  | Dedicated page will be provided in First Port.

5. The NHS Board and local authority have created a capacity plan to manage any potential increase in demand for mortuary services over the winter period; this process has involved funeral directors.

   A Robertson; K Wratten; A McMann  | September 2016

6. The partnership will test the effectiveness of its winter plan by 30 Oct with stakeholders. The final version of the winter plan has been approved by the Integration Joint Board.

   A Robertson V de Souza J Hewitt  | Completed  | AR will develop scenario for desktop test. Date to be agreed.
   |  | North and South IJB’s which will consider final plans and the plan will be considered at the NHS Board by end of October.
|   | Unscheduled/Elective Care Preparedness  
(Assessment of overall winter preparations and further actions required) | RAG | Lead       | Completion Date | Comments                                      |
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<tr>
<td>1</td>
<td>Clinically Focussed and Empowered Management</td>
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</table>
| 1.1 | Clear site management process is in place with operational  
overview of all emergency and elective activity.  

* Ideally this should be a triumvirate approach of operational, medical and nursing Directors/leads with autonomy to make decisions to manage the site. | Green | Acute Site Directors | complete | Site huddles, barometer and escalation measures in place on all acute sites |
| 1.2 | Effective communication protocols are in place between clinical  
departments and senior managers to ensure that potential system pressures are identified as they emerge and as soon as they occur escalation procedures are invoked. | Green | Acute Site Directors | complete | In place                                      |
| 1.3 | Effective communication protocols are in place between key  
partners, particularly across local authority housing, equipment  
and adaptation services, Mental Health Services, and the  
independent sector.  

* Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements. | Green | C Cunningham | Being prepared | The winter planning ‘folder’ with key contacts, rotas etc will be available in a number of formats |
| 1.4 | A Target Operating Model has been communicated to all staff.  
Escalation policies are well defined, clearly understood, and well tested.  

* Clear thresholds and authorities for triggering, and standing down, escalation plans should be established and clearly communicated. | Green | Acute Site Directors | Ongoing |                                               |
| 1.5 | Escalation policies are in place and consider the likely impact of emergency admissions on elective work and vice versa, including respiratory, circulatory, orthopaedics, cancer patients, ICU/PICU.  

* This should be based on detailed modelling, pre-emptive scheduling of electives throughout the autumn, and early spring, and clear strategies regarding which lists may be subject to short-notice cancellation with a minimum impact. | Green | Acute Site Directors | Completed | Modelling of elective work has been undertaken. Extra escalation includes elective capacity. This will be augmented by detailed T&O planning at WGH and HM. |
1.6 Escalation policies are focused around in-patient capacity across the whole system. Pressures are often due to an inability to discharge patients timeously. Systems should be in place for the early identification of patients who no longer require acute care and discharged without further delay.

1.7 Escalation procedures are linked to a sustainable resourcing plan, which encompasses the full use of step-down community facilities, such as community hospitals and care homes. All escalation plans should have clearly identified points of contact and should be comprehensively tested and adjusted to ensure their effectiveness.

2. Undertake detailed analysis and planning to effectively schedule elective activity (both short and medium-term) based on forecast emergency and elective demand, to optimise whole systems business continuity. This has specifically taken into account the surge in unscheduled activity in the first week of January.

2.1 Demand, capacity, and activity plans across emergency and elective provision are fully integrated. Weekly projections for scheduled and unscheduled demand and the capacity required to meet this demand are in place. Plans for scheduled services include a specific ‘buffering range’ for scheduled queue size, such that the scheduled queue size for any speciality/sub-speciality can fluctuate to take account of any increases in unscheduled demand without resulting in scheduled waiting times being exceeded. This requires scheduled queue size for specific specialities to be comparatively low at the beginning of the winter period.

Partnerships can evidence that for critical specialities scheduled queue size and shape are such that a winter surge in unscheduled demand can be managed at all times ensuring patient safety and clinical effectiveness without materially disadvantaging scheduled waiting times.

2.2 A range of analysis and management tools to enable effective and related planning and management of scheduled and unscheduled services have been implemented. e.g. Basic Building Blocks, Performance Toolkit, Statistical Process Control, Queuing Theory, Discreet Event Simulation, Variation Methodology, etc.
2.2 Pre-planning has optimised the use of capacity for the delivery of emergency and elective treatment, including identification of winter surge beds for emergency admissions. This will be best achieved through the use of structured analysis and tools to understand and manage all aspects of variation that impact on services, by developing metrics and escalation plans around flexing or cancelling electives, and by covering longer term contingencies around frontloading activity for autumn and spring.

<table>
<thead>
<tr>
<th>Planning has been undertaken to confirm where additional surge capacity could be provided if sufficient resources/staff are available.</th>
</tr>
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<tbody>
<tr>
<td>Acute Site Directors/ H&amp;SCP Leaders</td>
</tr>
</tbody>
</table>

2.3 Pre-planning and modelling has been undertaken around elective activity to plan responses, escalation and recovery to minimise the impact of winter peaks in demand on the delivery of routine elective work. A set of clear actions should be developed based on a firm understanding of demand and capacity, prediction and management of variation. In the event of severe weather impacting significantly on elective capacity, NHS Boards, should contact SGHSCD Access Support Team to advise of any service disruption.

