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Scottish Borders
Health and Social Care
PARTNERSHIP

A Meeting of the Scottish Borders Health and Social Care Integration Joint Board Audit Committee will be held on Monday 26 September 2016 at 3.00pm in Committee Room 3, Scottish Borders Council, Newtown St Boswells.

BUSINESS		
1.	**Announcement and Apologies**	
2.	**Declarations of Interest**	
3.	**Scottish Borders Health and Social Care Integration Joint Board Internal Audit Annual Plan 2016/17** (Pages 1 - 6) Consider a report by IJB's Chief Internal Auditor (the Council's Chief Officer Audit & Risk) on the proposed strategic priorities for the delivery of Internal Audit assurance and support services and on the proposed Internal Audit programme of work 2016/17 to enable preparation of an annual internal audit opinion on the adequacy of the arrangements for risk management, governance and control of the delegated resources. (Copy attached.)	
4.	**Scottish Borders Health and Social Care Integration Joint Board Annual Audit Report 2015/16.** (Pages 7 - 48) Consider the annual audit report from the IJB's External Auditors, KPMG. (Copy attached.) **Joint Board Annual Report and Accounts 2015/16** Consider report by IJB's interim Chief Financial Officer on audited Pension Fund Annual Report and Statement of Accounts for the year ended 31 March 2016. (Copies attached)	
5.	**Scottish Borders Health and Social Care Integration Joint Board Financial Governance and Management** (Pages 49 - 74) Consider report by interim Chief Financial Officer of Scottish Borders Health and Social Care Integration Joint Board providing an update on financial governance and management arrangements, and the progress made to date and compliance assessment with legislation / recommended best practice within the Scottish Borders Health and Social Care Integration programme. (Copy attached.)	
6.	**Accounts Commission reports 'Health and Social Care Integration'** (Pages 75 - 162) Consider the key messages from the Accounts Commission reports 'Health	

	and Social Care Integration' and 'Changing Models of Health and Social Care' which were published in December 2015 and March 2016 respectively.	
7.	**Any Other Items which the Chairman Decides are Urgent.**	
8.	**Items Likely To Be Taken In Private.** Before proceeding with the private business, the following motion should be approved:- "That under Section 50A(4) of the Local Government (Scotland) Act 1973 the public be excluded from the meeting for the following items of business on the grounds that they involve the likely disclosure of exempt information as defined in paragraph 14 of Part 1 of Schedule 7A to the aforementioned Act."	

NOTES

1. **Timings given above are only indicative and not intended to inhibit Members' discussions.**

2. **Members are reminded that, if they have a pecuniary or non-pecuniary interest in any item of business coming before the meeting, that interest should be declared prior to commencement of discussion on that item. Such declaration will be recorded in the Minute of the meeting.**

Membership of Committee:- Councillors J. G. Mitchell, G. H. T. Garvie, Mr D. Davidson and Mr J. Raine.

Please direct any enquiries to Iris Bishop, Board Secretary - Health & Social Care Integration Joint Board. Address: NHS Borders, Headquarters, Room 1EC1, Borders General Hospital, MELROSE, TD6 9BD
Tel: 01896 825525. Email: iris.bishop@borders.scot.nhs.uk

INTERNAL AUDIT ANNUAL PLAN 2016/17 FOR SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

Aim

1.1 To gain approval to the proposed Internal Audit Annual Plan 2016/17 for the Scottish Borders Health and Social Care Integration Joint Board to enable the IJB Chief Internal Auditor to prepare an annual internal audit opinion on the adequacy of the arrangements for risk management, governance and control of the delegated resources.

Background

2.1 Management are responsible for setting up suitable and sound systems of internal control, risk management and governance arrangements and for monitoring the continuing effectiveness of these systems and arrangements to ensure robust and efficient governance of the health and social care partnership. These are not fixed but evolve as the partnership changes.

2.2 Internal Audit is an independent appraisal function established for the review of the internal control system and governance as a service to the Health and Social Care Integration Joint Board. It objectively examines, evaluates and reports on the adequacy of internal control and governance as a contribution to the proper, economic, efficient and effective use of delegated resources and the management of risk.

2.3 The role of the IJB Audit Committee will be to provide high-level oversight of the IJB's governance, risk management and control frameworks and to oversee the financial reporting and annual governance processes. It will receive reports from Internal Audit and External Audit, helping to ensure efficient and effective assurance arrangements are in place.

Proposal

3.1 The SBC Internal Audit function follows the professional standards as set out in Public Sector Internal Audit Standards (PSIAS) effective 1 April 2013 which requires the chief audit executive to establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals. This plan also requires to be sufficiently flexible to reflect the changing risks and priorities of the organisation.

3.2 The proposed Internal Audit Annual Plan 2016/17 for the Scottish Borders Health and Social Care Integration Joint Board is detailed in Appendix 1. The Plan: defines the purpose, authority and responsibility of the Internal Audit activity; sets out the relative allocation of resources; outlines the Assurance Framework (including assurance from partners' Internal Audit providers); specifies the Internal Audit priorities; and sets out the range and breadth of audit areas and sufficient work within the audit programme of work to enable the IJB Chief Internal Auditor to prepare an annual internal audit opinion. Key components of the audit planning process include a clear understanding of the IJB's functions, associated risks, and assurance framework.

Recommendation

The Integration Joint Board Audit Committee is asked to approve the Internal Audit Annual Plan 2016/17 for Scottish Borders Health and Social Care Integration Joint Board as detailed in Appendix 1 of this report.

Policy/Strategy Implications	The establishment of appropriate audit arrangements is one of the key components of good governance.
Consultation	The IJB Chief Officer and Interim Chief Financial Officer have been consulted on the risk-based audit approach and the resultant planned audit coverage to ensure it will provide assurance on controls and governance relating to the key risks facing the IJB and to assist them in discharging their roles and responsibilities. Other key stakeholders, including senior financial management and internal and external auditors of the partner organisations, have been consulted on the approach to ensure that audit work is co-ordinated and programmed to avoid duplication and maximise assurance.
Risk Assessment	Key components of the audit planning process include a clear understanding of the IJB's functions, associated risks, and potential range and breadth of audit areas for inclusion within the plan. To capture potential areas of risk and uncertainty more fully, key stakeholders have been consulted.
Compliance with requirements on Equality and Diversity	It is anticipated that there are no adverse impact due to race, disability, gender, age, sexual orientation or religion/belief arising from the proposals in this report.
Resource/Staffing Implications	Internal Audit services for the IJB will be provided by the Council's Internal Audit team. There are staff and other resources currently in place to achieve the IJB Internal Audit Annual Plan 2016/17 and to meet its objectives.

Approved by

Name	Designation
Jill Stacey	Chief Internal Auditor, Scottish Borders Health and Social Care Integration Joint Board (the Council's Chief Officer Audit & Risk)

Author(s)

Name	Designation
Jill Stacey	Chief Internal Auditor, Scottish Borders Health and Social Care Integration Joint Board (the Council's Chief Officer Audit & Risk)

Jill Stacey
Chief Officer Audit & Risk, Scottish Borders Council
Chief Internal Auditor, Scottish Borders Health and Social Care Integration Joint Board

SBC Internal Audit Section

Internal Audit Annual Plan 2016/17 for Scottish Borders Health and Social Care Integration Joint Board

to

Integration Joint Board Audit Committee, Chief Officer and Interim Chief Financial Officer

19 September 2016

1 Introduction

1.1 The Scottish Borders Integration Joint Board (the Board) of Scottish Borders Health and Social Care Partnership (the Partnership) was established as a body corporate by Scottish Ministers on 6 February 2016. The Partnership has prepared a Strategic Plan for 2016 – 2019 which sets out what it wants to achieve to improve health and well-being in the Scottish Borders through integrating health and social care services. The Strategic Plan was approved by the Board on 7 March 2016 which became live on 1 April 2016 when functions and budget resources were delegated by the partners to the Board.

1.2 The Integration Joint Board (IJB) is responsible for ensuring that its business is conducted in accordance with the law and appropriate standards, that public money is safeguarded, properly accounted for, and used economically, efficiently and effectively.

1.3 The Partnership's Code of Corporate Governance was approved by the IJB at its meeting of 7 March 2016. The roles and responsibilities of Board members and officers are defined within a comprehensive suite of governance documents relating to the arrangements within which the partnership will operate which specifically covers:

- Scheme of Integration
- Key Principles of the Local Code of Governance
- Standing Orders
- Audit Arrangements including Terms of Reference for the Audit Committee
- Care and Clinical Governance Assurance Framework
- Risk Management Strategy
- Financial Arrangements and Financial Regulations

1.4 In addition to its own governance arrangements, the IJB places reliance on the governance arrangements adopted by NHS Borders and Scottish Borders Council, the partners. Where appropriate existing mechanisms embedded within both NHS Borders and Scottish Borders Council will be used to provide assurance to the Health and Social Care Integration Joint Board. This will be a component of the Assurance Framework which comprises assurances from within the organisation and from external providers of assurance, with Internal Audit being part of that assurance framework.

1.5 The Board appointed Jill Stacey, Chief Officer Audit and Risk, Scottish Borders Council, as Chief Internal Auditor for the Integration Joint Board on 1 February 2016 with agreement that Internal Audit services for the IJB will be provided by the Council's Internal Audit team.

1.6 Internal Audit is an independent appraisal function established for the review of the internal control system and governance as a service to the Health and Social Care Integration Joint Board. It objectively examines, evaluates and reports on the adequacy of internal control and governance as a contribution to the proper, economic, efficient and effective use of delegated resources and the management of risk.

1.7 Scottish Borders Council's Chief Officer Audit & Risk acts as the head of internal audit in compliance with the requirements of the CIPFA Statement on 'The Role of the Head of Internal Audit in Public Organisations 2010' providing assurance and opinion on the IJB's internal control and governance arrangements to the Board and Management. The internal audit activity adds value to the organisation (and its stakeholders) when it considers strategies, objectives, and risks; strives to offer ways to enhance governance, risk management and control processes; and objectively provides relevant assurance. The internal audit programme of work is designed to add value to and improve the Integration Joint Board's operations in order to meet the objectives set out in the Strategic Plan.

2 Internal Audit Annual Planning Process

2.1 The SBC Internal Audit function follows the professional standards as set out in Public Sector Internal Audit Standards (PSIAS) which came into effect on 1 April 2013. The key standards within the PSIAS which relate to the preparation of the internal audit plan are summarised below:

- Standard 2010 – Planning which states that "the chief audit executive must establish risk-based plans to determine the priorities of the internal audit activity, consistent with the organisation's goals"
- Standard 2020 – Communication and Approval which states that "the chief audit executive must communicate the internal audit activity's plans and resource requirements, including significant interim changes, to senior management and the board for review and approval. The chief audit executive must also communicate the impact of resource limitations."

2.2 The CIPFA Publication 'Audit Committees 2013' states that "The audit committee should seek to make best use of the internal audit resource within the assurance framework. In particular, the audit committee should seek confirmation from internal audit that the audit plan takes into account the requirement to provide an annual internal audit opinion that can be used to inform the Annual Governance Statement. Specific activities will include:

- Approving (but not directing) the risk-based plan, considering the use made of other sources of assurance."

The CIPFA Publication also states that "The committee will wish to seek assurance from the HIA that appropriate risk assessment has been carried out as part of the preparation of the internal audit plans when they are presented."

2.3 Key components of the audit planning process include a clear understanding of the integration authority's role and responsibilities, priorities, plans, strategies, objectives, risks and mitigating controls, and the internal and external assurances provided to determine the potential range and breadth of audit areas for inclusion within the plan, consistent with the organisation's goals. This exercise is informed by key developments at both a national and local level and other relevant background information, for example the Strategic Plan.

3 Internal Audit Resources

3.1 The Council's Internal Audit Annual Plan 2016/17 approved by SBC's Audit and Risk Committee on 29 March 2016 has estimated that the total productive days available for audit work will be of the order of 809 days. Staff resources estimated in the plan totalling 35 days have been allocated from existing Council resources to provide Internal Audit services to the Scottish Borders Health and Social Care Integration Joint Board in its first year of operation, which reflects the Council's contribution of corporate support resources.

3.2 The Council's Internal Audit function must be adequately resourced to meet its objectives, in terms of diverse range of experience, knowledge, skills and technical competencies needed to complete the programme of work.

3.3 SBC Internal Audit staff resources comprise the Chief Officer Audit & Risk (50% allocation to Audit), three Senior Internal Auditors, and two Internal Auditors. This follows a recent net cost reduction restructure as an efficiency savings target and implementation of the people plans whereby the Internal Audit Manager post has been deleted arising from an early retirement, and a third Senior Internal Auditor post has been established with updates in the role to reflect current practice and additional duties. It is not anticipated that this change in Internal Audit resources would limit the level of Internal Audit assurances to all existing organisations within the Annual Plan 2016/17 though this will continue to be assessed.

3.4 The findings from the External Quality Assessment in October 2015 of conformance with the Public Sector Internal Audit Standards (PSIAS) state that "The Internal Audit team is appropriately qualified and experienced. It was acknowledged by key stakeholders that the team was knowledgeable and professional. All members of the team are aware of the professional and ethical standards required."

3.5 Internal Auditors will continue to attend relevant seminars, development workshops and user groups as part of their personal development plans, to meet Continuing Professional Development requirements as appropriate, ensuring that all remain well versed in new and emerging working practices, issues and risks and have the tools, processes and insights necessary to accomplish the objectives.

4 Planned Internal Audit Programme of Work 2016/17

4.1 Discussions with the IJB's Chief Officer and Interim Chief Financial Officer will take place on an ongoing basis to ensure Internal Audit assurance meet the needs of the IJB and Management and other key stakeholders.

4.2 The audit work for 2016/17 is designed to encompass:

(i) review and appraisal of operation of corporate governance arrangements in its first year of operation; and

(ii) review of performance against strategic objectives for 2016/17 described in the Scottish Borders Health and Social Care Strategic Plan, including relevant performance information and progress in delivering within the agreed financial framework.

4.3 The plan below gives an indication of the areas we plan to cover:

Category	Our planned audit approach within 2016/17
Internal Audit assurance on corporate governance, including key internal controls	We will assess the IJB's corporate governance arrangements in place to deliver services to meet the needs of service users and the strategic priorities for health and social care integration set out in the Strategic Plan. We will attend the IJB meetings to observe planning, approval, monitoring and review activity of Scottish Borders Health and Social Care Partnership business and performance. We will consider key areas of risk for the IJB and the roles and responsibilities of Board members and officers. We will take account of the IJB's Local Code of Corporate Governance to ensure clarity of roles and responsibilities and areas of review might include compliance with Scheme of Integration, arrangements for the operation of Standing Orders, the management of risk, and audit arrangements.

Category	Our planned audit approach within 2016/17
Internal Audit assurance on financial governance, including key internal financial controls	We will assess the IJB's financial governance arrangements in place to perform and account for its financial activities in an honest, legal and transparent manner in accordance with best accounting practice. We will review processes in place to ensure appropriate accountability for financial management of financial resources delegated to the partnership and to facilitate the delivery of efficient and effective services, including progress in achieving efficiencies. We will review and evaluate the key internal controls and processes within the financial arrangements and approved IJB Financial Regulations. We will rely on assurance from partners' Internal Audit providers, i.e. PwC for NHS Borders and in-house team for Scottish Borders Council, through their planned Internal Audit work undertaken on the effectiveness of the key financial controls in place and the financial monitoring and reporting controls in operation to fulfil their partners' roles and responsibilities.
	We will perform a specific audit engagement on the governance of the Integrated Care Fund which is a transitional resource, to assess the efficacy of decision-making and performance monitoring arrangements in the use of the Fund linked to strategic priorities and outcomes.
Internal Audit assurance on performance management	We will assess whether there is appropriate alignment of performance measures in the IJB's Performance Management Framework to key priorities and outcomes of the Strategic Plan 2016 – 2019. We will check to ensure that baseline performance information is in place for 2015/16 to enable the evidence of improvement of health and wellbeing in the Scottish Borders through integrating health and social care services over time. We will rely on assurance from partners' Internal Audit providers, i.e. PwC for NHS Borders and in-house team for Scottish Borders Council, through their planned Internal Audit work undertaken on the effectiveness of the performance monitoring and reporting controls in operation to fulfil their partners' roles and responsibilities.

5 Reporting of Internal Audit Results

5.1 The Internal Audit Annual Plan 2016/17 for the IJB includes sufficient work to enable the IJB's appointed Chief Internal Auditor to prepare an annual independent and objective audit opinion on the adequacy of the arrangements for risk management, governance and control of the delegated resources in its first year of operation. The audit opinion will be included within the Internal Audit Annual Report 2016/17 for the IJB which will be reported to Management, to the IJB Audit Committee, for governance and scrutiny purposes, and to the Board on an annual basis.

5.2 The Internal Audit Annual Report will state the results from each audit engagement outlining the risks, controls and conclusions. It will also state any Internal Audit recommendations that have been made to improve internal controls and governance in the form of an improvement action plan that will include the responsible owner and timescale for implementation. The outcomes of any monitoring of implementation of agreed actions or acceptance of risk will also be stated, as appropriate.

5.3 The Internal Audit findings and annual opinion will be used to inform the IJB's Annual Governance Statement for inclusion in the IJB's Annual Report and Accounts.

6 Internal Audit Added-Value Support

6.1 Internal Audit will support the development of the members of the IJB Audit Committee to enable effective scrutiny and challenge, support the members of the Board as appropriate to fulfil its role, and lead the self-evaluation of IJB Audit Committee against its remit and best practice, to fulfil the core principles in the IJB's Local Code of Corporate Governance.