| Acute Site Directors/ J Park | Completed |
|---|

2.4 Planning and analysis will facilitate the NHS Board to consistently deliver the 4 Hour Emergency Access target (95%) and work towards the (98% Standard), eliminate 12 hour breaches whilst avoiding 8 hour breaches, and maintain the delivery of all elective care. NHS Boards are expected to maintain performance against all LDP standards, while recognising that clinical decision making in the interests of all patients is paramount. This includes TTG (legal requirement), 18 weeks, Diagnostics, Outpatients and Cancer. Monitoring of these measures is required to support escalation policies and achieve sustainable flow through the system.

| Site Directors | Complete |
|---|

2.5 NHS Boards review and take stock of their performance against the British Association of Day Surgery (BADS) Directory version 4 to ensure that they have achieved optimum performance against the surgical procedures identified as being suitable for day case surgery. Achieving optimal performance against BADS version 4 will support NHS Boards to manage bed occupancy, admission and discharge of elective patients.

| Site Directors | Complete |
|---|

Part of existing capacity plan. It is important to note that 95% target is only one measure and has to be set against other key clinical/other indicators.

Day Surgery will be the main focus of elective activity over the peak demand period in January 2017.
Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned activities such as MDTs, and projected peaks in demand. These rotas should include services that support the management of inpatient pathways, (e.g.) diagnostics, pharmacy, phlebotomy, AHPs, IPCT, portering, cleaning etc.

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<tr>
<th>Task</th>
<th>Responsible</th>
<th>Due Date</th>
<th>Notes</th>
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<tr>
<td>3.1 Consultant (Medical and Surgical) cover along with multi-professional support teams, including IPCT cover, will be planned to effectively manage predicted activity and discharge over the festive holiday periods, by no later than the end of October. This should take into account predicted peaks in demand, including impact of significant events (e.g.). Hogmanay Street parties on services, and match the available staff resource accordingly. Any plans to reduce the number of hospitals accepting emergency admissions for particular specialties over the festive period, due to low demand and elective activity, need to be clearly communicated to partner organisations.</td>
<td>Site Directors</td>
<td>Complete</td>
<td>Each acute site working on this. Review status in November.</td>
</tr>
<tr>
<td>3.2 Extra capacity should be scheduled for the ‘return to work’ days after the four day festive break and this should be factored into annual leave management arrangements.</td>
<td>All</td>
<td>Confirm in October rostering</td>
<td></td>
</tr>
<tr>
<td>3.3 Additional festive services are planned in collaboration with partner organisations e.g. Police Scotland, SAS, Voluntary Sector etc. Partnerships are aware of externally provided festive services such as minor injuries bus in city centre, paramedic outreach services and mitigate for any change in service provision from partner organisations</td>
<td>All</td>
<td>Confirmation sought from planning partners to raise awareness of any issues</td>
<td></td>
</tr>
<tr>
<td>3.4 Out of Hours services, GP, Dental and Pharmacy provision over festive period will be communicated to clinician/manager on call to ensure alternatives to attendance are considered.</td>
<td>L Smith</td>
<td>November 2016</td>
<td>This will form part of the ‘Winter Planning Folder’. Regular information also provided to ERC</td>
</tr>
<tr>
<td>3.5 Ensure that IP/DC capacity in December/January is planned to take account of conversions from OPD during Autumn to minimise the risk of the TTG being breached.</td>
<td>J Park</td>
<td>Complete</td>
<td></td>
</tr>
</tbody>
</table>
4. **Optimise patient flow by proactively managing Discharge Process utilising 6EA - Daily Dynamic Discharge process which includes determining an Estimated Date of Discharge as soon as patients are admitted or scheduled for admission with supporting processes (e.g.) multi-disciplinary ward rounds. This will support the proactive management of simple discharge, ensuring there are no delays in patient pathways.**

4.1 **Discharge planning** will commence at the point of admission, prior to admission or at pre-admission assessment using, where available, protocols and pathways for common conditions to avoid delays during the discharge process.

*Patients, their families and carers should be involved in discharge planning with a multi-disciplinary team as early as possible to allow them to prepare and put in place the necessary arrangements to support discharge.*

*Utilise Criteria Led Discharge wherever possible.*

| Site Directors | Complete | Further work is required in this area and is being supported by T&O initiatives. This also features as part of the winter planning performance measures. (These are attached for reference). |

4.2 **There will be on-going engagement with the SAS to effectively plan patient transport when it is known, or anticipated, that patients will require transport home or to another care setting.**

*Where transport service is limited or there is higher demand, alternative arrangements are considered as part of the escalation process. Utilise the discharge lounge as a central pick-up point to improve turnaround time and minimise wait delays at ward level.*

| Site Directors | Complete | In place. Regular communication is being undertaken to measure improvement in this area. |

4.3 **Multi-disciplinary Ward Rounds** will be embedded to proactively manage the patient journey and prepare for discharge detailing the estimated date of discharge. Utilise electronic whiteboards.

*This should be displayed visually for the care team to see and should be the focus of all daily ward rounds and bed meetings and inform daily safety flow huddles. Task lists should be available for all actions leading towards early discharge.*

<p>| Site Directors | Complete | In place. |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Responsible</th>
<th>Status</th>
<th>Notes</th>
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<tbody>
<tr>
<td>4.4</td>
<td>Regular daily ward rounds and bed meetings will be conducted to ensure a proactive approach to discharge. Discharges should be made early in the day, over all 7 days, and should involve key members of the multidisciplinary team, including social work. Ward rounds should follow the ‘golden hour’ format – sick and unwell patients first, patients going home and then early assessment and review. Test scheduling and the availability of results, discharge medication, transport requirements and availability of medical and nursing staff to undertake discharge should all be considered during this process to optimise discharge pre-noon on the estimated date of discharge.</td>
<td>Site Directors</td>
<td>Ongoing</td>
<td>Under implementation This data will also be measured using the winter planning performance report.</td>
</tr>
<tr>
<td>4.5</td>
<td>Predictive data will be used to assess the hourly demand for beds allowing for discharges to be scheduled to optimise flow. Consider evaluating the accuracy of EDD to help improve the discharge process. Develop in/out balance for each ward level to improve speciality receiving and minimise boarding.</td>
<td>Site Directors</td>
<td>Ongoing</td>
<td>As per 4.1 above</td>
</tr>
<tr>
<td>4.6</td>
<td>Discharge lounges should be fully utilised to optimise capacity prior to noon. Processes should be in place to support morning discharge at all times (e.g.) breakfast club, pull policy to DL, default end point of discharge. Utilisation should be monitored for uptake and discharge compliance.</td>
<td>Site Directors</td>
<td>Complete</td>
<td>Utilisation of discharge lounges will also feature as part of the winter plan performance report</td>
</tr>
</tbody>
</table>
5. **Ensure that senior clinical decision making capacity is available for assessment, care planning, MDTs and discharge and that AHP rotas are structured, to facilitate the discharging of patients throughout weekends and the fortnight in which the two festive holiday periods occur in order to maximise capacity.**

5.1 There is adequate medical, nursing and AHP cover across both, the festive holiday period, and over weekends to conduct assessments, plan effective care programmes and perform dedicated discharge rounds.

*Criteria-led discharges should be put in place wherever possible to improve discharge process across 7 day.*

<table>
<thead>
<tr>
<th>Site Directors/GM’ S/AHO</th>
<th>Complete</th>
<th>There are currently a number of vacancies in medical and nursing staff groups. This maybe accentuated if ‘surge’ beds are required.</th>
</tr>
</thead>
</table>

5.2 Key partners such as: pharmacy, transport and social care services will have determined capacity and demand for services and be able to provide adequate capacity to support the discharge process. These services should be aware of any initiatives that impact on increased provision being required and communication processes are in place to support this.

*There should be a monitoring and communication process in place to avoid delays, remove bottlenecks and smooth patient discharge processes.*

6. **Agree anticipated levels of homecare packages that are likely to be required over the winter (especially festive) period and utilise intermediate care options such as Rapid Response Teams, enhanced supported discharge or reablement and rehabilitation (at home and in care homes) to facilitate discharge and minimise any delays in complex pathways.**

6.1 There is close partnership working between stakeholders, including the third and independent sector to ensure that adequate care packages are in place in the community to meet predicted discharge levels.

*This will be particularly important over the festive holiday periods.*

<table>
<thead>
<tr>
<th>A O’Boyle/ A Dunlop</th>
<th>Ongoing</th>
<th>H&amp;SCP’s identified additional resources to meet agreed trajectories.</th>
</tr>
</thead>
</table>

6.2 Ongoing and detailed engagement around the capacity of social care services to accommodate predicted discharge levels will start no later than October.

<p>| AO’Boyle/ A Dunlop | Ongoing | |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Responsible</th>
<th>Timeframe</th>
<th>Notes</th>
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<tbody>
<tr>
<td>6.3</td>
<td>A clear escalation plan is in place to resolve issues that might arise. Consideration should be given to developing local agreements on the direct purchase of homecare by ward staff.</td>
<td>V De Souza, J Hewitt, H Knox</td>
<td>Ongoing</td>
<td>Whilst there are clear escalation plans, there will not be an arrangement for ward staff to purchase homecare directly.</td>
</tr>
<tr>
<td>6.4</td>
<td>Intermediate care options, such as enhanced supported discharge, reablement and rehabilitation will be utilised, where possible. Rapid Response teams should have the ability to directly purchase appropriate homecare packages, following the period of Intermediate care.</td>
<td>V De Souza, J Hewitt, H Knox</td>
<td>Ongoing</td>
<td>Full range of options to be available. Homecare assessment will remain the responsibility of respective social work staff.</td>
</tr>
<tr>
<td>6.5</td>
<td>Host partnerships are taking the discharge requirements of patients who are receiving treatment at the Golden Jubilee Foundation into account.</td>
<td>J Park, H&amp;SCP</td>
<td>October 2016</td>
<td>This requires confirmation of extent of need.</td>
</tr>
<tr>
<td>6.6</td>
<td>Patients identified as being at high risk of admission from, both the SPARRA register and local intelligence, and who have a care manager allocated to them, will be identifiable on contact with OOH and acute services to help prevent admissions and facilitate appropriate early discharge. Anticipatory care plans are utilised to manage care pathways.</td>
<td>GM's</td>
<td>Ongoing</td>
<td>Existing effective arrangements in place. Work is also progressing to improve sharing of information across other agencies e.g. SAS</td>
</tr>
<tr>
<td>6.7</td>
<td>All plans for Anticipatory Care Planning will be implemented, in advance of the winter period, to ensure continuity of care and avoid unnecessary emergency admissions / attendances. If attendances or admissions occur Anticipatory Care Plans and key information summaries should be used as part of discharge hospital to inform home circumstances and fit for discharge.</td>
<td>GM's</td>
<td>Ongoing</td>
<td>ACP development well advanced accessed via ekis</td>
</tr>
</tbody>
</table>
7. **Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.**

7.1 Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as soon as they occur, and that escalation procedures are invoked at the earliest opportunity.