Jill Stacey
Chief Officer Audit & Risk, Scottish Borders Council
Chief Internal Auditor, Scottish Borders Health and Social Care Integration Joint Board

KPMG

cutting through complexity

Scottish Borders Health and Social Care Partnership Integration Joint Board

Annual audit report to the Members of Scottish Borders Health and Social Care Partnership and the Controller of Audit

For the year ended 31 March 2016

6 September 2016

Contents

About this report

This report has been prepared in accordance with the responsibilities set out within the Audit Scotland's *Code of Audit Practice* ("the *Code*").

This report is for the benefit of Scottish Borders Health and Social Care Partnership Integration Joint Board ('IJB'') and is made available to Audit Scotland and the Controller of Audit (together "the Beneficiaries"). This report has not been designed to be of benefit to anyone except the Beneficiaries. In preparing this report we have not taken into account the interests, needs or circumstances of anyone apart from the Beneficiaries, even though we may have been aware that others might read this report. We have prepared this report for the benefit of the Beneficiaries alone.

Nothing in this report constitutes an opinion on a valuation or legal advice.

We have not verified the reliability or accuracy of any information obtained in the course of our work, other than in the limited circumstances set out in the introduction and responsibilities section of this report.

This report is not suitable to be relied on by any party wishing to acquire rights against KPMG LLP (other than the Beneficiaries) for any purpose or in any context. Any party other than the Beneficiaries that obtains access to this report or a copy (under the Freedom of Information Act 2000, the Freedom of Information (Scotland) Act 2002, through a Beneficiary's Publication Scheme or otherwise) and chooses to rely on this report (or any part of it) does so at its own risk. To the fullest extent permitted by law, KPMG LLP does not assume any responsibility and will not accept any liability in respect of this report to any party other than the Beneficiaries.

Complaints

If at any time you would like to discuss with us how our services can be improved or if you have a complaint about them, you are invited to contact Hugh Harvie who is the engagement leader for our services to Scottish Borders Health and Social Care Partnership, telephone 0131 527 6682, email: hugh.Harvie@kpmg.co.uk who will try to resolve your complaint. If your problem is not resolved, you should contact Alex Sanderson, our Head of Audit in Scotland, either by writing to him at Saltire Court, 20 Castle Terrace, Edinburgh, EH1 2EG or by telephoning 0131 527 6720 or email to alex.sanderson@kpmg.co.uk. We will investigate any complaint promptly and do what we can to resolve the difficulties. After this, if you are still dissatisfied with how your complaint has been handled you can refer the matter to Russell Frith, Assistant Auditor General, Audit Scotland, 4th Floor, 102 West Port, Edinburgh, EH3 9DN.

Executive summary

Audit conclusions

- We expect to issue an unqualified audit opinion on the financial statements of Scottish Borders Health and Social Care Partnership Integration Joint Board (‘IJB’’), following receipt of management representation letters.

Financial position

- The notional financial resources expended to support the IJB in 2015-16 have been identified and disclosed within the financial statements. However, the IJB was not charged for these services, the costs being borne in their entirety by either Scottish Borders Council or NHS Borders.

Financial statements and related reports

- We have concluded satisfactorily in respect of each significant risk and audit focus area identified. We concur with management’s accounting treatment and judgements, including going concern. We have no matters to highlight in respect of: unadjusted audit differences; independence; and changes to management representations.
- Financial statements were of good quality when received; with only a few minor presentational changes required.

Wider scope matters

- We considered the wider scope audit dimensions and concluded positively in respect of financial management, governance and transparency and value for money.
- We also considered financial sustainability and have recommendations in this area.

Audit Conclusions

- The IJB is required to prepare its financial statements in accordance with International Financial Reporting Standards, as interpreted and adapted by the Code. Additional guidance on accounting for the integration of the health and social care has been created by LASAAC. Our audit confirmed that the financial statements have been prepared in accordance with the LASAAC guidance and relevant legislation.
- We did not encounter any significant difficulties during the audit. There were no other significant matters arising from the audit that were discussed, or subject to correspondence with management that have not been included within this report. There are no other matters arising from the audit, that, in our professional judgement, are significant to the oversight of the financial reporting process.

Executive summary
Scope and responsibilities

Purpose of this report

The Accounts Commission has appointed KPMG LLP as auditor of the Scottish Borders Health and Social Care Partnership Integration Joint Board ("the IJB") under the Local Government (Scotland) Act 1973 ("the Act"). This document summarises our opinion and conclusions on significant issues arising from our audit.

Audit Scotland's Code of Audit Practice ("the Code") sets out the wider dimensions of public sector audit which involves not only the audit of the financial statements, but also consideration of areas such as financial management and sustainability, governance and transparency and value for money.

Auditor and audited bodies' responsibilities

The Code sets out the responsibilities in respect of:

- the financial statements;
- corporate governance and systems of internal control;
- prevention and detection of fraud and irregularities;
- standards of conduct and arrangements for the prevention and detection of bribery and corruption;
- arrangements for preparing and publishing statutory performance information;
- financial position; and
- Best Value, uses of resources and performance.

Scope

An audit of the financial statements is not designed to identify all matters that may be relevant to those charged with governance. Management of the audited body is responsible for preparing financial statements that show a true and fair view and for implementing appropriate internal control systems.

Weaknesses or risks identified are only those which have come to our attention during our normal audit work in accordance with the Code, and may not be all that exist.

Communication by auditors of matters arising from the audit of the financial statements or of risks or weaknesses does not absolve management from its responsibility to address the issues raised and to maintain an adequate system of control.

Under the requirements of International Standard on Auditing (UK and Ireland) ('ISA') 260 *Communication with those charged with governance*, we are required to communicate audit matters arising from the audit of financial statements to those charged with governance of an entity. This annual audit report to the Board discharges the requirements of ISA 260.

Financial position

SECTION 2

Overview

An order to establish the Integration Joint Board was laid in the Scottish Parliament on Friday 8 January 2016 for 28 days. On 6 February 2016 the Scottish Borders Health & Social Care Partnership Integration Joint Board was legally established.

Whilst the Scottish Borders Health and Social Care Partnership operated only as a shadow board during 2015-16, with budgets and functions being aligned only and not delegated until 1st April 2016, the IJB was required to prepare financial statements for 2015-16, following the 2015-16 Code. Guidance was issued by The Local Authority (Scotland) Accounts Advisory Committee ("LASAAC") in September 2015 on the expected content of the IJB accounts. The LASAAC guidance states that IJBs should comply with the Local Authority Accounts (Scotland) Regulations 2014, which includes the preparation of a remuneration report. The IJB appointed a Chief Officer and, on an interim basis, a Chief Finance Officer.

Financial position

CIES	£000
Income	19
Expenditure	(19)
Net expenditure	-
Balance Sheet	**£000**
Current assets	4
Current liabilities	(4)
Net assets	-

The IJB accounts relate only to the operating costs of the Board from its establishment date of 6 February 2016 to 31 March 2016. During this period, the Board received income of £19,000 and incurred expenditure of £19,000. The Board had no reserves at either its establishment date or at 31 March 2016.

The IJB received contributions from Scottish Borders Council and NHS Borders as income.

The remuneration report is appropriately produced to include the Chief Officer as this position is deemed to be a 'relevant position'. Per LASAAC guidance the Chief Officer costs should be allocated to the IJB from its establishment date.

The balance sheet consists of Scottish Borders Council and NHS Borders debtor and creditor amounts.

Significant risks

SECTION 3

Significant risks and audit focus areas

International Standard on Auditing (UK and Ireland) 315 (ISA): *Identifying and assessing risks of material misstatement through understanding the entity and its environment* requires the auditor to determine whether any of the risks identified as part of risk assessment are significant risks and therefore requiring specific audit consideration. Professional standards require us to make a rebuttable presumption that the fraud risk from income recognition is a significant risk. As the IJB did not direct services during 2015-16, it did not receive income for operations and therefore we do not consider the fraud risk from revenue recognition to be significant.

We summarise below the risks of material misstatement. We set out the key audit procedures to address those risks and our findings from those procedures on the following pages, in order that the IJB may better understand the process by which we arrived at our audit opinion.

SIGNIFICANT RISK	OUR RESPONSE	AUDIT CONCLUSION
Fraud risk from management override of controls	Professional standards require us to communicate the fraud risk from management override of controls as a significant risk; as management is typically in a unique position to perpetrate fraud because of its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively.	We have no changes to the risk or our approach to addressing the assumed ISA risk of fraud in management override of controls. We do not have findings to bring to your attention in relation to these matters. No control overrides were identified.
FOCUS AREA	**OUR RESPONSE**	**AUDIT CONCLUSION**
First year financial statements preparation	■ As 2015-16 is the first period of the preparation of the IJB's financial statements we reviewed the disclosures in the financial statements against the 2015-16 Code, the Local Authority Accounts (Scotland) Regulations 2014 and LASAAC guidance. ■ The remuneration report was reviewed to check the officers disclosed are appropriate and that the amounts are accurate by agreeing to supporting documentation.	The accounts have been prepared in accordance with the relevant legislation and guidance. Only the Chief Officer's remuneration has been disclosed as the IJB had no other employees.

Wider scope
Audit dimensions introduction

We summarise below the work we have undertaken in the year to obtain assurances over the arrangements in place for each audit dimension and our conclusions on the effectiveness and appropriateness of these arrangements.

Financial sustainability

In considering financial sustainability of the IJB we performed the following work:

- *review of the financial position of the IJB as at 31 March 2016 and future budgets and forecasts;*
- *review of Health and Social Care Partnership financial statement 2016-17 and Assurance over the Sufficiency of Resources*; and
- *review of Due Diligence 2016-17 outturn analysis.*

Management continue to work closely with the two funding providers and Scottish Government to anticipate the impact of future local government budget allocations. We consider that the IJB is financially sustainable and a going concern.

Financial management

Our conclusion below is derived from the following audit tests, carried out to determine the effectiveness of the financial management arrangements. This included:

- *review of Financial Statement 2016-17 – Overview of Due Diligence Process;*
- *review of the financial regulations for the SBC Joint Integration Board; and*
- *consideration of the finance function and financial capacity within the IJB.*

The chief financial officer was appointed on an interim basis for six months on 7 March 2016. We noted that the chief financial officer has the appropriate skills, capacity and experience to support the IJB and effectively manage the organisation.

Best Value

Governance and transparency

In considering governance and transparency we performed the following work:

- *review of the the annual governance statement within 2015-16 accounts; and*
- *review of the Health and Social Care IJB code of corporate governance*

The IJB agreed to establish an audit committee in February 2016 and agreed the membership of the committee in June 2016. The chief internal auditor was appointed in February 2016 and will provide an independent opinion on the adequacy and effectiveness of the governance framework from 2016-17.

We consider the governance framework to be appropriate for the IJB.

Value for money

We consider value for money and Best Value throughout our testing. Areas where we had a specific focus on value for money and Best Value are:

- *reviewing the expenditure of the IJB to ensure it was only concerned with the running costs of the IJB. This identified that all expenditure was in relation to running costs; and*
- *reviewing the 2016-17 financial statements and assurance over the sufficiency of resources; ensuring the focus is delivering quality service to meet increasing demand with a clear focus on value for money.*

The IJB have evidenced using their resources for the purposes of initial set up and running costs of the IJB.

Financial sustainability

Financial sustainability looks forward to the medium and longer term to consider whether the body is planning effectively to continue to deliver its services or the way in which they should be delivered.

Our conclusion below is derived from the following audit tests, carried to determine the effectiveness of the financial sustainability arrangements.

Review of Health and Social Care Partnership financial statement 2016-17 and Assurance over the Sufficiency of Resources:

- *The report sets out the financial statement of Scottish Borders IJB for 2016-17 to 2018-19. For the year 2016-17 and 2017-18, the total integrated budget is expected to be £157.2 million in both years, it is then forecast to increase to £158.3 million in 2018-19. It should be noted that for 2017-18 and 2018-19 the budget is indicative as both NHS Borders and Scottish Borders Council's funding settlements with the Scottish Government are for 2016/17 only and will be subject to change in absolute terms for future financial years.*
- *There are considerable efficiencies and savings assumptions requiring delivery within both NHS Borders and Scottish Borders Council's respective financial plans for 2016-17, on which the proposed levels of delegated and notional resources are based. Whilst the majority of these savings have been identified and plans have been or are in the process of being developed, the majority remain high risk and, in particular, there remains £0.793 million requiring further efficiencies or service change plans to be identified.*
- *To provide the IJB with assurance over the sufficiency of the resources, scrutiny has been undertaken as part of due diligence and risk assessment.*
- *There are a number of areas of emerging or unknown financial pressures that may impact the IJB during or beyond 2016-17 for which no budget provision has been made. The IJB will work with its partners to address any pressures which may emerge in order to identify appropriate remedial action through the development of appropriate solutions, including the use of additional Social Care funding, further targeted savings on service delivery and the issuing of supplementary directions over functions to be provided and the resources accompany them.*

Recommendations

1	*The IJB should agree funding levels for 2017-18 and 2018-19 as soon as possible from both partners to allow for budget setting and planning.*
2	*Plans should be put in place as a matter of urgency for efficiency savings.*
3	*Budget provision should be put in place for areas of emerging financial pressures. A risk register should be maintained and regularly updated as financial risks emerge. The budget should also be updated regularly to reflect these risks so that financial plans can be amended accordingly.*

Conclusion: Management continues to work closely with the two partners and the Scottish Government to anticipate the impact of future local government budget and NHS allocations. We consider that the IJB is a going concern, however there are risks around the uncertainty of future funding.

Wider scope
Audit dimensions (continued)

Financial management

Financial management is concerned with financial capacity, sound budgetary processes and whether the control environment and internal controls are operating effectively.

Our conclusion below is derived from the following audit tests, carried out to determine the effectiveness of the financial management arrangements. This included:

- *review of Financial Statement 2016-17 – Overview of Due Diligence Process;*
- *review of the financial regulations for the Integration Joint Board; and*
- *consideration of the finance function and financial capacity within the IJB.*

The chief financial officer was appointed on an interim basis for six months on 7 March 2016. We noted that the chief financial officer has the appropriate skills, capacity and experience to support the IJB and effectively manage the organisation.

Conclusion:

The IJB has appropriate financial capacity for current operations. This is supported by financial directions and scrutiny by senior management and IJB members.

Wider scope
Audit dimensions (continued)

Governance and transparency

Governance and transparency is concerned with the effectiveness of scrutiny and governance arrangements, leadership and decision making, and transparent reporting of financial and performance information.

In considering governance and transparency we performed the following work:

- *review of the annual governance statement within 2015-16 accounts; and*
- *review of the Health and Social Care IJB code of corporate governance.*

The IJB agreed to establish an audit committee in February 2016 and agreed the membership of the committee in June 2016. The chief internal auditor was appointed in February 2016.

Conclusion:

We consider the governance framework to be appropriate for IJB. Transparency was achieved through the online publication of IJB papers and minutes.

Value for money

Value for money is concerned with using resources effectively and continually improving services.

We consider value for money and Best Value throughout our testing. Areas where we had a specific focus on value for money and Best Value are:

- *reviewing amounts disclosed in the of the IJB's financial statements to ensure they are in relation to the IJB.* This identified that all expenditure was in relation to running costs, after removing the Chief Officer's remuneration prior to the establishment date*;* and
- *reviewing the 2016-17 financial statements and assurance over the sufficiency of resources; ensuring the focus is delivering quality service to meet increasing demand with a clear focus on value for money.*

Conclusion:

The IJB has evidenced using its resources for the purposes of initial set up and running costs of the IJB. One adjustment was made to the financial statements to correctly reflect the remuneration of the Chief Officer.

Appendices

Appendix one
Auditor independence

APPENDIX 1

To the Integration Joint Board members

Assessment of our objectivity and independence as auditor of Scottish Borders Integration Joint Board ('the IJB')

Professional ethical standards require us to provide to you at the conclusion of the audit a written disclosure of relationships (including the provision of non-audit services) that bear on KPMG LLP's objectivity and independence, the threats to KPMG LLP's independence that these create, any safeguards that have been put in place and why they address such threats, together with any other information necessary to enable KPMG LLP's objectivity and independence to be assessed.

This letter is intended to comply with this requirement and facilitate a subsequent discussion with you on audit independence and addresses:

- General procedures to safeguard independence and objectivity;
- Independence and objectivity considerations relating to the provision of non-audit services; and
- Independence and objectivity considerations relating to other matters.

General procedures to safeguard independence and objectivity

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP partners and staff annually confirm their compliance with our ethics and independence policies and procedures including in particular that they have no prohibited shareholdings. Our ethics and independence policies and procedures are fully consistent with the requirements of the APB Ethical Standards. As a result we have underlying safeguards in place to maintain independence through:

- Instilling professional values
- Communications
- Internal accountability
- Risk management
- Independent reviews.

We are satisfied that our general procedures support our independence and objectivity.

Independence and objectivity considerations relating to the provision of non-audit services

We have considered the fees charged by us to the IJB for professional services provided by us during the reporting period.

The audit fee charged by us for the period ended 31 March 2016 was £4,000. No other fees were charged in the period. No non-audit services were provided to the IJB and no future services have been contracted or had a written proposal submitted.

Independence and objectivity considerations relating to other matters

There are no other matters that, in our professional judgment, bear on our independence which need to be disclosed to the IJB.

Confirmation of audit independence

We confirm that as of the date of this letter, in our professional judgment, KPMG LLP is independent within the meaning of regulatory and professional requirements and the objectivity of the partner and audit staff is not impaired.

This report is intended solely for the information of the IJB and should not be used for any other purposes.

We would be very happy to discuss the matters identified above (or any other matters relating to our objectivity and independence) should you wish to do so.

Yours faithfully

KPMG LLP

Appendix two
Audit findings

APPENDIX 2

Adjusted and unadjusted audit differences

We are required by ISA (UK and Ireland) 260 to communicate all corrected and uncorrected misstatements, other than those which are trivial, to you. There were no audit adjustments required to the draft annual accounts.