*Utilise ED Capacity Management Guidance to develop whole system approach and response to crowding.*

| Site Directors/H&SC Leads | Complete |

7.2 Demand, capacity, and activity plans across emergency and elective provision are fully integrated.

*Collaboration between partners, including NHS 24, Locality Partnerships, Scottish Ambulance Service, SNBTS through to A&E departments, OOH services, hospital wards and critical care, is vital in ensuring that winter plans are developed as part of a whole systems approach.*

| Site Director J Park | Ongoing |

7.3 Effective communication protocols are in place between key partners, particularly across local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector.

*Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*

| H&SCP | Ongoing |

7.4 Communications with the public, patients and staff will make use of all available mediums, including social media, and that key messages will be accurate and consistent.

*NHS 24 are leading on the 2016/17 ‘Be Healthwise This Winter’ media campaign, and SG Health Performance & Delivery Directorate is working with partners and policy colleagues to ensure that key winter messages, around repeat prescriptions’, respiratory hygiene, and norovirus are*

| C Brown | Ongoing | Plans being updated to reflect the various developments and protocols being established |
effectively communicated to the public.

In late October the SG will launch its Resilience Campaign, in partnership with the British Red Cross, and other organisations to highlight the risks and consequences of all kinds of severe weather and the simple practical ways people can reduce these risks. Messages will continue to be targeted at more vulnerable and harder to reach people in our communities.

The public facing website http://www.readyscotland.org/ will continue to provide a one stop shop for information and advice on how to prepare for and mitigate against the consequences from a range of risks and emergencies. This information can also be accessed via a smartphone app accessible through Google play or iTunes.

The Met Office National Severe Weather Warning System provides information on the localised impact of severe weather events.
|   | **Out of Hours Preparedness**  
  
  *(Assessment of overall winter preparations and further actions required)* | **RAG** | **Lead** | **Completion Date** | **Comments** |
|---|---|---|---|---|
| 1 | The OOH plan covers the full winter period and pays particular attention to the festive period.  
  *This should include an agreed escalation process.*  
  Have you considered/discussed local processes with NHS 24 on providing pre-prioritised calls during the OOH period? | L Smith | Ongoing | Full rostering has been identified and shifts offered to staff |
| 2 | The plan clearly demonstrates how the partnership will manage both predicted and unpredicted demand from NHS 24 and includes measures to ensure that pressures during weekends, public holidays are operating effectively. The plan demonstrates that resource planning and demand management are prioritised over the festive period. | GM/SM OOH | As above | Rosters prepared accordingly |
| 3 | There is evidence of attempts at enabling and effecting innovation around how the partnership will predict and manage pressures on public holidays/Saturday mornings and over the festive period. The plan sets out options, mitigations and solutions considered and employed. | As above | As above | The H&SCPs are offering GPs the opportunity to operate on PHs, thereby reducing demand on OOH and A&E. |
| 4 | There is reference to direct referrals between services.  
  *For example, are direct contact arrangements in place, for example between Primary Care Emergency Centres (PCECs)/Accident & Emergency (A&E) Departments/Minor Injuries Units (MIUs) and other relevant services? Are efforts being made to encourage greater use of special notes, where appropriate?* | As above | As above | Work identified in supporting greater numbers of paediatric and mental health patients being managed in OOH – away from A&E |
<p>| 5 | The plan encourages good record management practices relevant to maintaining good management information including presentations, dispositions and referrals; as well as good patient records. | As above | As above | Access to clinical portal available for mental health and paediatric staff |</p>
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<th>Text</th>
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<th>Progress Notes</th>
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<tr>
<td>6</td>
<td>There is reference to provision of pharmacy services, including details of the professional line, where pharmacists can contact the out of hours centres directly with patient/prescription queries and vice versa.</td>
<td>As above</td>
<td>Pharmacist will be available in OOH service</td>
</tr>
<tr>
<td>7</td>
<td>Clear arrangements are in place to enable access to mental health crisis teams/services, particularly during the festive period.</td>
<td>GM/SM</td>
<td>Complete</td>
</tr>
<tr>
<td>8</td>
<td>There is reference to provision of dental services, to ensure that services are in place either via general dental practices or out of hours centres.</td>
<td>M Devine</td>
<td>Ongoing Full access to OOH Dental Service is available across all services in Lanarkshire</td>
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<td></td>
<td>This should include an agreed escalation process for emergency dental cases; i.e. trauma, uncontrolled bleeding and increasing swelling.</td>
<td></td>
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<td>9</td>
<td>The plan displays a confidence that staff will be available to work the planned rotas.</td>
<td>L Smith</td>
<td>Ongoing It is anticipated that there will be good coverage against planned rotas</td>
</tr>
<tr>
<td></td>
<td>While it is unlikely that all shifts will be filled at the moment, the plan should reflect a confidence that shifts will be filled nearer the time. If partnerships believe that there may be a problem for example, in relation to a particular profession, this should be highlighted.</td>
<td></td>
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<td>10</td>
<td>There is evidence of what the partnership is doing to communicate to the public how their out of hours services will work over the winter period and how that complements the national communications being led by NHS 24.</td>
<td>As per commu</td>
<td>NHS24 full members of winter planning process and participants in agreed actions</td>
</tr>
<tr>
<td></td>
<td>This should include reference to a public communications strategy covering surgery hours, access arrangements, location and hours of PCECs, MIUs, pharmacy opening, etc.</td>
<td>nication strategy above</td>
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<tr>
<td>11</td>
<td>There is evidence of joint working between partnerships and the SAS in how this plan will be delivered through joint mechanisms, particularly in relation to discharge planning, along with examples of innovation involving the use of ambulance services.</td>
<td>CA Jamieson</td>
<td>SAS full members of winter planning process and participants in agreed actions</td>
</tr>
<tr>
<td></td>
<td>This should confirm agreement about the call demand analysis being used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>There is evidence of joint working between partnerships and NHS 24 in preparing this plan.</td>
<td>M Waterson</td>
<td>NHS24 full members of winter planning process and participants in agreed actions</td>
</tr>
</tbody>
</table>
|   | There is evidence of joint working between the acute sector and primary care Out-of-Hours planners in preparing this plan.  
This should cover possible impact on A&E Departments, MIUs and any other acute receiving units (and vice versa), including covering the contact arrangements. | L Smith/ Acute Site Directors | Ongoing | Both acute and OOH managers have participated in preparation of the plan. |
|---|---|---|---|---|
| 14 | There is evidence of working with social work services in preparing this plan.  
This should be include referral systems, social work on-call availability, support for primary care health services in the community and support to social services to support patients / clients in their own homes etc. | H&SCPs | Ongoing | Social work staff are key members of the Winter Planning Group. |
| 15 | There is evidence of clear links to the pandemic plan including provision for an escalation plan.  
The should reference plans to deal with a higher level of demand than is predicted and confirm that the trigger points for moving to the escalation arrangements have been agreed with NHS 24. | H Kholi | Ongoing | Public Health staff are members of the Winter Planning Group and Pandemic plans have previously been tested. |
|   | **Prepare for & Implement Norovirus Outbreak Control Measures**  
  * (Assessment of overall winter preparations and further actions required) | **RAG** | **Lead** | **Completion Date** | **Comments** |
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<tbody>
<tr>
<td>1</td>
<td>Infection Prevention and Control Teams (IPCTs) should read the HPS Norovirus Outbreak Guidance due to be refreshed in September 2016.</td>
<td></td>
<td>E Shepherd</td>
<td>Complete</td>
</tr>
</tbody>
</table>
| 2 | IPCTs will be supported in the execution of a Norovirus Preparedness Plan before the season starts.  
  *Boards should ensure that their Health Protection Teams (HPTs) support the advance planning which care homes are undertaking to help keep people out of hospital this winter and provide advice and guidance to ensure that norovirus patients are well looked after in care homes.* | | E Shepherd | October 2016 |
| 3 | HPS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff, e.g. available on ward computer desk tops, or in A4 folders on the wards.  
  *Staff should be reminded of the need to remain absent for 48 hours post last symptom of Diarrhoea and vomiting. Where staff are prevented from returning to work NHS Boards should refer to the guidance note issued in 2010 relating to staff absence and infection control.* | | E Shepherd | October 2016 |
| 4 | NHS Board communications regarding bed pressures and norovirus ward closures are optimal and everyone will be kept up to date in real time.  
  *Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak.* | | C Brown | October 2016 |
5. Debriefs will be provided following individual outbreaks or end of season outbreaks to ensure system modifications to reduce the risk of future outbreaks.