A small number of minor presentational adjustments were required to some of the financial statement notes.

Appendix three
Appointed auditors responsibilities

APPENDIX 3

Area	Appointed auditors responsibilities	How we've met our responsibilities
Corporate governance	Review and come to a conclusion on the effectiveness and appropriateness of arrangements to ensure the proper conduct of the bodies affairs including legality of activities and transactions. Conclude on whether the monitoring arrangements are operate and operating in line with recommended best practice.	Page 9 sets out our conclusion on these arrangements.
Financial statements and related reports	Provide an opinion on audited bodies' financial statements on whether financial statements give a true and fair view of the financial position of audited bodies and their expenditure and income. Provide an opinion on whether financial statements have been properly prepared in accordance with relevant legislation, the applicable accounting framework and other reporting requirements.	Page 2 summarises the opinion we expect to provide.
Financial statements and related reports	Review and report on, as appropriate, other information such as annual governance statements, management commentaries and remuneration reports.	Page 2 reports on the other information contained in the financial statements, covering the annual governance statement, management commentary and remuneration report.
Financial statements and related reports	Notify the Auditor General or Controller of Audit when circumstances indicate that a statutory report may be required.	No notifications to Controller of Audit required.
Financial statements and related reports	Review and conclude on the effectiveness and appropriateness of arrangements and systems of internal control, including risk management, internal audit, financial, operational and compliance controls.	Pages 2 and 9 set out our conclusion on these arrangements.
WGA returns and grant claims	Examine and report on WGA returns. Examine and report on approved grant claims and other returns submitted by local authorities.	The IJB is below the threshold for the completion of audit work on the WGA return. We have not reported on any grant claims.

Appendix three
Appointed auditors responsibilities (continued)

Area	Appointed auditors responsibilities	How we've met our responsibilities
Standards of conduct – prevention and detection of fraud and error	Review and conclude on the effectiveness and appropriateness of arrangements for the prevention and detection of fraud and irregularities, bribery and corruption and arrangements to ensure the bodies affairs are managed in accordance with proper standards of conduct. Review National Fraud Initiative participation and conclude on the effectiveness of bodies engagement.	Page 9 sets out our conclusion on these arrangements. Participation in the National Fraud Initiative is not relevant for the IJB in 2015-16.
Financial position	Review and conclude on the effectiveness and appropriateness of arrangements to ensure that the bodies financial position is soundly based.	Pages 4 and 7 set out our conclusions on these arrangements.
Financial position	Review performance against targets.	This is not applicable as no targets have been set in the IJB's first year.
Financial position	Review and conclude on financial position including reserves balances and strategies and longer term financial sustainability.	Pages 4 and 7 set out our conclusion on the IJB's financial position and longer term financial sustainability.
Best Value	Be satisfied that proper arrangements have been made for securing Best Value and complied with responsibilities relating to community planning.	Page 6 sets out our conclusion on these arrangements.
Performance information	Review and conclude on the effectiveness and appropriateness of arrangements to prepare and publish performance information in accordance with Accounts Commission directions.	The Annual Performance Report for 2015-16 has not yet been published.

KPMG

cutting through complexity

The contacts at KPMG in connection with this report are:

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SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 2015/16 STATEMENT OF ACCOUNTS

Aim

1.1 The purpose of this report is to provide the IJB Audit Committee with an update on the process of production, audit and approval of Integration Joint Board (IJB) accounts for the period to the 31 March 2016, complying with its statutory responsibility to produce financial statements in respect of the period from its establishment on 06 March 2016 to this date.

Background

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires that the Integration Joint Board is subject to the audit and accounts provisions of a body under Section 106 of the Local Government (Scotland) Act 1973. This means that the IJB is required to prepare and publish audited annual accounts that meet the reporting requirements specified in relevant legislation and regulation (specifically s.12 of the Local Government in Scotland Act 2003 and regulations under s.105 of the Local Government (Scotland) Act 1973).

2.2 These accounts require to be proportionate to the limited number of transactions of the IJB, yet comply with the public-sector requirement for transparency and true and fair financial reporting. Whilst these accounts formally represent the operating activities of the partnership in financial terms, NHS Borders and Scottish Borders Council are also required to report additional disclosures within their statutory accounts reflecting the formal relationship with the IJB.

2.3 The IJB accounts require to be prepared in draft by 30 June each financial year subject to audit, following which they require approval by its Audit Committee by 30 September and onward approval by the board itself thereafter. IJB's are specified in legislation as 'section 106' bodies under the terms of the Local Government (Scotland) Act 1973 as amended and as such they are expected to prepare their financial statements in compliance with the Code of Practice on Accounting for Local Authorities in the United Kingdom.

Summary

3.1 During 2015/16, the Health and Social Care Partnership operated as a shadow board, until its 'integration start day' date on 01 April 2016, the date from which the delivery of its Strategic Plan commenced. As a result of the parliamentary process however, the date of establishment of the IJB as specified in the order and on which it became a legal entity was 06 February 2016.

3.2 The commencement date for delegation of functions to the IJB was 01 April 2016. Since this date did not occur during 2015/16, the IJB accounts do not need to include part-year contributions from NHS Borders or Scottish Borders Council or part-year payments from the IJB to respective partners for carrying out its directions.

3.3 As such, because the commencement date for delegation of functions and resources published in the Strategic Plan was 01 April 2016, the 2015/16 statutory accounts only require to include the operating costs of the IJB for the period from its establishment to 31 March 2016. This situation will obviously change for 2016/17, when fuller accounts will be required reflecting payment to / from the IJB.

3.4 Draft accounts were submitted to KPMG, the partnership's appointed External Auditor on 30 June 2016. Following a process of audit involving the supply of supplementary evidence, discussion and suggested amendments, a final draft version subject to audit opinion has been produced. This version is included as **Appendix 1** to this report.

3.5 **Appendix 2** details the External Auditor's draft Annual Audit Report to the Members of the IJB. When agreed, an Audit Certificate expressing the External Auditor's opinion over the Statement of Accounts will be provided for inclusion therein within it.

3.6 **Statement of Accounts**
Under the Code of Practice on Accounting for Local Authorities in the United Kingdom, the IJB accounts must meet a number of specific reporting requirements. These include:

- Management Commentary
- Statement of Responsibilities
- Annual Governance Statement
- Remuneration Report
- Balance Sheet
- Statement of Income and Expenditure
- Statement of Accounting Policies and Notes to the Accounts
- Audit Report

3.7 The Partnership's governance arrangements determine who is responsible for signing the financial statements, following specification in Regulations under s.105 of the Local Government (Scotland) Act 1973. This is provided for within the Statement.

External Audit Conclusions and Recommendations

3.8 A statement containing the audit opinion of the External Auditor has been received along with the final Annual Audit Report for 2015/16 and Management Representation Letter. The Statement is included in the section Independent Auditor's Report of the IJB Statement of Accounts 2015/16. There are no matters that are required to be brought to the attention of the IJB Audit Committee.

3.9 Within the Annual Audit Report for 2015/16, the External Auditor has made a number of conclusions over the Statement of Accounts 2015/16 and the wider operation of the IJB during the period to 31 March 2016, based on the audit work undertaken. In summary, these are:

Significant Risks	*There are no findings in relation to fraud risk or over-ride of controls.* *The accounts have been prepared in accordance with relevant legislation and guidance within which the remuneration report has been appropriately produced.*
Financial Sustainability	*The IJB is financially sustainable and a going concern.*
Financial Management	*The Chief Financial Officer (interim) has been appointed and has appropriate skills, capacity and experience.*
Governance and Transparency	*The IJB's governance framework is considered appropriate.*
Value for Money	*The IJB has evidenced using its resources for the purposes of meeting initial set-up and operating costs*

3.10 Specific to Financial Sustainability, recommendations have been made by the External Auditor. Again, in summary, these are:

Financial Sustainability	1. *The IJB should agree funding levels for 2017-18 and 2018-19 as soon as possible from both partners to allow for budget setting and planning.* 2. *Plans should be put in place as a matter of urgency for efficiency savings.* 3. *Budget provision should be put in place for areas of emerging financial pressures. A risk register should be maintained and regularly updated as financial risks emerge. The budget should also be updated regularly to reflect these risks so that financial plans can be amended accordingly.*

3.11 Work is already ongoing in respect of the areas covered by these external audit recommendations.

3.12 No audit adjustments required to be made to the draft annual accounts and a small number of minor presentational adjustments were made to some of the financial statement notes on advice of the External Auditor.

Recommendations

The IJB Audit Committee is asked to:

a) Consider the audited IJB Statement of Accounts for the operating activities of the IJB from the period of its establishment (06 February 2016) to 31 March 2016, and approve the Accounts for signature by the appropriate individuals and for submission to the IJB; and

b) Consider the conclusions and recommendations made within the IJB Annual Audit Report for the year-ended 31 March 2016 and the management actions identified in response, and recommend the Audit Report for submission to the IJB.

Policy/Strategy Implications	The Public Bodies (Joint Working) (Scotland) Act 2014 requires that the Integration Joint Board is subject to the audit and accounts provisions of a body under Section 106 of the Local Government (Scotland) Act 1973.
Consultation	The audited IJB Statement of Accounts 2015/16 and the IJB Annual Audit Report 2015/16 have been shared with the NHS Borders' Director of Finance and Scottish Borders Council's Chief Financial Officer and the partner organisations' Audit Committees (or equivalent) for noting as part of the governance arrangements.
Risk Assessment	To be reviewed in line with agreed IJB Risk Management Strategy. The key risks outlined in the report form part of the draft financial risk register for the partnership. The external audit recommendations are designed to mitigate associated risks.
Compliance with requirements on Equality and Diversity	There are no equalities impacts arising from the report.
Resource/Staffing Implications	No resourcing implications beyond the financial resources identified within the report.

Approved by

Name	**Designation**
Paul McMenamin	Interim IJB Chief Financial Officer

Author(s)

Name	**Designation**
Paul McMenamin	Interim IJB Chief Financial Officer

Scottish Borders
Health and Social Care
PARTNERSHIP

ANNUAL ACCOUNTS 2015/16

For the period 6 February 2016 to 31 March 2016

(Audited)

Management Commentary

Purpose

The purpose of the Management Commentary is to inform all users of the accounts and help them assess how the Integration Joint Board (IJB) has performed in fulfilling its duties.

Strategic Plan

The Scottish Borders Integration Joint Board (the Board) of Scottish Borders Health and Social Care Partnership (the Partnership) was established as a body corporate by Scottish Ministers on 6 February 2016. The Partnership has prepared a Strategic Plan for 2016 – 2019 which sets out what we want to achieve to improve health and well-being in the Borders through integrating health and social care services.

This Plan sets out a high level summary of some of what we will do when working together to deliver more personalised care, making best use of advancing technology to achieve "Best Health, Best Care, Best Value". This high-level Plan will be supported by the implementation of Strategies related to specific themes (such as Dementia, Mental Health) and Locality Plans that reflect differing patterns of need across the Borders.

The partnership's Strategic Plan describes some of the actions we will take to start to make the shift towards more community-based health and social care services, the outcomes we will seek to achieve and the steps we will take to deliver our local objectives. In addition, we describe some of the performance measures we will use to assess the progress we are making.

Our 9 Local Objectives are:

1. We will make services more accessible and develop our communities
2. We will improve prevention and early intervention
3. We will reduce avoidable admissions to hospital
4. We will provide care close to home
5. We will deliver services within an integrated care model
6. We will seek to enable people to have more choice and control
7. We will further optimise efficiency and effectiveness
8. We will seek to reduce health inequalities
9. We want to improve support for Carers to keep them healthy and able to continue in their caring role

Key Priorities

The Partnership has set itself the following key priorities for its first year of operation following its establishment on the 06 February 2016:

- To develop integrated accessible transport.
- To integrate services at a local level.
- To roll out care coordination to provide a single point of access to local services.
- To improve communication and accessible information across groups with differing needs.
- Work with communities to develop local solutions.

- Provide additional training and support for staff and for people living with dementia.
- Further develop our understanding of housing needs for people across the Borders.
- To promote healthy living and active ageing.
- To improve the transition process for young people with disabilities moving into adult disability services.
- To improve the quality of life of people with long term conditions by promoting healthy lifestyles, access to leisure services, along with support from the Third Sector.
- To improve support for Carers within our communities.
- Promote support for independence and reablement so that all adults can live as independent lives as possible.

Locality Planning

There are five commonly recognised localities in the Borders as the maps in this section show. These are based on the five existing Area Forum localities - Berwickshire, Cheviot, Eildon, Teviot & Liddesdale, and Tweeddale. Summary profiles for each of the five localities show some of the differences between them. As part of the planning process, we will build more detailed locality profiles, including a wider range of measures relevant to health and social care. This will allow us to target need most appropriately.

Financial Performance

The Scottish Borders Health and Social Care Partnership operated only as a shadow board during 2015/16, with budgets and functions being aligned only and not delegated until 01 April 2016. These accounts relate therefore only to the operating costs of the Board from its establishment date of 6 February 2016 to 31 March 2016. During this period, the Board received income of £19,000 and incurred expenditure of £19,000. The Board had no reserves at either its establishment date or at 31 March 2016.

Financial Risks

Management of risk and in particular, Financial Risk is one of the key responsibilities of the Board. Work continues currently to develop both Strategic and Operational Risk Registers for the Partnership and in relation to Financial Risk in particular, the following key areas of risk and uncertainty have been identified:

- Real-term funding reductions
- Insufficient transformation funding
- Slippage in the ambitious programme to transform to new models of care
- Further political policy initiatives and funding conditions
- The delivery of challenging efficiency and savings programmes
- Future demographic (demand) pressures
- Increasing market / provider costs of health and social care services
- Market / provider failure
- Price volatility, in particular increased Drugs costs
- Failure of financial planning, management and governance
- Other emerging pressures

Annual Accounts

The Integration Joint Board is required to prepare Annual Accounts by the Local Authority Accounts (Scotland) Regulations 2014, which section 12 of the Local Government in Scotland Act 2003 requires to be prepared in accordance with proper accounting practices. These practices primarily comprise the Code of Practice on Local Authority Accounting in the United Kingdom 2015/16 (the Code) and the Service Reporting Code of Practice 2015/16 (SeRCOP), supported by International Financial Reporting Standards (IFRS) and statutory guidance issued under section 12 of the 2003 Act.

Councillor Catriona Bhatia **Chair**	**Susan Manion** **Chief Officer**	**Paul McMenamin** **Interim Chief Financial Officer**

On behalf of the Councillors and Officers of Scottish Borders Health and Social Care Partnership

30 September 2016

Remuneration Report

Introduction

The remuneration report has been prepared in accordance with the Local Authority Accounts (Scotland) Regulations 2014. These Regulations require various disclosures about the remuneration and pension benefits of senior employees in respect of earnings etc. paid by the Board. The Board does not make payment to any member of the Board, by way of salary, enhanced pension benefits or reimbursement of expenses.

The Chief Finance Officer and Secretary to the Integration Joint Board do not receive remuneration from the IJB. The duties of these posts are covered by each post holder's substantive posts in Scottish Borders Council and NHS Borders respectively.

Remuneration

The term remuneration means gross salary, fees and bonuses, allowances and expenses, and compensation for loss of employment. It excludes pension contributions paid by the Employer. Pension contributions made to a person's pension are disclosed as part of the pension benefits disclosure below.

Remuneration of Senior Employees

The term 'Senior Employee' means:

1. Any employee who has responsibility for the management of the Integration Joint Board to the extent that the person has the power to direct or control the major activities of the Board (including activities involving the expenditure of money), during the year to which the Report relates, whether solely or collectively with other persons;
2. Who holds a post that is politically restricted by reason of section 2(1) (a), (b) or (c) of Local Government and Housing Act 1989 (4); or
3. Whose annual remuneration, including any remuneration from a local authority subsidiary body, is £150,000 or more.

Susan Manion, IJB Chief Officer is the only employee of the Board remunerated during the period. No Board employee received more than £50,000 remuneration during the period. The Chief Officer of the Board holds an employment contract with NHS Borders on NHS pay terms and conditions.

The annual remuneration of all employees of the Board is set by reference to national arrangements agreed by the Scottish Government under Ministerial Direction and in accordance with relevant NHS Pay and Conditions of Service Circulars.

Officers receive reimbursement for business mileage and subsistence allowances in accordance with nationally agreed rates which form part of the employee's contractual terms and conditions of employment. The table below details the reimbursement payment of business mileage and subsistence allowances received by the Chief Officer.

Salaries, Fees and Allowances relating to the Chief Officer for the period amounted to **£15,866.**

	Salaries, Fees and Allowances for Period to 31 March 2016 £	Total Remuneration £
Chief Officer (Full Year Equivalent = £102,749)	15,160	15,160
Other Employee Expenses	706	706
Totals	**15,866**	**15,866**

*Based on 54/366ths of £102,749 pro-rata of total annual costs representing period from 06 February to 31 March 2016

During the period, there was no payment of bonuses, taxable expenses, compensation for loss of employment or non-cash benefits. No exit packages were agreed by the Board during this period.

NHS Pension Scheme

All employees working for the Board are eligible to become members of the National Health Service Superannuation Scheme for Scotland or the Scottish Borders Local Government Pension Scheme.

The Chief Officer of the Board holds an employment contract with NHS Borders on NHS pay terms and conditions of employment and is a member of the NHS Pension Scheme. Details of the NHS Scheme are provided below. Full information on the NHS Pension Scheme can be sourced from the Scottish Public Pensions Agency website via the following link: http://www.sppa.gov.uk

The NHS Board participates in the National Health Service Superannuation Scheme for Scotland. The scheme is an unfunded statutory public service pension scheme with benefits underwritten by the UK Government. The scheme is financed by payments from employers and those current employees who are members of the scheme and paying contributions at progressively higher marginal rates based on pensionable pay, as specified in the regulations.

The National Health Service Superannuation Scheme for Scotland is a multi-employer scheme where the share of the assets and liabilities applicable to each employer is not identified. The NHS Board will therefore account for its pension costs on a defined contribution basis as permitted by IAS 19. NHS Borders has no liability for other employers' obligations to the multi-employer scheme.

The most recent actuarial valuation at 31 March 2014 discloses a liability of £39.5 billion (March 2013: £29.1 billion) with £1.4 billion to be met by employing authorities. Consequently the employer's rate of contribution increased from 13.5% to 14.9% on 1 April 2015.

Changes to the scheme were implemented from 01 April 2008 and again from 01 April 2015.

The new NHS Pension Scheme (Scotland) 2015: From 01 April 2015 the NHS Pension Scheme (Scotland) 2015 was introduced. This scheme is a Career Average Re-valued Earnings (CARE) scheme. Members will accrue 1/54th of their pay as pension for each year they are a member of the scheme. The accrued pension is re-valued each year at an above inflation rate to maintain its buying power. This is currently 1.5% above increases to the Consumer Prices Index (CPI). This continues until the member leaves the scheme or retires. In 2015/16 members paid tiered contribution rates ranging from 5.2% to 14.7% of pensionable earnings. The retirement age for members of the CARE scheme is the Employee's State Pension age. Members can access their accrued pension benefits earlier than their retirement age however an actuarial reduction is applied to the sum received. All members, unless covered by full or partial transitional protection arrangements, automatically became members of the NHS 2015 scheme on 01 April 2015.

Previous NHS Superannuation Schemes (Scotland):

Details of the two NHS Superannuation Schemes previously available to NHS employees are noted below.

The 1995 Section: Benefits are calculated on a 'final salary' basis at a normal retirement age of 60. Annual benefits are normally based on 1/80th of the best of the last three years pensionable pay for each year of service. In addition, a lump sum equivalent to three years' pension is payable on retirement. Members pay contributions on a tiered basis, dependent on earnings, of between 5.2% and 14.7% of pensionable earnings. Pensions are increased in line with the Consumer Price Index.

The 2008 Section: Benefits are calculated on a "final salary" basis at a normal retirement age of 65. Pension will have an accrual rate of 1/60th and be calculated on the basis of the average of the best consecutive three years pensionable pay in the ten years before retirement. There is an option to exchange part of Pension benefits for a cash lump sum at retirement, up to 25% of overall Pension Value. Members pay tiered contribution rates ranging from 5.2% to 14.7% of pensionable earnings.

Both the 1995 & 2008 schemes closed to new members on 31 March 2015. Accrued benefits in either NHS 1995 or NHS 2008 schemes are protected and will be paid at the section's normal pension age based on final pensionable pay when members leave or retire.

Pension Benefits of Senior Employees

	In-Year Pension Contributions for Period to 31 March 2016* £	Accrued Annual Pension Benefits as at 31 March 2016^ £	Accrued Pension Lump Sum as at 31 March 2016^ £
Chief Officer	1,499	10,640	27,475
Totals			

*Contributions during period 06 February to 31 March 2016 based on 54/366^{ths} of total annual contributions (£10,162.99)

^Total pension benefits / lump sum accrued as at 31 March 2016 in both '1995' and '2008' schemes (NB: '2008' scheme no lump sum entitlement – value above relates to '1995' scheme only)

Councillor Catriona Bhatia
Chair

Susan Manion
Chief Officer

On behalf of the Councillors and Officers of Scottish Borders Health and Social Care Partnership

30 September 2016

Statement of Responsibilities

Integration Joint Board

The Integration Joint Board has appointed its Chief Officer. It has also appointed its Chief Financial Officer on an interim secondment basis.

The Integration Joint Board is required to:

- Make arrangements for the proper administration of its financial affairs and to secure that one of its officers has the responsibility for the administration of those affairs (section 95 of the Local Government (Scotland) Act 1973). In this Joint Board, that officer is the Chief Financial Officer;
- Manage its affairs to secure economic, efficient and effective use of resources and safeguard its assets.
- Ensure the Annual Accounts are prepared in accordance with legislation (The Local Authority Accounts (Scotland) Regulations 2014), and so far as is compatible with that legislation, in accordance with proper accounting practices (section 12 of the Local Government in Scotland Act 2003; and
- Approve the Annual Accounts for signature.

I confirm that these Annual Accounts were approved for signature by the Integration Joint Board at its meeting on 17 October 2016.

Signed on behalf of Scottish Borders Health and Social Care Partnership

Councillor Catriona Bhatia
Chair

Chief Officer

The Integration Joint Board has appointed a Chief Officer in accordance with section 10 of the Act.

The Chief Officer is accountable directly to the Integration Joint Board for the preparation, implementation and reporting on the Strategic Commissioning Plan, including overseeing the operational delivery of delegated services.

The Chief Officer is a member of the Parties' relevant Executive / Corporate Management teams and is accountable to and managed by the Chief Executives of both Parties.

The Chief Officer is seconded to the Integration Joint Board from NHS Borders.

Chief Financial Officer

The Chief Financial Officer is and will be seconded at no cost to the IJB from one or other partner organisation. Currently, this post is filled on an interim basis.

The Chief Finance Officer is responsible for the preparation of the Board's Annual Accounts in accordance with the proper practices as set out in the CIPFA/LASAAC Code of Practice on Local Authority Accounting in the United Kingdom (the Code).

In preparing the Annual Accounts, the Chief Finance Officer has:

- selected suitable accounting policies and then applied them consistently;
- made judgements and estimates that were reasonable and prudent;
- complied with legislation; and
- complied with the Code (in so far as it is compatible with legislation).

The Chief Finance Officer has also:

- kept adequate accounting records which were up to date; and
- taken reasonable steps for the prevention and detection of fraud and other irregularities.

I certify that the financial statements give a true and fair view of the financial position of Scottish Borders Integration Joint Board at the reporting date and the transactions of the Joint Board for the year ended 31 March 2016.

Paul McMenamin, BA CPFA
Interim Chief Financial Officer

Annual Governance Statement

The Scottish Borders Health & Social Care Integration Scheme was submitted to Scottish Ministers on 17 December 2015 and received Cabinet Secretary approval on 18 December 2015.

An Order to establish the Integration Joint Board was laid in the Scottish Parliament on Friday 8 January 2016 for 28 days. From Saturday 06 February 2016 the Scottish Borders Health & Social Care Integration Joint Board was legally established.

The Integration Joint Board (IJB) is responsible for ensuring that its business is conducted in accordance with the law and appropriate standards, that public money is safeguarded, properly accounted for, and used economically, efficiently and effectively.

Chief Officer

In discharging the responsibilities of the IJB on its behalf, the Chief Officer has a reliance on the NHS and Local Authority's systems of internal control that support compliance with both organisations' policies and promotes achievement of each organisation's aims and objectives, as well as those of the IJB. Additionally, the IJB has through a range of instruments, put in place a system of governance over its operations.

The Chief Officer, Susan Manion, was appointed formally by the IJB on 07 March 2016.

Code of Corporate Governance

As part of the programme of preparing for the integration of health and social care, a Code of Corporate Governance was developed by the Legal and Governance work-stream.

The Partnership's Code of Corporate Governance was approved by the IJB at its meeting of 7 March 2016. The roles and responsibilities of Board members and officers are defined within a comprehensive suite of governance documents relating to the arrangements within which the partnership will operate which specifically covers:

- Scheme of Integration
- Key Principles of the Local Code of Governance
- Standing Orders
- Audit Arrangements including Terms of Reference for the Audit Committee
- Care and Clinical Governance Assurance Framework
- Risk Management Strategy
- Financial Arrangements and Financial Regulations

In addition to its own governance arrangements, the Board places reliance on the governance arrangements adopted by NHS Borders and Scottish Borders Council. Where appropriate existing mechanisms embedded within both NHS Borders and Scottish Borders Council will be used to provide assurance to the Health & Social Care Integration Joint Board to ensure unnecessary double handling of business does not occur.

Integration Joint Board

Services were delegated to the IJB on 01 April 2016. As such, 2015/2016 was a shadow year for the IJB and during this year the governance framework was established. The overarching strategic vision and local objectives of the IJB are detailed in the IJB's Strategic Plan which sets out the key outcomes the IJB is committed to delivering with its partners for the Scottish Borders. The Plan was approved at the meeting of the IJB on the 07 March 2016.

Performance management, monitoring of service delivery and financial governance is provided by the Health and Social Care Partnership to the IJB who are accountable to both the Health Board and the Local Authority. It reviews reports on the effectiveness of the integrated arrangements including the financial management of the integrated budget.

The Strategic Planning Group sets out the IJB's approach to engaging with stakeholders. Consultation on the future vision and activities of the IJB is undertaken with its health service and local authority partners. The IJB publishes information about its performance regularly as part of its public performance reporting.

The IJB's approach to risk management is set out in its risk management strategy, and the Partnership's Strategic and Operational Risk Registers which are in development. Regular reporting on risk management will be undertaken and reported regularly to the Executive Management Team and the IJB.

Audit Arrangements

Prior to the establishment of the IJB, a programme of work was undertaken to evaluate the progress made within the Scottish Borders Health and Social Care Integration (H&SCI) programme in advance of 01 April 2016. This work assessed the position against compliance with the legislative provisions within The Public Bodies (Joint Working) Scotland Act 2014 and the subsequent recommended best practice guidance issued by the Scottish Government / Integrated Resources Advisory Group (IRAG), in terms of the establishment of the arrangements for Financial Governance and Management within NHS Borders, Scottish Borders Council and the Scottish Borders Health and Social Care partnership, specific to the establishment of the Integrated Joint Board (IJB). Following the programme of work, reports were made to the IJB on 07 March 2016, NHS Borders Audit Committee on 01 February 2016 and 04 April 2016 and Scottish Borders Council's Audit Committee on 29 March 2016.

The IJB agreed to establish an Audit Committee as part of the governance arrangements of the Health & Social Care Integration Joint Board on 01 February 2016. On the same date, it approved the Terms of Reference of the IJB Audit Committee. The Audit Committee's core function is to provide the IJB with independent assurance on the adequacy of the risk management framework, the internal control environment and the integrity of the financial reporting and governance arrangements.

At its meeting of 20 June 2016, the Board agreed the membership of its Audit Committee. At 31 March 2016, the Committee had not yet met.

The Partnership complies with the requirements of the CIPFA Statement on "The Role of the Head of Internal Audit in Public Organisations 2010". The IJB's appointed Chief Internal Auditor has responsibility for the IJB's internal audit function and is professionally qualified and suitably experienced to lead and direct internal audit staff. The Internal Audit service operates in accordance with the CIPFA "Public Sector Internal Audit Standards

2013" as confirmed by self-assessment since 2014 and external peer review quality assessment during 2015 which was reported to Audit and Risk Committee and is stated within internal audit plans and reports. The Board appointed Jill Stacey, Chief Officer Audit and Risk, Scottish Borders Council as Chief Internal Auditor for the Integration Joint Board on 01 February 2016.

The Chief Internal Auditor will, from 2016/17, provide an annual report to the Audit Committee and an independent opinion on the adequacy and effectiveness of the governance framework, risk management and internal control.

Chief Financial Officer

The IJB complies with the CIPFA Statement on "The Role of the Chief Financial Officer in Local Government 2010". The IJB's Chief Finance Officer has overall responsibility for the Partnership's financial arrangements and is professionally qualified and suitably experienced to lead the IJB's finance function and to direct finance staff. The Chief Financial Officer was appointed on a 6-month interim basis by the IJB on 07 March 2016.

Responsibility for maintaining and operating an effective system of internal financial control rests with the Chief Finance Officer. The system of internal financial control is based on a framework of regular management information and financial governance arrangements.

On the 30 March 2016, the Chief Financial Officer made a full report to the IJB containing a Statement of Assurance over the sufficiency of resources prior to approval of the partnership's Financial Statement 2016/17. Supplementary reports were also made as part of the due diligence and assurance process to the IJB on 07 March 2016 and 18 April 2016.

Internal Control

The system of internal control is based on an ongoing process designed to identify, prioritise and manage the risks facing the organisation. The system aims to evaluate the nature and extent of failure to achieve the organisation's policies, aims and objectives and to manage risks efficiently, effectively and economically. As such it can therefore only provide reasonable and not absolute assurance of effectiveness.

Review

The IJB has responsibility for conducting (at least annually) a review of effectiveness of the system of internal control as part of its wider governance arrangements. The partnership's Chief Internal Auditor will facilitate an annual review of its governance arrangements against its Code of Corporate Governance, informed by the work of the Executive Management Team (who have responsibility for the development and maintenance of the internal control framework environment), the work of the internal auditors and the Chief Internal Auditor's annual report, and reports from external auditors and other review agencies and inspectorates.

Councillor Catriona Bhatia
Chair

Susan Manion
Chief Officer

On behalf of the Councillors and Officers of Scottish Borders Health and Social Care Partnership

30 September 2016

Independent Auditor's Report

Independent Auditor's Report to the members of the Scottish Borders Integration Joint Board and the Accounts Commission for Scotland

We certify that we have audited the financial statements of Scottish Borders Health and Social Care Partnership for the period ended 31 March 2016 under Part VII of the Local Government (Scotland) Act 1973. The financial statements comprise of the Comprehensive Income and Expenditure Statement, Balance Sheet and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Code of Practice on Local Authority Accounting in the United Kingdom 2015/16 (the 2015/16 Code).

This report is made solely to the parties to whom it is addressed in accordance with Part VII of the Local Government (Scotland) Act 1973 and for no other purpose. In accordance with paragraph 125 of the Code of Audit Practice approved by the Accounts Commission for Scotland, we do not undertake to have responsibilities to members or officers, in their individual capacities, or to third parties.

Respective responsibilities of the Chief Finance Officer and auditor

As explained more fully in the Statement of Responsibilities, the Chief Finance Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland) as required by the Code of Audit Practice approved by the Accounts Commission for Scotland. Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the circumstances of the body and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Chief Finance Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual accounts 2015/16 to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view in accordance with applicable law and the 2015/16 Code of the state of the affairs of the body as at 31 March 2016 and of the income and expenditure of the body for the then ended;
- have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 Code; and
- have been prepared in accordance with the requirements of the Local Government (Scotland) Act 1973, The Local Authority Accounts (Scotland) Regulations 2014, and the Local Government in Scotland Act 2003.

Opinion on other prescribed matters

In our opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with The Local Authority Accounts (Scotland) Regulations 2014; and
- the information given in the Management Commentary for the financial period for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if, in our opinion:

- adequate accounting records have not been kept; or
- the financial statements and the part of the Remuneration Report to be audited are not in agreement with the accounting records; or
- we have not received all the information and explanations we require for our audit; or
- the Annual Governance Statement has not been prepared in accordance with Delivering Good Governance in Local Government; or
- there has been a failure to achieve a prescribed financial objective.

We have nothing to report in respect of these matters.

Hugh Harvie, for and on behalf of KPMG LLP
20 Castle Terrace
Edinburgh
EH1 2EG
29 September 2016

Statement of Accounts

Comprehensive Income and Expenditure Statement (CIES) for the Period Ended 31 March 2016 (06 February 2016 to 31 March 2016)

	Gross Expenditure 2015/16 £'000	Income 2015/16 £'000	Net Expenditure 2015/16 £'000	Notes Ref.
Corporate Services	20	(20)	0	2, 3
Deficit on Provision of Services	**20**	**(20)**	**0**	
Total Comprehensive Income and Expenditure	**20**	**(20)**	**0**	
Other Notes				1

Balance Sheet at 31 March 2016

	Gross Expenditure 2015/16 £'000	Notes Ref.
Short Term Debtors	4	4
Current Assets	**4**	
Short Term Creditors	(4)	5
Current Liabilities	**(4)**	
Net Assets	**0**	
Useable Reserves	0	
Total Reserves	**0**	
Other Notes		6

Paul McMenamin BA, CPFA
Interim Chief Financial Officer

30 September 2016

Notes to the Statement of Accounts

1 – Significant Accounting Policies

1.1 General Principles

The Annual Accounts summarise the Board's transactions for the 2015/16 financial year and its position at the year end of 31 March 2016. The Board is required to prepare Annual Accounts by the Local Authority Accounts (Scotland) Regulations 2014, which section 12 of the Local Government in Scotland Act 2003 requires these to be prepared in accordance with proper accounting practices. These practices primarily comprise the Code of Practice on Local Authority Accounting in the United Kingdom 2015/16 (the Code) and the Service Reporting Code of Practice 2015/16 (SeRCOP), supported by International Financial Reporting Standards (IFRS) and statutory guidance issued under section 12 of the 2003 Act. The accounting convention adopted in the Annual Accounts is historical cost.

1.2 Accruals of Income and Expenditure

Activity is accounted for in the year in which it takes place, not simply when cash payments are made or received. In particular:

- expenses in relation to services received (including services provided by employees) are recorded as expenditure when the services are received rather than when payments are made; and
- where revenue and expenditure have been recognised but cash has not been received or paid, a debtor or creditor for the relevant amount is recorded in the Balance Sheet. Where there is evidence that debts are unlikely to be settled, the balance of debtors is written down and a charge made to revenue for the income that might not be collected.

1.3 Events after the Reporting Period / Balance Sheet Date

Events after the Reporting Period / Balance Sheet Date are those events, both favourable and unfavourable, that occur between the end of the reporting period and the date when the Annual Accounts are authorised for issue. Two types of events can be identified:

- those that provide evidence of conditions that existed at the end of the reporting period – the Annual Accounts are adjusted to reflect such events; and
- those that are indicative of conditions that arose after the reporting period – the Annual Accounts are not adjusted to reflect such events, but where a category of events would have a material effect disclosure is made in the notes of the nature of the events and their estimated financial effect.