   *Multiple ward outbreaks at one point in time at a single hospital might also merit an evaluation.*

6. IPCTs will ensure that the partnership and NHS Board are kept up to date regarding the national norovirus situation.

   | C Cunningham | Ongoing | Reporting data shared with all members of the Winter Planning team.

7. Before the norovirus season has begun, staff in emergency medical receiving areas will confirm with the IPCTs the appropriateness of procedures to prevent outbreaks when individual patients have norovirus symptoms, e.g. patient placement, patient admission and environmental decontamination post discharge.

   *The SG HAI team has contacted the HOAG to request that they liaise with the SMVN to reach consensus around testing procedures for patients that have been in the vicinity of norovirus outbreaks.*

8. NHS Boards must ensure arrangements are in place to provide adequate IPCT cover across the whole of the festive holiday period. While there is no national requirement to have 7 day IPCT cover, outwith the festive holiday period, Boards might wish to consider their local IPC arrangements.

   | Infection Control/ Site Directors | October 2016 |

9. The NHS Board is prepared for rapidly changing norovirus situations, e.g. the closure of multiple wards over a couple of days. As part of their surge capacity plan, Boards should consider how wards will maintain capacity in the event that wards are closed due to norovirus.

   | Infection Control/ Site Directors | Ongoing |

10. There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation. This should include the notification of 'tweets' to help spread key message information.
The partnership is aware of norovirus publicity materials and is prepared to deploy information internally and locally as appropriate, to spread key messages around norovirus and support the ‘Stay at Home Campaign’ message.

*This should include the notification of ‘tweets’ to help spread key message information.*

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### Seasonal Flu, Staff Protection & Outbreak Resourcing

**Assessment of overall winter preparations and further actions required**

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It is the responsibility of health care staff to get vaccinated to protect themselves from seasonal flu and in turn protect their vulnerable patients, but NHS Boards have responsibility for ensuring vaccine is easily and conveniently available; that sufficient vaccine is available for staff vaccination programmes; and that senior management and clinical leaders with NHS Boards fully support vaccine delivery and uptake.

3 The winter plan takes into account the predicted surge of flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu outbreaks across this period.