Events taking place after the date of authorisation for issue are not reflected in the Annual Accounts. There are no post-balance sheet date events known currently.

1.4 Contingent Liabilities and Contingent Assets

A contingent liability is a possible future financial obligation which is reported as a specific note to the annual accounts because it cannot be judged as probable enough to warrant a provision. Contingent liabilities are not recognised in the Balance Sheet but disclosed in a note to the accounts. Similarly, a contingent asset arises where an event has taken place that gives the Board a possible asset, but where its existence will only be confirmed by the occurrence of uncertain future events over which the Board does not have full control. Again, these are not recognised in the Balance Sheet but disclosed in a note to the accounts, where there is some probability that there will be an inflow of economic benefit.

There are no probable contingent liabilities or assets known at the Balance Sheet date.

1.5 Reserves
The IJB has the authority to maintain a General Fund Reserve. No reserve existed however at the start or end of the accounting period.

Planned underspends going forward will be returned by the Health Board and Local Authority to the IJB and carried forward through the General Fund. This will require adjustments to the allocations from the IJB to these bodies for the sum of the underspend.

In future, when expenditure is to be financed from the reserve, it will be charged to the appropriate service in that year offsetting the surplus/deficit on the Provision of Services in the Comprehensive Income and Expenditure Statement.

1.6 VAT
The IJB is a non-taxable entity and therefore neither charges, nor recovers VAT on its functions.

HMRC has issued an Interim Decision on the VAT treatment of the secondment of the Chief Officer to the IJB which states that *"Secondment of the Chief Officer (CO): under Section 10(1) of the Act requires an IJB to appoint a CO; and section 10(3) can be read as meaning that the relevant authority must second that person (or, under section 10(4), employ and then second that person). Therefore, it is recognised that the requirement on the HB/LA to provide a CO is a statutory requirement, so when fulfilling this the HB/LA would be acting under a Special Legal Regime, and therefore the transaction would be an act as a public body, and in acting as such would make the transaction not taxable, and deemed as outside the scope of VAT."*

There are no known VAT implications over the supply of the Chief Officer to the IJB therefore at the current time.

2 – Related Party Transactions

Income - Payment for Integrated Functions	31 March 2016 £'000
NHS Borders	(10)
Scottish Borders Council	(10)
Total Corporate Expenditure	**(20)**

Expenditure - Payment for Delivery of Integrated Functions	31 March 2016 £'000
NHS Borders	10
Scottish Borders Council	10
Total Corporate Expenditure	**20**

The above values are based on a 50/50 cost-sharing arrangement between NHS Borders and Scottish Borders Council in respect of the operating costs incurred by the IJB during the period.

3 – Corporate Expenditure

	31 March 2016 £'000
Staff Costs	16
Audit Fee	4
Total Corporate Expenditure	**20**

4 – Short-Term Debtors

	31 March 2016 £'000
Central Government Bodies	2
Other Local Authorities	2
Total Corporate Expenditure	**4**

5 – Short-Term Creditors

	31 March 2016 £'000
Central Government Bodies	(2)
Other Local Authorities	(2)
Total Corporate Expenditure	**(4)**

6 – Events After the Reporting Period / Balance Sheet Date

The unaudited accounts were issued on 30 June 2016 by Paul McMenamin, BA, CPFA, Interim Chief Finance Officer, who is the proper officer of the IJB in accordance with Section 95 of the Local Government (Scotland) Act 1973. Where events taking place before the balance sheet date provided information about conditions existing at 31 March 2016, the figures in the financial statements and notes have been adjusted in all material respects to reflect the impact of this information.

There have been no material events since the date of the balance sheet which necessitate the revision of the figures in the financial statements or notes thereto including contingent assets and liabilities.

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IJB Audit Committee

Health and Social Care Integration –
Update: Progress to Date and Compliance Assessment with Legislation/Recommended Best Practice

Aim

The aim of this report is to provide further update of the progress made within the Scottish Borders Health and Social Care Integration (H&SCI) programme in relation to compliance with the legislative provisions within The Public Bodies (Joint Working) Scotland Act 2014 and the subsequent recommended best practice guidance issued by the Scottish Government / Integrated Resources Advisory Group (IRAG).

These provisions relate to the establishment of the arrangements for Financial Governance and Management within NHS Borders, Scottish Borders Council and the Scottish Borders Health and Social Care partnership.

Background

Previous reports to the audit committee have identified that specific to the establishment of an integration model within the Scottish Borders – delegation to a (body corporate) Integration Joint Board – there are 69 key financial-related provisions / recommendations within the IRAG guidance that require to be considered.

An updated summary of progress by the Scottish Borders partnership, with the recommended requirements, is detailed in Appendix 1 to this report.

This report updates the previous report to the Audit Committee in April 2016.

Summary

The 69 provisions considered cover a range of areas across financial governance and management:

- Governance Structure
- Assurance and Governance
- Financial Reporting
- Financial Planning and Financial Management
- VAT
- Capital and Asset Management
- Accounting Standards

In undertaking the evaluation and monitoring progress against the provisions, review of progress has been against a “RAG” rating (Red, Yellow, Amber, Green, Grey) applied against each provision. These were defined as:

Actions Complete
Actions Complete, Minor Remaining Actions Profiled
Actions On Track, Actions Planned
Requires Further Action to be Instigated
Does Not Currently Apply – No Actions Currently Required

At the end of March 2016:

- 32 provisions were assessed as Green
- 11 provisions were assessed as Yellow
- 14 provisions were assessed as Amber
- 4 provisions were assessed as Red
- 8 provisions remained grey as not requiring any action currently

Update on all Outstanding Provisions

At the time of reporting, 4 provisions were reported as having just been completed. These related to the approval by the IJB on 30 March 2016 of the 2016/17 Financial Statement and the process of due diligence leading to the provision of financial assurance over the sufficiency of resources. These are therefore now green and complete.

In respect of the remaining 25 provisions, the following updated position is presented in order of those requiring timely action or where no plans / progress was in place / being made.

Review of NHS Borders' and Scottish Borders Council's Financial Regulations and Schemes of Delegation	Materiality / Risk: Med	Provision Refs: 18, 59

Both NHS Borders and Scottish Borders Council have continued to update Financial Regulations during the financial year. Specific to ensuring linkage to and appropriate consideration of the impact of health and social care integration however, a final version requires approval by both partners' board/council. It is expected that this will happen for both organisations in late 2016.

Timescale: 31 December 2016

Internal Audit Arrangements and Audit Plan	Materiality / Risk: High	Provision Refs: 24, 25

The Chief Internal Auditor to the partnership was appointed at the IJB meeting of the 07 March 2016, when the Local Code of Governance was also approved. Audit Committee membership was subsequently agreed at the IJB meeting on 20 June 2016. It is expected

that the inaugural meeting of the partnership Audit Committee will take place at the end of September 2016, when a draft Audit Plan for the remainder of 2016/17 will be presented. This will complete the two required actions within the provisions.

Timescale: 30 September 2016

The publication of written Directions from the IJB to NHS Borders and Scottish Borders Council detailing the duties of the IJB and partners and amount of delegated budget/set-aside and how it will be used, a description of services together with any supplementary provisions	Materiality / Risk: Low	*Provision Refs:* 6, 37, 46, 47

The IJB approved the issue of Directions on 18 April 2016, following which formal written direction was made to each of NHS Borders and Scottish Borders Council. These Directions met each of the required provisions within the guidance and included a list of all directed functions and the amount and method of payment made to fulfil these functions.

Timescale: Complete

Further work is also required in relation to clear identification of the nature, value, source and services supported by current Health Board Resource Transfer which will then require to be accounted for in the method of calculating the Integrated Budget of the IJB. Similarly, further work is also required in relation to hosted services.	Materiality / Risk: Med	Provision Refs: 48, 49, 50

Work is ongoing to analyse and agree the basis for and amount of Resource Transfer. Significant detail has been examined during the summer of 2016 and a number of discussions have taken place between partners. This is expected to conclude by agreement shortly. Work on hosted services remains ongoing.

Timescale: 30 September 2016

An integrated Financial Planning process, involving the IJB, within each organisation, which takes account of priorities and results in a negotiated contribution from each partner must further be developed for 2017/18	Materiality / Risk: High	*Provision Refs:* 42, 43

This work will now commence during the Autumn of 2016 as part of the 2017/18 Financial Planning process. This will ensure that the 2017/18 Financial Plan for the partnership is based on the current year budget adjusted incrementally to reflect:

- Partners' absolute level of funding by the Scottish Government
- Past performance and known areas of financial pressure arising due to cost, demand, legislative and other factors
- Efficiencies and other required savings delivery to ensure overall affordability
- New priorities as expressed within partners' plans and the Integration Joint Board's Strategic Plan
- Other emerging areas of financial impact

In order to enable this, there is clear provision within the partnership's Scheme of Integration (SOI) (8.4.1) in relation to payment to the IJB for delegated functions beyond year 1, whereby the partnership Chief Financial Officer will develop a case for the Integrated Budget based on the Strategic Plan, recognising the financial parameters within which both partners are required to operate within and reflecting such within the Integrated Budget. The SOI also states that both partners, when considering the Strategic Plan, will consider factors such as government financial settlements / funding uplift and required efficiencies and it is only through a process of joint discussion and planning between all partners that the financial plan can be agreed and delivered in support of the partnership's strategic aims and objectives.

Timescale: October 2016 to March 2017

The allocation of resources within the outcomes of the Strategic Plan requires to be developed further	Materiality / Risk: Med	*Provision Refs:* 55

This is a key piece of work scheduled for the second half of 2016. This will clearly show how component elements of both the delegated and set-aside budgets financially support the delivery of the partnership's strategic plan. It will also provide the baseline position against which future resource shifts can be planned and measured.

This piece of work also links to the locality planning workstream of the integration programme and specifically will contribute to the development of a financial plan for each of the 5 localities across the Scottish Borders.

Timescale: October 2016 to March 2017

A Financial Strategy will be developed which will cover a number of key areas including forecast funding levels for the Integrated Budget, priority areas for investment and disinvestment and identification of financial risks and an approach to a strategy for building and managing IJB reserve levels	Materiality / Risk: Med	*Provision Refs:* 57

This work will be undertaken during the remainder of this financial year and reported to the IJB as part of the process of approving its Financial Statement for 2017/18.

Timescale: 31 March 2017

The Integration Joint Board will identify the asset requirements to support the Strategic Plan to enable the Chief Officer to identify capital investment projects, or business cases to submit for consideration as part of each organisation's capital financial planning processes	Materiality / Risk: Med	*Provision Refs:* 68

The Health Board and Local Authority may make use of non-current assets, owned or otherwise, to deliver the services in scope of the Strategic Plan. Arrangements for Capital Financial Planning require to be developed post April 2016	Materiality / Risk: Med	Provision Refs: 13, 67

Capital Planning will be undertaken as part of the integrated approach to the 2017/18 Financial Planning process which is planned to commence in Autumn 2016. The IJB does not receive any capital allocations or grants, nor can it borrow to invest like a local authority. All fixed assets remain owned by NHS Borders and Scottish Borders Council and as such, it is only through accessing partners' capital funding allocations that any capital investment requirements can be met. Where the Chief Officer identifies as part of the Strategic Plan new capital investment requirements, a business case will be developed for the proposal for both partners to consider and local agreement between the partners here in the Scottish Borders as to approval and funding of any proposal will be sought.

Timescale: 31 March 2017

A proposed strategy for Insurance over the activities of the IJB still requires agreement and approval	Materiality / Risk: Med	Provision Refs: 23

Both partner organisations operate under the same insurance arrangements as previously. Whilst a separate legal entity, it is not anticipated that there will be any significant insurance implications for the partnership, although a review of these arrangements is planned as part of corporate services planning during the remainder of 2016/17.

Timescale: 31 March 2017

Completion of the risk analysis process (for both the IJB and NHSB/SBC – updated risk registers for both the latter organisations) is required and a Risk Register and Risk Management Strategy both require completion	Materiality / Risk: High	Provision Refs: 19, 20, 22

The partnership approved its Risk Management Strategy as part of its Code of Corporate Governance in March 2016. Since then, work has been undertaken to develop both Strategic and Operational Risk Registers for the partnership and these are scheduled to be reported to its next meeting on 17 October 2016 for approval and onward management.

Timescale: 17 October 2017

At an operational financial management level, a policy on the application of monthly accrual accounting requires further discussion and agreement	Materiality / Risk: Med	Provision Refs: 54

Currently NHS Borders operates a monthly accrual policy whilst Scottish Borders Council only accrues outstanding receipts and payments at year-end. It is the aspiration of the partnership to implement a consistent policy of monthly accrual accounting across all delegated and set-aside budgets. Scottish Borders Council are currently considering this option as part of its migration to a new ledger system and its supporting processes within its Digital Transformation agenda, due to go live on 1st April 2017. No decision in respect of this accounting policy has yet been made although functionality is clearly possible and going forward, the partnership's Chief Financial Officer will work with key Finance officers within the authority to ensure that consistency of this fundamental accounting policy requirement is implemented for all health and social care functions.

Timescale: 31 March 2017

Refinement of and quality assurance over large hospitals budget set-aside remains ongoing following and will be incorporated into any revised financial statement	Materiality / Risk: High	*Provision Refs:* 62, 64

From October 2016, monitoring of both the delegated budget and large hospital budget set-aside will be reported to the IJB. Further work developing and interpreting the latter will also take place during the remainder of 2016/17 and incorporated into future years' financial statements.

Timescale: 31 March 2017

The IJB Chief Financial Officer will be appointed on a permanent basis by 31st August 2016	Materiality / Risk: Low	Provision Refs: 4

The interim arrangement over the appointment of the partnership's Chief Financial Officer is ongoing and will continue to apply until formal permanent recruitment to the post is made during the Autumn of 2016 following agreement between partners over the basis and role of the post.

Timescale: 31 October 2017

Other Information

At the time of reporting last to the Audit Committee in April, it was stated that at that point in time, it was unclear as to whether statutory reports and financial accounts for the partnership would be required for 2015/16. This was in direct response to the financial provisions within IRAG relating to:

- Statutory Accounts (10, 30,32)
- Additional Disclosures within Partners' Accounts (11,31)

These form 5 of the 8 provisions previously classified as “grey - not requiring any action currently”.

Subsequently to the April report, confirmation was required that accounts relating to the operating costs of the partnership for the period between its establishment on 06 February 2016 and 31 March 2016 would be required. These were completed within the statutory timescale and are currently being audited. The final audited accounts will be reported to the 17 October meeting of the IJB for approval. Both partners included an additional disclosure within the notes to its 2015/16 accounts in relation to the existence and operation of the health and social care partnership.

At the end of August 2016 therefore:

- 46 provisions are now assessed as Green
- 8 provisions are assessed as Yellow
- 10 provisions are assessed as Amber
- 2 provisions are assessed as Red
- 3 provisions remain grey

Recommendation

The IJB Audit Committee is asked to:

- **Note the further progress made to date in the development and implementation of the financial arrangements which require to be in place prior across NHS Borders, Scottish Borders Council and the Health and Social Care Partnership**
- **Note the plan of actions for the remaining work requiring completion during the remainder of 2016/17**

Approved by

Name	Designation
Paul McMenamin	Interim Chief Financial Officer IJB

Author(s)

Name	Designation
Paul McMenamin	Interim Chief Financial Officer - IJB

Date: 01 September 2016

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Complete
Complete, Minor Remaining Actions Profiled
OnTrack, Actions Planned
Requires Further Action
Does not currently apply

SCOTTISH BORDERS INTEGRATED JOINT BOARD
COMPLIANCE CHECK WITH INTEGRATED RESOURCES ADVISORY GROUP GUIDANCE

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>
1. DELEGATION TO AN IJB					
1.1 INTEGRATION SCHEME AND STRATEGIC PLAN					
1	22/1.1.1	The Integration Scheme sets out the detail of the integration arrangement, as agreed by the Local Authority and Health Board and submitted to Scottish Ministers for approval	Detailed in Final Scheme 151215	None	Received ministerial approval mid-2015 s2-6 set out governance and delivery arrangements, functions delegated and accountability / etc
2	22/1.1.1	The SOI will cover a number of matters provided for by the legislation and Regulations and for finance related matters these will include: • Functions which are to be delegated to the Integration Joint Board by the Health Board and Local Authority; • The method for the determination of the resources to be made available by the Local Authority and Health Board to the Integration Joint Board for the delegated functions; • Reporting arrangements between the Integration Joint Board, Health Board and Local Authority; and • Financial management arrangements.	SOI appendix 2 and 3 outlines functions delegated Method for determining resource allocationand treatment of variations is detailed in SOI s8.	None	Also covers arrangeements in relation to large hospital budgets set-aside
3	22/1.1.3	Integration Scheme should also define those services which are not delegated to the Integration Joint Board but are managed by the Chief Officer on behalf on the partner Local Authority and Health Board.	There are no services of this nature managed by the Chief Officer	None	This does not preclude such an arrangement taking place in the future
1.2 CHIEF OFFICER					

Complete
Complete, Minor Remaining Actions Profiled
OnTrack, Actions Planned
Requires Further Action
Does not currently apply

SCOTTISH BORDERS INTEGRATED JOINT BOARD
COMPLIANCE CHECK WITH INTEGRATED RESOURCES ADVISORY GROUP GUIDANCE

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
4	22/1.2.1	The Integration Joint Board must make arrangements for the proper administration of its financial affairs and appoint an officer with this responsibility, (the Integration Joint Board financial officer)	IJB Chief Financial Officer appointed on an interim basis from 1st March 2016	Permanent appointment will be made during 2016	The Chief Financial Officer will be responsible for developing a number of further governance and operational planning, management and reporting arrangements going forward	
1.3 FINANCIAL MODEL						
5	23/1.3.0.1	The Health Board and Local Authority will delegate functions and make payments to the Integration Joint Board in respect of the delegated functions and the Health Board will also set aside amounts in respect of large hospitals for use by the Integration Joint Board.	This is set out in section 8 of the SOI. Specifically, 8.3/8.4 set out the provisions for making payments to the IJB whilst 8.5 sets out the method for determining the amount set aside for large hospital services.	None	Amount delegated / Set-aside is subject to due dilligence process and assessment of sufficiency of resources when compared to current spend levels and current and future risks	
6	23/1.3.0.1	The Integration Joint Board will produce the Strategic Plan for the use of these resources and give direction and make payment where relevant to the Health Board and Local Authority for delivery of the services in line with the Strategic Plan.	Strategic Plan approved 7th March 2016 Initial Directions issued April 2016			
7	23/1.3.1.1	Resources within the scope will comprise: • The payment made to the Integration Joint Board by the Local Authority for delegated adult social care services (A); • The payment made to the Integration Joint Board by the Health Board for delegated primary and community healthcare services and for those delegated hospital services which will be managed by the Chief Officer (B); and • The amount set aside by the Health Board for delegated services provided in large hospitals for the population of the Integration Joint Board (C).	This is explicitly stated within the SOI 3.3 and sections 8.3-8.5 clearly reflect that this will be the case. Figure 1 P24 graphically reflects this - also detailed within Appendices 2 and 3.	It is intended that a financial statement and assurance report will be approved by the IJB at its extraordinary meeting of 30 March 2016, detailing the amout of resources following within the scope across each of the 3 elements	3 areas of resource (A+B+C) constitute all available resources supporting the delivery of the Strategic Plan, whilst only A+B form part of the delegated budget Rated green in anticipation of IJB approval on 30th March	

Scottish Borders Health and Social Care PARTNERSHIP	Complete
	Complete, Minor Remaining Actions Profiled
	OnTrack, Actions Planned
	Requires Further Action
	Does not currently apply

NHS Borders | Scottish Borders COUNCIL

SCOTTISH BORDERS INTEGRATED JOINT BOARD
COMPLIANCE CHECK WITH INTEGRATED RESOURCES ADVISORY GROUP GUIDANCE

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
8	24/1.3.1.2	The Integrated Budget comprises of parts (A) and (B).	This is explicitly stated within the SOI 3.3 and sections 8.3-8.5 clearly reflect that this will be the case. Figure 1 P24 graphically reflects this - also detailed within Appendices 2 and 3.	In the report to IJB on 30 March which will propose the resources delegated and due dilligence over them, this should be stated	These are the budget heads over which CO has direct management responsibility	
9	24/1.3.2.1	In addition to the services within scope of the Strategic Plan and managed by the Chief Officer, the Local Authority and Health Board may request that the Chief Officer manage services that are outside of the scope of the Strategic Plan.	Presently, this is not the case within the Scottish Borders. The Chief Officer is only responsible for functions delegated to the IJB. There is scope for this however, within the SOI 1.3.2.1.	None	Is not precluded from future arrangements	
1.4 FINANCIAL GOVERNANCE						
10	25/1.4.1.1	The Integration Joint Board will be required to produce its own statutory accounts as a body under Section 106 of the Local Government (Scotland) Act 1973.	Draft accounts in relation to operating costs prepared for the period 06 February to 31 March 2016.	None	Currently being audited and will be submitted to the IJB in October	
11	25/1.4.1.2	The Local Authority and Health Board will be required to include additional disclosures and group accounts as part of their financial statements which reflect their relationship with the Integration Joint Board.	Noted to the accounts of both partner organisations.	None	15/16 may require to be restated for comparative purposes / or produced for period from IJB establishment date	
12	25/1.4.2.1	The Integration Joint Board must appoint an officer to be responsible for the administration of its financial affairs, referred to in this guidance as the Integration Joint Board financial officer.	4.4b of SOI Scheme P9 explicitly refers to the IJB requiring to appoint a CFO.	None	Interim IJB CFO appointed from 1 March 2016	
13	25/1.4.2.3	The Health Board and Local Authority may make use of non-current assets, owned or otherwise, to deliver the services in scope of the Strategic Plan. Ownership of the assets and the associated liabilities will be unchanged and remain with the partner Local Authority and Health Board.	This will be the case for the Scottish Borders partnership, explicitly defined in 8.7.1.	None	Arrangements for Capital Financial Planning require to be developed and applied during the medium-term planning from 17/18	
14	26/1.4.3.1	The Integration Joint Board should establish a system of risk management arrangements for the functions delegated to it.	This is explicitly defined in section 13 of the SOI.	None		
2. ASSURANCE AND GOVERNANCE						
2.1 FINANCIAL ASSURANCE						

Scottish Borders Health and Social Care PARTNERSHIP	Complete
	Complete, Minor Remaining Actions Profiled
	OnTrack, Actions Planned
	Requires Further Action
	Does not currently apply

NHS Borders | Scottish Borders COUNCIL

SCOTTISH BORDERS INTEGRATED JOINT BOARD
COMPLIANCE CHECK WITH INTEGRATED RESOURCES ADVISORY GROUP GUIDANCE

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
15	27/2.1.1	The Health Board accountable officer and the Local Authority Section 95 Officer discharge their responsibility, as it relates to the resources that are delegated to the Integration Joint Board, by setting out in the Integration Scheme - the purpose for which resources are used - and the systems and monitoring arrangements for financial performance management.	Provision within the SOI for the processes through which performance and resources will be managed.	None	Performance Management and Reporting group established in order to deliver rounded financial and performance information and processes to inform integrated decision making from 16/17	
16	27/2.1.3	The Chief Officer is: • Accountable to the Chief Executive of the Health Board for financial management of the operational budget, and is advised by the Health Board Director of Finance; • Accountable to the Section 95 Officer of the Local Authority for financial management of the operational budget; and • Accountable to the Chief Executive of the Local Authority and Chief Executive of the Health Board for the operational performance of the services managed by the Chief Officer.	This is the arrangement proposed for the Scottish Borders partnership, supplemented by the CO's accountability to the IJB for all matters on services and budgets integrated and for which she is responsible. SOI 6.4 explicitly defines accountability to Chief Executives. There is less explicit reference to the COs accountability for matters financial.	None		
17	27/2.1.4	The financial regulations should be developed by its financial officer and incorporate a minimum set of controls. It is recommended that the financial regulations are approved by the Integration Joint Board.	Developed, agreed and reported to the IJB for approval on 01/02/16 following IJB members development session 20/01/16.	None		
18	27/2.1.5	The financial regulations of the Health Board and Local Authority should be revised, if necessary, to incorporate changes resulting from the financial integration arrangements including the arrangements for virement associated with the Integrated Budget.	Still to be completed.	A review of both NHSB and SBC Financial Regulations is required to ensure complementary and consistent governance policy and application.		
2.2 RISK MANAGEMENT						
19	28/2.2.1	The Chief Officer will be responsible for establishing the Integration Joint Board's risk strategy and profile and developing the risk reporting arrangements.	This is explicitly defined in 13.1 of the SOI. Risk Management Strategy approved by IJB March 2016.	None	Risk registers to be reported to the IJB 17 October 2016.	

Complete	
Complete, Minor Remaining Actions Profiled	
OnTrack, Actions Planned	
Requires Further Action	
Does not currently apply	

SCOTTISH BORDERS INTEGRATED JOINT BOARD
COMPLIANCE CHECK WITH INTEGRATED RESOURCES ADVISORY GROUP GUIDANCE

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
20	28/2.2.2	The participating authorities should identify and manage within their own risk management arrangements any risks they consider to have retained under the integration arrangements.	Complete	Requires to be further reviewed within both NHSB and SBC following establishment of the IJB.		
21	27/2.2.3	The Integration Scheme should consider provisions to address the key risks inherent in integration and include: • Governance, management and strategy; • Financial management; • Asset management; • Information management; • Performance management; and • Customer management.	Arrangements/provisions for control and governance across each of these areas is provided for within the Scheme of Integration, including complaints handling, etc, primarily within sections 10 to 13	None		
22	27/2.2.4	It is also recommended that the provisions for risk management in the Integration Scheme include: • Leadership/lines of accountability; • Arrangements for recording, updating, monitoring and reporting of risk management information; and • Arrangements for accessing professional risk management support.	None of this is explicitly defined in detail within the Scheme of Integration.	A report to the IJB on the Code of Governance including Risk Management arrangements and strategy was made to the IJB on 07 March 2016 with further organic development planned during 2016		
2.3 INSURANCE						
23	29/2.3.1	Integration Joint Boards should make appropriate provision for insurance according to the risk management strategy.		Requires inclusion and finalisation.	Interim insurance options are currently being considered	
24	29/2.4.1	It is the responsibility of the Integration Joint Board to establish adequate and proportionate internal audit arrangements for review of the adequacy of the arrangements for risk management, governance and control of the delegated resources. This will include determining who will provide the internal audit service for the Integration Joint Board and nominating a Chief Internal Auditor.	IJB has approved the appointment of CIA to the IJB. Audit committee will be established. Internal Audit plan to be developed Etc.	Work ongoing.	IJB Audit Committee to meet. Audit Plan to be approved.	

Complete	
Complete, Minor Remaining Actions Profiled	
OnTrack, Actions Planned	
Requires Further Action	
Does not currently apply	

SCOTTISH BORDERS INTEGRATED JOINT BOARD
COMPLIANCE CHECK WITH INTEGRATED RESOURCES ADVISORY GROUP GUIDANCE

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>
25	30/2.4.6	There should be a risk based internal audit plan developed by the Chief Internal Auditor of the Integration Joint Board and approved by the Integration Joint Board or other committee.	Not complete.	To be completed.	As above
26	30/2.4.7	Internal audit service should be provided by one of the internal audit teams from the Health Board or Local Authority and the Chief Internal Auditor from either of the partner Health Board or Local Authority fulfil this role in the Integration Joint Board.	IJB has approved the appointment of CIA to the IJB. Audit committee will be established. .Audit committee has been approved and established.	Approved February 2016	
27	30/2.4.9	The Integration Joint Board Chief Internal Auditor should report to the Chief Officer and the Integration Joint Board on the annual audit plan, delivery of the plan and recommendations and should provide an annual internal audit report including the audit opinion.	From 2016/17	None	
28	31/2.5.2	The Accounts Commission will appoint the auditors to the Integration Joint Board.	KPMG, Scottish Borders Council's external auditors, have been appointed as auditors to the IJB	None	
29	31/2.6.1	The Integration Joint Board should make appropriate and proportionate arrangements, for consideration of the audit provision and annual financial statements, which are compliant with good practice governance standards in the public sector.	From 2016/17	None	
3. FINANCIAL REPORTING					
3.1 STATUTORY ACCOUNTS					
30	33/3.1.0.1	Audited annual accounts to be prepared with the reporting requirements specified in the relevant legislation and regulations	Draft accounts in relation to operating costs prepared for the period 06 February to 31 March 2016.	None	Currently being audited and will be submitted to the IJB in October
31	33/3.1.0.2	The Local Authority and Health Board should include additional disclosures in their statutory accounts which reflect their formal relationship with the Integration Joint Board. .	Noted to the accounts of both partner organisations.	None	15/16 may require to be restated for comparative purposes / or produced for period from IJB establishment date

Complete
Complete, Minor Remaining Actions Profiled
OnTrack, Actions Planned
Requires Further Action
Does not currently apply

SCOTTISH BORDERS INTEGRATED JOINT BOARD
COMPLIANCE CHECK WITH INTEGRATED RESOURCES ADVISORY GROUP GUIDANCE

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
32	34/3.1.1.4	The Integration Joint Board financial statements must be completed to meet the audit and publication timetable specified in regulations	Draft accounts in relation to operating costs prepared for the period 06 February to 31 March 2016 - submitted to External Audit by 30 June statutory timescale.	None	Currently being audited and will be submitted to the IJB in October	
Further work will be undertaken during 2016/17 to ensure full compliance with IRAG in relation to Financial Reporting						
4. FINANCIAL MANAGEMENT						
4.1 RESOURCES WITHIN THE SCOPE OF THE STRATEGIC PLAN						
33	38/4.1.1	The legislation requires that the Integration Joint Board produce a Strategic Plan, which sets out the services for their population over the medium term (3 years)	Approved. Complete.			
34	38/4.1.2	The Strategic Plan should incorporate a medium term financial plan (3 years) for the resources within scope of the Strategic Plan which will comprise: • the Integrated Budget, i.e. the sum of the payments to the Integration Joint Board (see 4.2); plus • the notional budget, ie the amount set aside by the Health Board, for large hospital services used by the Integration Joint Board population (see 4.4).	This is not explicitly within the Strategic Plan although the services to be integrated are defined in Appendix A. These resources within scope will be formally defined within the 2016/17 Financial Statement which will be approved by the IJB in March 2016 and which will support the delivery of the Strategic Plan. This will also include large hospital set-aside notional budget. Formal Written Directions, including the value of specific integrated budget, will also be issued by the IJB to its partners	Complete		
35	38/4.1.4	The relative proportions of partners' contributions to the resources within scope of the plan will not influence the proportion of services that will be directed by The Integration Joint Board through the Strategic Plan, although it is likely that in the first years they will be similar.	This is not specifically referred to within either the SOI or the Strategic Plan but has been a working principle of the financial planning work to date as proposed at a member development session in 2015.			
4.2 THE INTEGRATED BUDGET						
36	39/4.2.1	The legislation requires that Health Boards and Local Authorities make payments to the integration joint board for the delegated functions and that the method for determining the value of the payments is included in the Integration Scheme	8.3.1 of the SOI states that "the baseline payment will be established by reviewing recent past performance and existing plans for NHSB and SBC for the functions delegated adjusted for material items" and 8.1-8.2 provides for the mechanism of value determination.	None		

Complete
Complete, Minor Remaining Actions Profiled
OnTrack, Actions Planned
Requires Further Action
Does not currently apply

SCOTTISH BORDERS INTEGRATED JOINT BOARD
COMPLIANCE CHECK WITH INTEGRATED RESOURCES ADVISORY GROUP GUIDANCE

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
37	39/4.2.2	The legislation also requires that where the Integration Joint Board gives direction for the partner Local Authority and Health Board for the operational delivery of services, that the value of the payment or the method of agreeing the value of the payment be included in the direction	Directions issued April 2016			
38	39/4.2.3	Integration authorities should undertake a shadow period in 2014-15. The allocations in the shadow period should be based on the existing financial plans of the Local Authority and Health Board including the planned efficiencies and consideration of recent financial outturn and trends in expenditure; this process must be transparent and the assumptions underlying the budgets must be available to all partners.	Shadow period commenced 1st April 2016 - aligned budgets reflected approved 2015/16 Financial Plans for both NHSB and SBC, including planned efficiencies, savings/income proposals and service pressures/growth. Financial Plans between both partners shared and published.	None		
39	39/4.2.4	The financial performance of the Integrated Budget is monitored during the shadow period with full transparency so that all partners have a clear understanding of the cause and type (recurrent/non-recurrent) of variances and the remedial actions taken by the Local Authority and Health Board. They should have a clear understanding of the adequacy of the budgets in the financial plan for the following year and the assumptions on which they are based.	Monthly aligned financial monitoring reports by exception to Programme Implementation Board / Executive Management Team, with a full quarterly report to IJB detailing current and projected position to date and key areas of pressure/savings variances with detailed explanation where required, including proposed remedial action across integrated and non-integrated budget heads. Financial Plan process paper to be developed for IJB.	Complete	Regular and frequent monitoring reports to IJB	

Complete
Complete, Minor Remaining Actions Profiled
OnTrack, Actions Planned
Requires Further Action
Does not currently apply

SCOTTISH BORDERS INTEGRATED JOINT BOARD
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ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
40	39/4.2.5	The initial payments to the Integration Joint Board should be based on analysis of the shadow period in 2014-15 to provide the Local Authority, Health Board and Integration Joint Board with reassurance that the delegated resources are sufficient to deliver the delegated functions. It should also consider the respective financial plans of the Local Authority and Health Board including full transparency on the budget assumptions and planned efficiency savings. These allocations should be tested against the actual performance in the shadow period and adjusted if necessary. Although not included in the payment, the analysis in the shadow period should include the notional budget for hospital services.	This is the approach and takes account of both organisations existing financial plans. Assurance over the sufficiency of resources has been undertaken and key risks identified. Both organisations are experiencing significant pressures presently on functions which will be delegated - full assurance / risk assessment has been undertaken allowing a view over the resources and demands on them to be formed.	Complete		
41	40/4.2.7	The method for determining the allocations to the Integrated Budget in subsequent years will be contingent on the respective financial planning and budget setting processes of the Local Authority and Health Board. They should aim to be able to give indicative three year allocations to the integration joint board, subject to annual approval through the respective budget setting processes.	Section 8.4 of the SOI clearly lays out the detailed method through which payment in subsequent years to the IJB for delegated functions will be made. Reference is also made to the IJB agreeing and delivering the Strategic Plan/Financial Plan but through a process of joint discussion and planning with partners.	None presently	Integrated Financial Planning process to be developed for 17/18 onwards	
42	40/4.2.8	The Chief Officer, and the Integration Joint Board financial officer where such is appointed separately, should develop a case for the Integrated Budget based on the Strategic Plan and present it to the Local Authority and Health Board for consideration and agreement as part of the annual budget setting process.	This hasn't been the case for 2016/17 budget directly. Will require to be the case for 2017/18 however. In the interim, the CO also acts as manager of services within both organisations and is therefore part of the management team and financial planning process within each respective partner's organisation.		2017/18 Financial Planning process	