If there are reported flu outbreaks during the season, where evidence shows that vaccination uptake rates are not particularly high, NHS Boards may undertake targeted immunisation. In addition, the centralised contingency stock of influenza vaccine, purchased by the Scottish Government can be utilised if required and an agreed protocol is in place with NHS Boards on the use of the contingency stock. Antiviral prescribing for seasonal influenza may also be undertaken when influenza rates circulating in the community reach a trigger level (advice on this is generated by a CMO letter to health professionals)

4 HPS weekly updates, showing the current epidemiological picture on influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity.

Health Protection Scotland and the Health Protection Team within the Scottish Government monitor influenza rates during the season and take action where necessary. The Health Protection Team brief Ministers of outbreak/peaks in influenza activity where necessary. HPS produce a weekly influenza bulletin and a distillate of this is included in the HPS Winter Pressures Bulletin.
Adequate resources are in place to manage potential outbreaks of seasonal flu that might coincide with norovirus, severe weather and festive holiday periods.

*NHS board contingency plans have a specific entry on plans to mitigate the potential impact of potential outbreaks of seasonal influenza to include infection control, staff vaccination and antiviral treatment and prophylaxis. Contingency planning to also address patient management, bed management, staff redeployment and use of reserve bank staff and include plans for deferral of elective admissions and plans for alternative use of existing estate or opening of reserve capacity to offset the pressures.*

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<td><strong>Respiratory Pathway</strong>&lt;br&gt;(Assessment of overall winter preparations and further actions required)</td>
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1. **There is an effective, co-ordinated respiratory service provided by the NHS Board**

1.1 Clinicians (GP’s, Out of Hours services, A/E departments and hospital units) are familiar with their local pathway for patients with different levels of severity of exacerbation in their area.

|   | L Anderson T/L | October 2016 | These will be re-circulated and emphasised to all relevant staff. |

1.2 Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.

|   | L Anderson T/L | November 2016 | Rotas to be confirmed |

1.3 Anticipatory Care/ Palliative care plans for such patients are available to all staff at all times.

*Consider use of an effective pre admission assessment/checklist i.e. appropriate medication prescribed, correct inhaler technique, appropriate O2 prescription, referred to the right hospital/right department, referred directly to acute respiratory assessment service where in place.*

|   | L Anderson T/L | Complete | Work is ongoing in identifying all patients with ACP, ensuring these are up to date and that all have been shared with all respective partners/staff. The current IT systems do not always allow for sharing of content of ACP. |
Consider use of self-management tools including anticipatory care plans/asthma care plans and that patients have advice information on action to take/who to contact in the event of an exacerbation.

Patients should have their regular and emergency medication to hand, their care needs are supported and additional care needs identified (should they have an exacerbation).

1.4 Simple messages around keeping warm etc. are well displayed at points of contact, and are covered as part of any clinical review. This is an important part of ‘preparing for winter for HCPs and patients.

Simple measures are important in winter for patients with chronic disease/COPD. For example, keeping warm during cold weather and avoiding where possible family and friends with current illness can reduce the risk of exacerbation and hospitalisation.

2. There is effective discharge planning in place for people with chronic respiratory disease including COPD

2.1 Discharge planning includes medication review, ensuring correct usage/dosage (including O2), checking received appropriate immunisation, good inhaler technique, advice on support available from community pharmacy, general advice on keeping well e.g. keeping warm, eating well, smoking cessation.

Local arrangements should be made to ensure that the actions described are done in the case of all admissions, either in hospital, before discharge, or in Primary Care soon after discharge, by a clinician with sufficient knowledge and skills to perform the review and make necessary clinical decisions (specifically including teaching or correcting inhaler technique).

2.2 All necessary medications and how to use them will be supplied on hospital discharge and patients will have their planned review arranged with the appropriate primary, secondary or intermediate care team.
3. People with chronic respiratory disease including COPD are managed with anticipatory and palliative care approaches and have access to specialist palliative care if clinically indicated.

3.1 Anticipatory Care Plans (ACPs) will be completed for people with significant COPD and Palliative Care plans for those with end stage disease.

- Spread the use of ACPs and share with Out of Hours services.
- Consider use of SPARRA/Risk Prediction Models to identify those at risk of emergency admission over winter period.

SPARRA Online: Monthly release of SPARRA data, [https://www.bo.scot.nhs.uk/](https://www.bo.scot.nhs.uk/). This release estimates an individual’s risk of emergency admission.

Consider proactive case/care management approach targeting people with heart failure, COPD and frail older people.

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<tbody>
<tr>
<td></td>
<td>L Anderson T/L</td>
<td>Ongoing</td>
<td>As per 1.3 above</td>
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</table>

4. There is an effective and co-ordinated domiciliary oxygen therapy service provided by the NHS board

4.1 Staff are aware of the procedures for obtaining/organising home oxygen services.

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<tbody>
<tr>
<td></td>
<td>L Anderson T/L</td>
<td>Ongoing</td>
<td>As per 1.3 above</td>
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</tbody>
</table>

Staff have reviewed and are satisfied that they have adequate local access to oxygen concentrators and that they know how to deploy these where required. If following review, it is deemed that additional equipment is needed to be held locally for immediate access, please contact Health Facilities Scotland for assistance (0131 275 6860)

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<td>L Anderson T/L</td>
<td>Ongoing</td>
<td>As per 1.3 above</td>
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Appropriate emergency plans/contacts are in place to enable patients to receive timely referral to home oxygen service over winter/festive period.