Complete
Complete, Minor Remaining Actions Profiled
OnTrack, Actions Planned
Requires Further Action
Does not currently apply

SCOTTISH BORDERS INTEGRATED JOINT BOARD
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ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
43	40/4.2.9	Local Authority and Health Board will evaluate the case for the Integrated Budget against their other priorities and are expected to negotiate their respective contributions accordingly. The allocations will be a negotiated process based on priority and need and it should not be assumed that they will be the same as the historic or national allocations to the Health Board and Local Authority.	Whilst little reference has been made to specifically 'integrated' services as part of NHSB's/SBC's financial planning process for 2016/17, budgets, pressures and requirement for proposed savings have been recognised as part of a prioritisation process. This has the impact of increasing/decreasing certain budgets supporting integrated services.		A clearer approach to prioritisation of integrated services' budgets as part of a wider approach to financial planning in partner organisations will require development for 2017/18.	
44	40/4.2.9	The method for determining the contributions is required to be included in the Integration Scheme.	SOI 8.3-8.5	Complete		
45	41/4.2.10	The allocations made from the Integration Joint Board to the Local Authority and Health Board for operational delivery of services will be approved by the Integration Joint Board. The value of the payments will be those set out in the Strategic Plan approved by the Integration Joint Board	Report to IJB in March 2016, accompanied by Financial Statement.	Complete		
46	41/4.2.11	The legislation will require that a direction should be in writing and must include information on (Section 26): • The integrated function/(s) that are being directed and how they are to be delivered; and • The amount of and method of determining the payment to carry out the delegated functions.	Complete			
47	41/4.2.12	It anticipated that a direction from the Integration Joint Board will take the form of a letter from the Chief Officer to the Health Board or Local Authority referring to the arrangements for delivery set out in the Strategic Plan and/or other documentation. Once issued they can be amended or varied by a subsequent direction	Complete			

Complete	
Complete, Minor Remaining Actions Profiled	
OnTrack, Actions Planned	
Requires Further Action	
Does not currently apply	

Scottish Borders Health and Social Care PARTNERSHIP

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SCOTTISH BORDERS INTEGRATED JOINT BOARD
COMPLIANCE CHECK WITH INTEGRATED RESOURCES ADVISORY GROUP GUIDANCE

ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS /	STATUS>
48	41/4.2.14	Some social work expenditure budgets will be funded by resource transfer payments. It is recommended that partners identify these and adopt a transparent and consistent approach to their inclusion in the payment to the Integration Joint Board. The options for this are: • For the Health Board to stop paying resource transfer to the Local Authority and instead to include it in its payment to the Integration Joint Board. The Local Authority would need to make a corresponding reduction in its payment to the Integration Joint Board to cover the loss of resource transfer income from the Health Board; or • For the Health Board to continue paying resource transfer to the Local Authority and to exclude it from its payment to the Integration Joint Board. The Local Authority would include in its	Work is ongoing in this area analysing out the level of resource transfer, its basis and its current application.	Ongoing		
49	41/4.2.15	It is recommended that the local decision on treatment of resource transfer be set out in the Integration Scheme.	Resource transfer is not referred to within the SOI. This will therefore require local agreement and may require reporting to IJB.	Further work and agreement required		
50	42/4.2.17	Resources used by the population of an Integration Joint Board for delegated services that are provided on a hosted arrangement, should be included in the respective Integrated Budget	Further work required	Further work required		
4.3 MANAGING FINANCIAL PERFORMANCE						
51	42/4.3.0.1	The partners should include in the Integration Scheme provisions for managing in-year financial performance of the Integrated Budget. This will require that the Chief Officer receive financial performance information for both her/his operational role in the Health Board and Local Authority and strategic role in the Integration Joint Board.	SOI 8.6 outlines how any in-year variations will be addressed. Within the Shadow Year, the CO receives financial performance information for both her operational role in the Health Board and Local Authority and strategic role in the Integration Joint Board.	None	Single entity reporting still in development	

Scottish Borders Health and Social Care PARTNERSHIP	Complete
	Complete, Minor Remaining Actions Profiled
	OnTrack, Actions Planned
	Requires Further Action
	Does not currently apply

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ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>	
52	42/4.3.0.2	It is recommended that the Health Board and Local Authority Directors of Finance and the Integration Joint Board financial officer establish a process of regular in-year reporting and forecasting to provide the Chief Officer with management accounts for both arms of the operational budget and for the Integration Joint Board as a whole.	A monthly management report is presented to the CO for discussion and approval covering all functions delegated. This is also reported to her management team on a monthly basis where detailed discussion and (if required) remedial actions are planned and approved.	None	Single entity reporting still in development	
53	42/4.3.0.2	It is also recommended that a joint appointment from the senior finance teams of the Health Board and Local Authority provide the Chief Officer with financial advice for the respective operational budgets. This would allow for the same person carry out both this role and the role of financial officer for the joint board, but this is a matter for local determination.	Interim CFO appointment from 1 March 2016			
54	42/4.3.0.3	It is recommended that the Health Board and Local Authority agree a consistent basis for the preparation of management accounts, i.e. accruals vs. cash basis; this is a matter for local decision.	This is a matter for further discussion. Whilst an accruals basis is consistently applied for statutory reporting, there is inconsistency between the partners in terms of monthly accrual accounting for management reporting purposes.	Ongoing work package		
55	43/4.3.0.4	Integration Joint Board will allocate the resources it receives from the partner Health Board and Local Authority in line with the Strategic Plan; in doing this it will be able to use its power to hold reserves	This will be undertaken as part of the work developing the approach to Strategic and Operational Financial Planning during 2016/17			
56	43/4.3.0.5	In her/his operational role, the Chief Officer will manage the respective operational budgets so as to deliver the agreed outcomes within the operational budget viewed as a whole. The Chief Officer will be responsible for the management of in-year pressures and will be expected to take remedial action to mitigate any net variances and deliver the planned outturn	This is currently happening to a degree. The CO takes full responsibility for the management of in-year pressures during 2015/16. Whilst in shadow year and budgets only as aligned presently, the operational budget is not viewed as a whole for the purposes of such remedial action however.	None		

Complete	
Complete, Minor Remaining Actions Profiled	
OnTrack, Actions Planned	
Requires Further Action	
Does not currently apply	

SCOTTISH BORDERS INTEGRATED JOINT BOARD
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ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS / STATUS>
57	43/4.3.0.7	It is recommended that the Integration Joint Board has a reserves policy and reserves strategy, which include the level of reserves required and their purpose. This should be agreed as part of annual budget setting and reflected in the Strategic Plan agreed by the Integration Joint Board.	This has yet to be developed and be approved during 2016/17 in preparation for 2017/18 financial planning process.	CFO will develop and seek agreement from CO/IJB and respective partners	Will form part of IJB Financial Strategy
58	43/4.3.0.9	The Chief Officer will not be able to vire between the operational Integrated Budget and those budgets that are managed by the Chief Officer, but are outside of the scope of the Strategic Plan, unless agreed by the partner Local Authority and Health Board.	The arrangements for this are defined in s8.6 of the SOI	None	Specifically stated in 8.6.4 - 8.6.6 of SOI
59	43/4.3.0.9	The arrangements for the virement of budgets should be specified in the scheme of delegation within the partner authorities.	Outstanding - partners' Financial Regulations require review and if appropriate, updating	Schemes of administration in NHSB and SBC require review and update accordingly.	
60	44/4.3.1.1	The Integration Scheme should include provisions for the treatment of in-year under and overspends.	s8.6 of SOI clearly defines these provisions	None	
61	44/4.3.1.5	In-year underspends on either arm of the operational integrated budget should be returned from the Local Authority and Health Board to the Integration Joint Board and carried forward through the general fund.	8.6.8 of the SOI states "Any unplanned underspend will be returned to Borders Health Board or Scottish Borders Council by the Integration Joint Board either in the proportion that individual pressures have been funded or based on which service the savings are related to. " 8.6.7 states "Where there is a planned underspend in operational budgets arising from specific action by the Integration Joint Board it will be retained by the Integration Joint Board. This underspend may be used to fund additional capacity in-year or, with agreement with the partner organisations, carried forward to fund capacity in subsequent years. . The carry forward will be held in an ear-marked balance within Scottish Borders Council's general reserve."	None	Treatment of planned overspends defined in SOI 8.6.7, unplanned overspends in 8.6.8

4.4 NOTIONAL BUDGET FOR DIRECTED HOSPITAL SERVICES

Scottish Borders Health and Social Care PARTNERSHIP	Complete
	Complete, Minor Remaining Actions Profiled
	OnTrack, Actions Planned
	Requires Further Action
	Does not currently apply

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ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS /	STATUS>
62	46/4.4.0.3	Legislation requires that the method for determining the amount to be set aside by the Health Board should be included in the Integration Scheme	This is defined in s8.5 of the SOI, specifically referencing IRF. Currently, further work to develop IRF by partner organisations is required before this can inform fully the calculation - resources have been identified on a 'direct-only' basis in the interim			
63	.	Where material; the notional budget should include the resources for the in scope hospital services used by the partnership population in all Health Boards.	Not relevant within Scottish Borders			
64	46/4.4.1.4	It is recommended that partners should establish a process for the Chief Officer and the hospital sector to jointly monitor in year actual demand against plan and provide for virements, if required, based on practical thresholds.	t.b.a.	t.b.a.		
5. VAT						
5.1 REVENUE						
5.2 CAPITAL						
65	50/5.2.1	In the short term the Integration Joint Board will not be empowered to own capital assets and the VAT regimes of the Local Authority and Health Board will apply to capital assets used to provide the delegated services.	8.7.1 of SOI states "The Integration Joint Board will not own any capital assets but will have use of such assets which will continue to be owned by Borders Health Board and Scottish Borders Council who will have access to sources of funding for capital expenditure". The SOI does not refer to VAT regimes, however, following national recommended practice (HSCI Finance Leads recommendations, existing partners' VAT regimes will apply.	None	VAT approach should be simple and pragmatic - watching brief presently to ensure all decisions proposed and implemented are VAT neutral	
6. CAPITAL AND ASSET MANAGEMENT						
6.1 ASSET MANAGEMENT						

Complete	
Complete, Minor Remaining Actions Profiled	
OnTrack, Actions Planned	
Requires Further Action	
Does not currently apply	

SCOTTISH BORDERS INTEGRATED JOINT BOARD
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ACTION POINT	IRAG REFERENCE	IRAG PROVISION	PROGRESS	ACTIONS REQUIRED	COMMENTS /	STATUS>
66	51/6.1.1	The Integration Joint Board should identify the asset requirements to support the Strategic Plan. This will enable the Chief Officer to identify capital investment projects, or business cases to submit to the Health Board and Local Authority for consideration as part of the capital planning processes, recognising that partnership discussion would be required at an early stage if a project was jointly funded.	SOI 8.7.2 states "The Chief Officer will consult with Borders Health Board and Scottish Borders Council to identify need for asset improvement owned by either party and where investment is identified, will submit a business case to the appropriate party which will be considered as part of each party's existing capital planning and asset management arrangements." Following the IRAG guidance therefore, a formal process will be in place to consider IJB capital requirements as part of both organisations' wider capital planning process".	None		
67	51/6.1.3	The Integration Joint Board, Health Board and Local Authority are recommended to undertake due diligence to identify all non-current assets which will be used in the delivery of the Strategic Plan.	This is not stipulated in SOI, nor has any work been undertaken to identify fixed assets specifically.	An audit of all fixed assets supporting the functions delegated will be require undertaking and a report to the IJB, linking them to the delivery of the Strategic Plan will be made during 2016/17	2016/17	
6.2 CAPITAL FUNDING						
68	52/6.2.1	The Integration Joint Board will not receive any capital allocations, grants or have the power to borrow to invest in capital expenditure. The Health Board and Local Authority will continue to own any property and assets used by the Integration Joint Board and have access to sources of funding for capital expenditure.	SOI s8.7.1 states that "In line with guidance, the Integration Joint Board will not receive any capital allocations, grants or have the power to borrow to invest in capital expenditure." Asset ownership will be retained by each partner and a formal process for accessing sources of capital funding from either organisation will be develoepd".	Capital Planning process		
6.3 R&M						
69	53/6.3.1	The Integrated Budget may include payments from the Local Authority and Health Board to cover the revenue costs of assets e.g. rents, repairs and maintenance, rates, cleaning, property insurance etc.	Locally, we have decided not to include property repairs, maintenance and servicing within the Integrated Budget and both partners' will retain the responsibility for this function.	None		

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IRAG-SPECIFIC PROGRESS SINCE APRIL

- ✓ Production and agreement of 3-year (Yr 1 plus Yrs 2/3 indicative) IJB Financial Statement
- ✓ Reports to IJB on Assurance over the Sufficiency of Resources and Due Diligence
- ✓ Issue of Directions stating functions commissioned and supporting resources
- ✓ Production of 2015/16 IJB Statutory Accounts
- ✓ Additional Disclosures within 2015/16 NHS Borders and Scottish Borders Council Statutory Accounts

OUTSTANDING IRAG PROVISIONS

✗ Approval of Risk Register in line with approved Risk Management Strategy	30-Sep-16
✗ Finalisation and agreement of Resource Transfer and Hosted Services values	30-Sep-16
✗ Audit Committee Meetings and Approval of Internal Audit Plan	30-Sep-16
✗ Permanent appointment to IJB CFO post	31-Oct-17
✗ Review and update of NHSB and SBC Financial Regulations	31-Dec-16
✗ Fixed Asset Management / Capital Planning Processes	31-Mar-17
✗ 2017/18 - An integrated Financial Planning process between the IJB and its partners	31-Mar-17
✗ Fully costed Strategic and Locality Plans in terms of allocation of resources across aims, objectives and communities	31-Mar-17
✗ Review of Insurance Arrangements for IJB	31-Mar-17
✗ Agreed monthy accruals policy between partners	31-Mar-17
✗ Review and agreement of large hospitals budget set-aside	31-Mar-17

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Health and social care series

Health and social care integration

ACCOUNTS COMMISSION

AUDITOR GENERAL

Prepared by Audit Scotland
December 2015

The Accounts Commission

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

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

Our work includes:

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

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

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The Auditor General's role is to:

- appoint auditors to Scotland's central government and NHS bodies
- examine how public bodies spend public money
- help them to manage their finances to the highest standards
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- NHS bodies
- further education colleges
- Scottish Water
- NDPBs and others, eg Scottish Police Authority, Scottish Fire and Rescue Service.

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

Contents

Key facts

Over **£8 billion**

Health and social care resources will be delegated to integration authorities in 2016/17

18-29 per cent

Scottish Government estimate of the increase in the need for health and social care services between 2010 and 2030

31

Integration authorities are required to be operating by April 2016

£138-£157m

Scottish Government estimates of annual savings from integration

9

National outcomes that integration authorities are required to contribute towards

Summary

Key messages

1 The Public Bodies (Joint Working) (Scotland) Act 2014 introduces a significant programme of reform affecting most health and care services and over £8 billion of public money. The reforms aim to ensure services are well integrated and that people receive the care they need at the right time and in the right setting, with a focus on community-based and preventative care. The reforms are far reaching, creating opportunities to overcome previous barriers to change.

2 We found widespread support for the principles of integration from the individuals and organisations implementing the changes. The Scottish Government has provided support to partnerships to establish the new arrangements, including detailed guidance on key issues and access to data to help with strategic planning. Stakeholders are putting in place the required governance and management arrangements and, as a result, all 31 integration authorities (IAs) are expected to be operational by the statutory deadline of 1 April 2016.

3 Despite this progress, there are significant risks which need to be addressed if integration is to fundamentally change the delivery of health and care services. There is evidence to suggest that IAs will not be in a position to make a major impact during 2016/17. Difficulties in agreeing budgets and uncertainty about longer-term funding mean that they have not yet set out comprehensive strategic plans. There is broad agreement on the principles of integration. But many IAs have still to set out clear targets and timescales showing how they will make a difference to people who use health and social care services. These issues need to be addressed by April 2016 if IAs are to take a lead in improving local services.

4 There are other important issues which also need to be addressed. The proposed governance arrangements are complex, with some uncertainty about how they will work in practice. This will make it difficult for staff and the public to understand who is responsible for the care they receive. There are significant long-term workforce issues. IAs risk inheriting workforces that have been organised in response to budget pressures rather than strategic needs. Other issues include different terms and conditions for NHS and council staff, and difficulties in recruiting and retaining GPs and care staff.

there are significant risks which need to be addressed if integration is to fundamentally change the delivery of health and care services

Recommendations

Stakeholders have done well to get the systems in place for integration, but much work remains. If the reforms are to be successful in improving outcomes for people, there are other important issues that need to be addressed:

- Partners need to set out clearly how governance arrangements will work in practice, particularly when disagreements arise. This is because there are potentially confusing lines of accountability and potential conflicts of interests for board members and staff. There is a risk that this could hamper the ability of an IA to make decisions about the changes involved in redesigning services. People may also be unclear who is ultimately responsible for the quality of care. In addition, Integration Joint Board (IJB) members need training and development to help them fulfil their role.

- IAs must have strategic plans that do more than set out the local context for the reforms. To deliver care in different ways, that better meets people's needs and improves outcomes, IAs need to set out clearly:
  - the resources, such as funding and skills, that they need
  - what success will look like
  - how they will monitor and publicly report on the impact of their plans.
- NHS boards and councils must work with IAs to agree budgets for the new IAs. This should cover both their first year and the next few years to give them the continuity and certainty they need to develop and implement strategic plans. IAs should be clear about how they will use resources to integrate services and improve outcomes.