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<td>L Anderson T/L</td>
<td>Ongoing</td>
<td>As per 1.3 above</td>
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</table>

Contingency arrangements exist, particularly in remote and rural areas, and arrangements are in place to enable clinical staff in these communities to access short term oxygen for hypoxaemic patients in cases where hospital admission or long term oxygen therapy is not clinically indicated. Take steps to remind primary care of the correct pathway for accessing oxygen, and its clinical indications.

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<tr>
<td></td>
<td>L Anderson T/L</td>
<td>Ongoing</td>
<td>As per 1.3 above</td>
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</tbody>
</table>
5. **People with an exacerbation of chronic respiratory disease/COPD have access to oxygen therapy and supportive ventilation where clinically indicated.**

5.1 Emergency care contact points have access to pulse oximetry. **Take steps to ensure that all points of first contact with such patients can assess for hypoxaemia, and are aware of those patients in their area who are at risk of CO2 retention. Such patients should be known to Ambulance services, Out of Hours Emergency centres and A/E departments, either through electronic notifications such as eKIS, or by patient help cards, message in a bottle etc.**

<table>
<thead>
<tr>
<th>RAG</th>
<th>Lead</th>
<th>Completion Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>L Anderson T/L</td>
<td>Ongoing</td>
<td>As per 1.3 above</td>
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</table>

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### 7 Management Information

(Assessment of overall winter preparations and further actions required)

<table>
<thead>
<tr>
<th>RAG</th>
<th>Lead</th>
<th>Completion Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Site directors</td>
<td>Ongoing</td>
<td>These reporting arrangements will continue through the Winter period.</td>
</tr>
</tbody>
</table>

1. **Admissions data will be input to the System Watch predictive modelling system as close to real time as possible. Local quality assurance of the site and board level data is in place.**

2. **Effective reporting lines are in place to provide the Scottish Government with routine weekly management information and any additional information that might be required on an exception / daily basis.**

   Over the winter period we will be augmenting the weekly management information collected on an all-year-round basis and will share this information across partnerships to help compare and benchmark performance.

3. **Effective reporting lines are in place to provide the SG Directorate for Health Workforce & Performance with immediate notification of significant service pressures that will disrupt services to patients as soon as they arise.**

   Any exception reporting should be set within the context of planned / actual capacity and demand activity.
|   | **Sign Off**  
  *(Assessment of overall winter preparations and further actions required)* | **RAG** | **Lead** | **Completion Date** | **Comments** |
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<tbody>
<tr>
<td>1</td>
<td>Draft winter plan(s) on local winter planning arrangements should be lodged with the Scottish Government by the end of August, and final plans by the end of October. Draft plans should cover the actions being taken around the critical areas and outcomes outlined in this guidance and include details of local governance arrangements. Final plans should have senior joint sign-off reflecting local governance arrangements and should be published online.</td>
<td></td>
<td>C Cunningham</td>
<td>Complete</td>
<td></td>
</tr>
</tbody>
</table>
| 2 | Arrangements are in place to include governance of winter planning within local Unscheduled Care Management Groups or other relevant management groups as appropriate.  

*Membership of these groups should include national and local Unscheduled Care Teams where applicable.* | | All | Complete | |
<table>
<thead>
<tr>
<th><strong>Key Roles / Services Integrated into Planning Process</strong></th>
<th><strong>RAG</strong></th>
<th><strong>Lead</strong></th>
<th><strong>Completion Date</strong></th>
<th><strong>Comments</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Heads of Service</td>
<td>All</td>
<td>Ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing / Medical Consultants</td>
<td>Site Directors</td>
<td>Ongoing</td>
<td></td>
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</tr>
<tr>
<td>Consultants in Dental Public Health</td>
<td>H Kholi</td>
<td>Ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AHP Leads</td>
<td>P McCrossan</td>
<td>Ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection Control Managers</td>
<td>E Shepherd</td>
<td>Ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managers Responsible for Capacity &amp; Flow</td>
<td>Site Directors</td>
<td>Ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy Leads</td>
<td>G Lindsay</td>
<td>Ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Leads</td>
<td>J Russell</td>
<td>Ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business Continuity / Emergency Planning Managers</td>
<td>A Robertson</td>
<td>Ongoing</td>
<td></td>
<td></td>
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<tr>
<td>OOH Service Managers</td>
<td>L Smith</td>
<td>Ongoing</td>
<td></td>
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<tr>
<td>GP’s</td>
<td>VJ Sonthalia</td>
<td>Ongoing</td>
<td></td>
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<tr>
<td>NHS 24</td>
<td>M Waterson</td>
<td>Ongoing</td>
<td></td>
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<tr>
<td>SAS</td>
<td>CA Jamieson</td>
<td>Ongoing</td>
<td></td>
<td></td>
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<tr>
<td>Territorial NHS Boards</td>
<td>All</td>
<td>Ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent Sector</td>
<td>J White</td>
<td>Ongoing</td>
<td></td>
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</tr>
<tr>
<td>Local Authorities</td>
<td>Both represented</td>
<td>Ongoing</td>
<td></td>
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</tr>
<tr>
<td>Integration Joint Boards</td>
<td>Both represented</td>
<td>Ongoing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic Co-ordination Group</td>
<td>C Cunningham</td>
<td>Ongoing</td>
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<tr>
<td>Third Sector</td>
<td>C Cunningham</td>
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<tr>
<td>SG Health &amp; Social Care Directorate</td>
<td>?</td>
<td>?</td>
<td></td>
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</tr>
<tr>
<td>Outcome</td>
<td>Indicator</td>
<td>Operational</td>
<td>Comments</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Outcome: Emergency and elective patients are safely and effectively admitted and discharged over the Christmas - New Year holiday period. Over this period the numbers of patients receiving elective treatment reduces. NHS Boards should minimise the risk of boarding medical patients in surgical wards. This will help ensure that patients do not have unnecessary stays in hospital; and hospitals are in a good position to deal with the surge in patients normally admitted in the first week back in January.</td>
<td>Daily and cumulative balance of admissions / discharges over the festive period;</td>
<td>Bed State Dashboard - Live bed usage used daily by staff.</td>
<td>Suggest total boarders as surgical wards can have medical beds.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Levels of boarding medical patients in surgical wards;</td>
<td>Bed State Dashboard - Levels of boarders used daily by staff.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Delayed discharge;</td>
<td>Reviewed daily within Discharge Hubs and data disseminated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community hospital bed occupancy;</td>
<td>The bed state monitored daily by CNMs. Formal bed occupancy reported monthly at management meeting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of Social Work assessments including variances from planned levels.</td>
<td>Delayed discharge data, including assessments reviewed daily &amp;weekly at CMT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The clinically focussed and empowered hospital management have a target operating model that sets out the expected range of daily emergency and elective admissions</td>
<td>Daily number of cancelled elective procedures;</td>
<td>Weekly number of cancelled elective procedures reviewed at CMT weekly.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
and discharges over the festive and winter period. The expected range takes account of the potential surge in emergency admissions in the first week of January and includes the potential surge in respiratory and circulatory admissions over the winter. The hospital models will include flows between front doors, receiving units, and downstream wards.

<table>
<thead>
<tr>
<th>Daily number of elective and emergency admissions and discharges;</th>
<th>Bed state dashboard reviewed daily - live bed usage.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of respiratory admissions and variation from plan.</td>
<td></td>
</tr>
</tbody>
</table>

The risk of an increase in the levels of boarding medical patients in surgical wards in the first week of January is minimised. The staffing plans for additional staffed medical beds and additional intermediate bed capacity for winter is agreed in October. The planned dates for introduction of additional staffed medical beds and intermediate beds in the community are agreed and the capacity is operational before the expected surge in admissions. It is essential that Boards who plan additional beds should make appropriate arrangements to create a safe and person centred environment.

<table>
<thead>
<tr>
<th>Levels of boarding.</th>
<th>Bed state dashboard - live boarders data</th>
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</tr>
</tbody>
</table>

- 227 -
Patients receive timely assessments in A&E, Acute Assessment Units, Acute Receiving Units and downstream specialty wards. Delays between decision to transfer/discharge and actual transfer/discharge are minimised. The capacity in these units reflect the arrival patterns and potential waiting times for assessment and/or transfer/discharge. Patients in downstream wards are discharged earlier in the day to avoid unnecessary stays in hospital and to improve flow through the hospital. There is early engagement with SAS for ambulance discharge and transfer.

<table>
<thead>
<tr>
<th>Metrics</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distributions of attendances/admissions;</td>
<td>Bed State Dashboard - Live bed usage used daily by staff.</td>
</tr>
<tr>
<td>Distribution of time to assessment;</td>
<td>Weekly review - shows any issues with Time to First Assessment</td>
</tr>
<tr>
<td>Distribution of time between decision to transfer/discharge and actual time;</td>
<td>Not available. Overall Bed Breach &amp; over 12 hour stays in A&amp;E reviewed daily.</td>
</tr>
<tr>
<td>% of discharges before noon;</td>
<td></td>
</tr>
<tr>
<td>% of discharges through discharge lounge;</td>
<td>Total discharges per site number from the discharge lounge reviewed daily.</td>
</tr>
<tr>
<td>% of discharges that are criteria led/supported by EDD;</td>
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</tbody>
</table>

Patients are discharged at weekend and bank holidays to avoid unnecessary stays in hospital and to improve flow through the hospital.

<table>
<thead>
<tr>
<th>Metrics</th>
<th>Data Source</th>
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<tbody>
<tr>
<td>Attendance profile by day of week and time of day managed against available capacity;</td>
<td>Live Dashboard</td>
</tr>
<tr>
<td>Locally identified indicators of pressure i.e. % occupancy of ED, utilisation of trolley/cubicle;</td>
<td>Live Dashboard</td>
</tr>
<tr>
<td>% patients waiting for admission over 2, 4 hours – all indicators should be locally agreed and monitored</td>
<td>Live Dashboard</td>
</tr>
</tbody>
</table>
The risk of norovirus outbreaks becoming widespread throughout a hospital is minimised. The HPS Norovirus Outbreak Guidance for 2015/16 is effectively implemented.

<table>
<thead>
<tr>
<th>Number of wards closed to norovirus; application of HPS norovirus guidance.</th>
<th>Ward Acute, continuing care and care home closures received. Closure of bays or part closures identified. Days closed and dates of closure/removal of restrictions.</th>
</tr>
</thead>
</table>

| CMO uptake targets for seasonal flu vaccination for those aged 65 and above, at risk groups, and front line staff are delivered as early as possible in the season before flu viruses are circulating. | % uptake for those aged 65+ and ‘at risk’ groups; % uptake of staff vaccine by site / speciality and variance from planned levels in line with CMO advice. |