Integration authorities need to shift resources, including the workforce, towards a more preventative and community-based approach. Even more importantly, they must show that this is making a positive impact on service users and improving outcomes.

A more comprehensive list of recommendations is set out in (Part 4).

Background

1. The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) sets out a framework for integrating adult health and social care services. Social care services include supporting people to live their daily lives and helping them with basic personal care like washing, dressing and eating. People are living longer and the number of people with long-term conditions such as diabetes, and complex needs, such as multiple long-term conditions, is increasing. Current health and social care services are unsustainable; they must adapt to meet these changing needs. This means shifting from hospital care towards community-based services, and preventative services, such as support to help prevent older people from falling at home or to encourage people to be more active.

2. Integrating health and social care services has been a key government policy for many years. Despite this, there has been limited evidence of a shift to more community-based and preventative services. The Act sets out an ambitious programme of reform affecting most health and social care services. The scale and pace of the changes anticipated are significant, with a focus on changing how people with health and social care needs are supported.

3. The Act creates new partnerships, known as IAs, with statutory responsibilities to coordinate local health and social care services. The Act puts in place several national outcomes for health and social care and IAs are accountable for making improvements to these outcomes. The Act also aims to ensure that services are integrated, taking account of people's needs and making best use of available resources, such as staff and money. Each IA must establish at least two localities, which have a key role, working with professionals and the local community to develop services local people need.

4. IAs are currently at various stages in their development; all are required to be operational, that is taking on responsibility for budgets and services, by April 2016. The Scottish Government has estimated that IAs will oversee annual budgets totalling over £8 billion, around two-thirds of Scotland's spending on health and social work.

About this audit

5. This is the first of three planned audits of this major reform programme. Subsequent audits will look at IAs' progress after their first year of being established, and their longer-term impact in shifting resources to preventative services and community-based care and in improving outcomes for the people who use these services.

6. This first audit provides a progress report during this transitional year. We reviewed progress at this relatively early stage to provide a picture of the emerging arrangements for setting up, managing and scrutinising IAs as they become formally established. This report highlights risks that need to be addressed as a priority to ensure the reforms succeed. The audit is based on fieldwork that was carried out up to October 2015. We hope that the issues raised in the report are timely and helpful to the Scottish Government and local partners as they continue to implement the Act.

7. We gathered audit evidence by:

- reviewing documents available at the time of our work, including integration schemes, strategic plans, and local progress reports on integration arrangements[1]
- drawing on the work of local auditors, the Care Inspectorate, and Healthcare Improvement Scotland
- issuing a short questionnaire to IAs on their timetable for reaching various milestones

- interviewing stakeholders who included, board members, chief officers and finance officers from six IAs, and representatives from the Scottish Government, the British Medical Association, the voluntary sector, the Convention of Scottish Local Authorities and NHS Information Services Division.[2]

Appendix 1 provides further information on our audit approach.

8. This work builds on previous audits that have examined joint working in health and social care. For example, our *Review of Community Health Partnerships* [PDF] highlighted the organisational barriers to improving partnership working between NHS boards and councils, and the importance of strong, shared leadership across health and social care.[3] Our subsequent report *Reshaping care for older people* [PDF] found continuing slow progress in providing joined up health and social care services.[4] This lack of progress in fundamentally shifting the balance of care from hospital to community settings, coupled with the unsustainability of current services, mean that there is a pressing need for this latest reform programme to succeed.

9. The Accounts Commission and Auditor General are currently conducting two other audits which complement this work:

- *Changing models of health and social care* examines the financial, demographic and other pressures facing health and social care and the implications of implementing the Scottish Government's 2020 vision for health and social care. We will publish the report in in spring 2016.

- *Social work in Scotland* will report on the scale of the financial and demand pressures facing social work. It will consider the strategies councils and integration authorities are adopting to address these challenges, how service users and carers are being involved in designing services, and leadership and oversight by elected members. We will publish the report in summer 2016.

Part 1

Expectations for integrated services

Integration authorities will oversee more than £8 billion of NHS and care resources

10. The Public Bodies (Joint Working) (Scotland) Act 2014 sets out a significant programme of reform for the Scottish public sector. It creates a number of new public organisations, with a view to breaking down barriers to joint working between NHS boards and councils. Its overarching aim is to improve the support given to people using health and social care services.

11. These new partnerships will manage more than £8 billion of resources that NHS boards and councils previously managed separately. Initially, service users may not see any direct change. In most cases, people seeking support will continue to contact their GP or social work services. But, behind the scenes, IAs are expected to coordinate health and care services, commissioning 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. There will be a greater emphasis on preventative services and allowing people to receive care and support in their home or local community rather than being admitted to hospital.

Change is needed to help meet the needs of an ageing population and increasing demands on services

12. Around two million people in Scotland have at least one long-term condition, and one in four adults has some form of long-term illness or disability. These become more common with age (Exhibit 1, page 10). By the age of 75, almost two-thirds of people will have developed a long-term condition.[5] People in Scotland are living longer. Combined life expectancy for males and females at birth has increased from 72 to 79 years since 1980, although there are significant variations across Scotland, largely linked to levels of deprivation and inequalities.[6] The population aged over 75 years is projected to increase by a further 63 per cent over the next 20 years.[7]

13. The ageing population and increasing numbers of people with long-term conditions and complex needs have already placed significant pressure on health and social care services. The Scottish Government estimates that the need for these services will rise by between 18 and 29 per cent between 2010 and 2030.[8] In the face of these increasing demands, the current model of health and care services is unsustainable:

- The Scottish Government has estimated that in any given year just two per cent of the population (around 100,000 people) account for 50 per cent of hospital and prescribing costs, and 75 per cent of unplanned hospital bed days.

the significant changes under way will have an impact on everyone who needs to access, provide or plan health and social care services

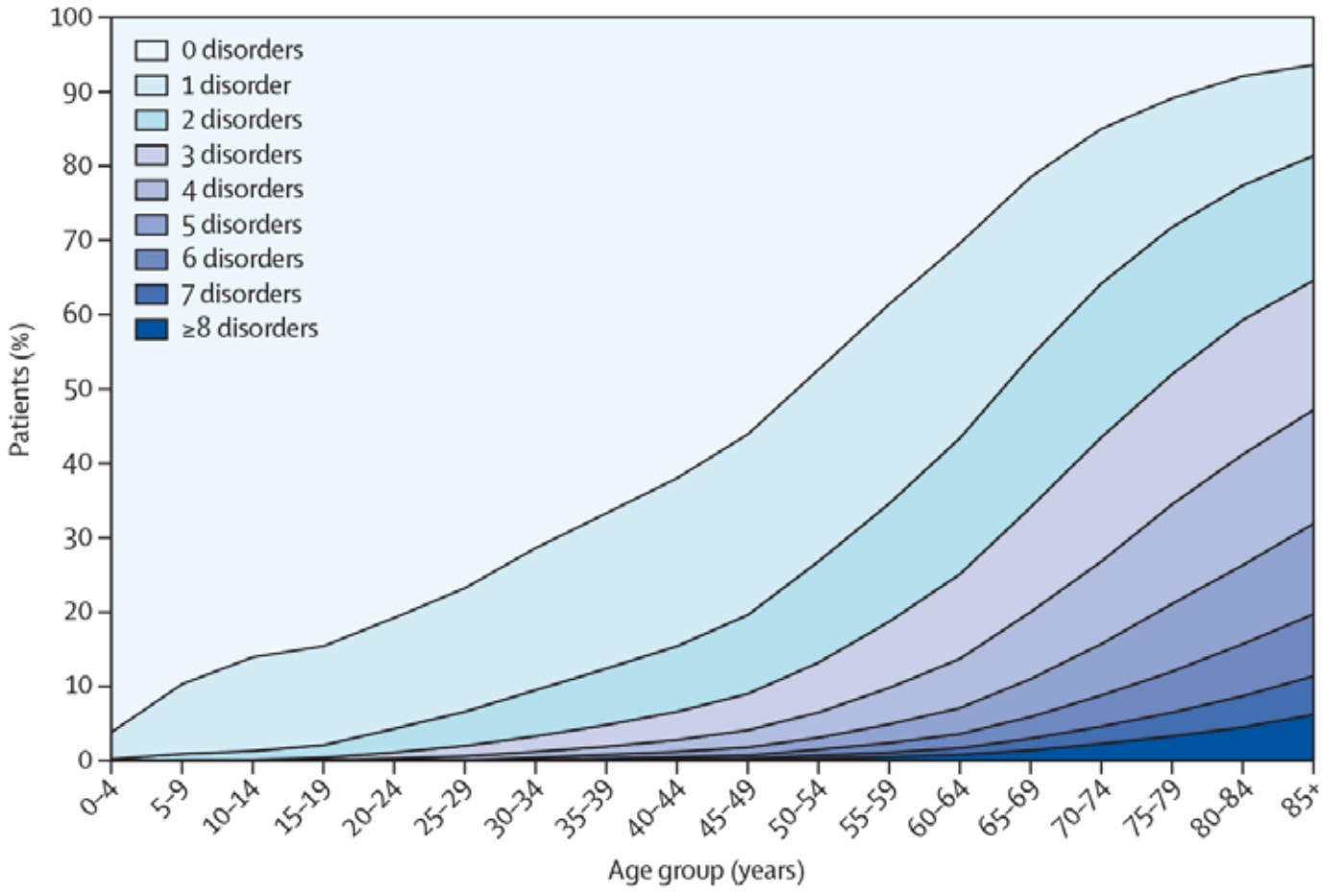
- A patient's discharge from hospital may be delayed when they are judged to be clinically ready to leave hospital but unable to leave because arrangements for care, support or accommodation have not been put in place. In 2014/15, this led to the NHS in Scotland using almost 625,000 hospital bed days for patients ready to be discharged.[9]

14. As a result of these pressures, there is widespread recognition that health and social care services need to be provided in fundamentally different ways. NHS boards, councils and the Scottish Government have focused significant efforts on initiatives to reduce unplanned hospital admissions and delayed discharges, yet pressures on hospitals remain. There needs to be a greater focus on anticipatory care, helping to reduce admissions to hospitals. There also needs to be better support to allow people to live independently in the community.

Exhibit 1

Long-term conditions by age

The number of long-term conditions that people have increases with age.



Source: Reprinted with permission from Elsevier (*The Lancet*, 2012, 380, 37-43)

15. None of this is unique to Scotland. Other parts of the UK and Europe face similar challenges. There have been various responses across the UK, but all try to deal with the changing needs of an ageing population, putting more emphasis on prevention and anticipatory care and seeking to shift resources from hospitals to community-based care.

16. A series of initiatives in Scotland over recent years has aimed to encourage a more joined-up approach to health and social care (Exhibit 2). Perhaps the most significant of these was creating Local Health Care Cooperatives (LHCCs) in 1999 and replacing them with Community Health Partnerships (CHPs) in 2004. While these reforms led to some local initiatives, LHCCs and CHPs lacked the authority to redesign services fundamentally. As a result, they had limited impact in shifting the balance of care, or in reducing admissions to hospital or delayed discharges.[10]

Exhibit 2

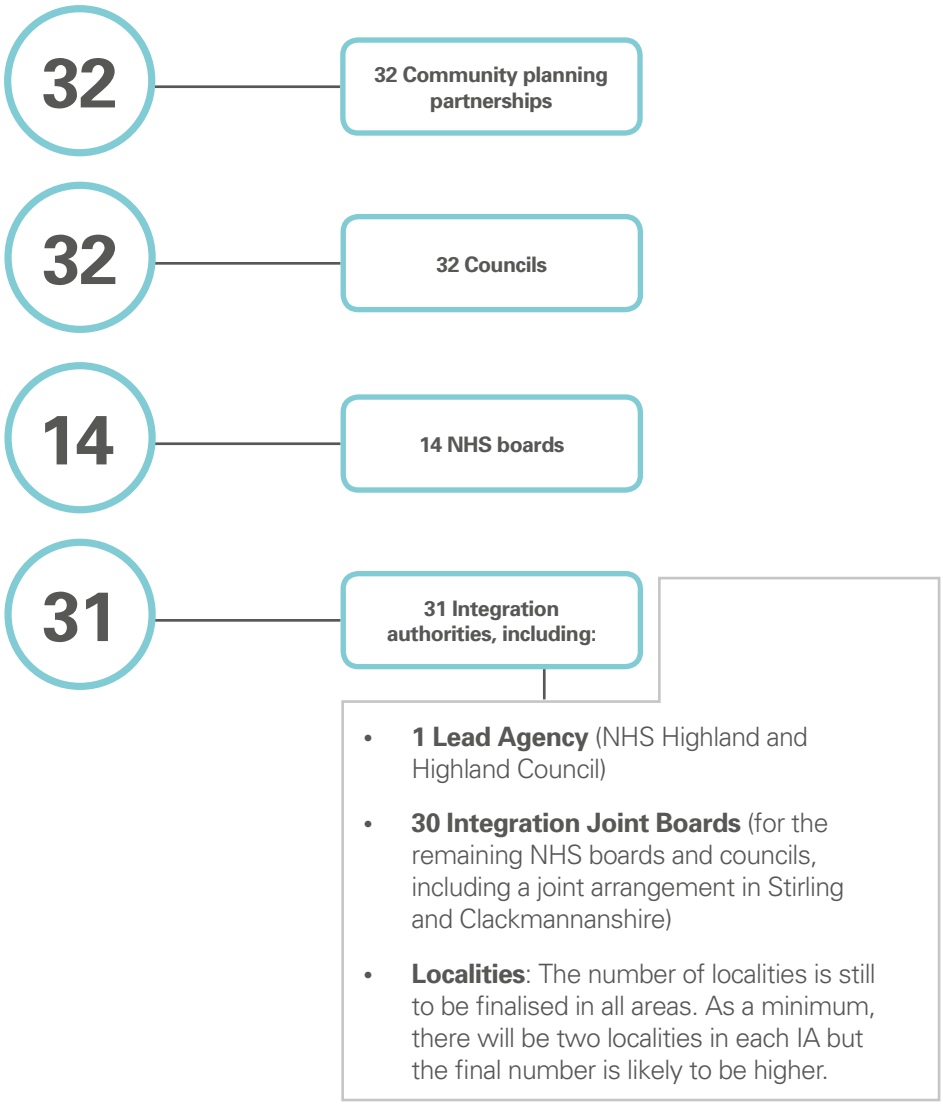
A brief history of integration in Scotland

1999	Seventy-nine **Local Health Care Cooperatives (LHCCs)** established, bringing together GPs and other primary healthcare professionals in an effort to increase partnership working between the NHS, social work and the voluntary sector.
2002	**Community Care and Health (Scotland) Act** introduced powers, but not duties, for NHS boards and councils to work together more effectively.
2004	**NHS Reform (Scotland) Act**, required health boards to establish CHPs, replacing LHCCs. This was a further attempt to bridge gaps between community-based care, such as GPs, and secondary healthcare, such as hospital services, and between health and social care.
2005	**Building a Health Service Fit for the Future: National Framework for Service Change**. This set out a new approach for the NHS that focused on more preventative healthcare, with a key role for CHPs in shifting the balance of care from acute hospitals to community settings.
2007	**Better Health, Better Care** set out the Scottish Government's five-year action plan, giving the NHS lead responsibility for working with partners to move care out of hospitals and into the community.
2010	**Reshaping Care for Older People Programme** launched by the Scottish Government. It introduced the Change Fund to encourage closer collaboration between NHS boards, councils and the voluntary sector.
2014	**Public Bodies (Joint Working) (Scotland) Act** introduced a statutory duty for NHS boards and councils to integrate the planning and delivery of health and social care services.
2016	All integration arrangements set out in the 2014 Act must be in place by 1 April 2016.

Source: Audit Scotland

17. The relative lack of progress of earlier attempts at integration led to the Public Bodies (Joint Working) (Scotland) Act 2014. This is the first attempt in the UK to place a statutory duty on the NHS and councils to integrate health and social care services. The Act abolished CHPs, replacing them with a series of IAs (Exhibit 3, page 12). These bodies will manage budgets for providing all integrated services. Most will not initially employ staff, but instead direct NHS boards and councils to deliver services in line with a strategic plan.

Exhibit 3
The public sector bodies overseeing health and social care services



Note: See Exhibit 4 for details of Integration Joint Board and lead agency approaches.

Source: Audit Scotland

The Scottish Government has set out a broad framework that allows for local flexibility

18. The Public Bodies (Joint Working) (Scotland) Act 2014 sets out a broad framework for creating IAs. The Act and the supporting regulations and guidance give councils and NHS boards a great deal of flexibility, allowing them to develop integrated services that are best suited to local circumstances. The main aspects of this flexible framework follow below.

Timing for establishing the new integration authorities

19. Scottish ministers must formally approve integration schemes for IAs: these set out the scope of services that are to be integrated and broad management and governance arrangements, including the structures and processes for

decision-making and accountability, controls and behaviour. Within this overall framework, IAs can choose when they become operational but all IAs must be established and operational, with delegated responsibility for budgets and services, by 1 April 2016.[11] Subject to the approval of their integration scheme, they can take on delegated responsibility for budgets and services at any time between April 2015 and 1 April 2016.

Scope of services to be integrated

20. Councils and NHS boards are required to integrate the governance, planning and resourcing of adult social care services, adult primary care and community health services and some hospital services. The hospital services included in integration are the inpatient medical specialties that have the largest proportion of emergency admissions to hospital. These include:

- accident and emergency services
- general medicine
- geriatric medicine
- rehabilitation medicine
- respiratory medicine
- psychiatry of learning disability
- palliative care
- addiction and substance dependence service
- mental health services and services provided by GPs in hospital.

Other, non-integrated, hospital services continue to be overseen directly by NHS boards. The Act also allows NHS boards and councils to integrate other areas of activity, such as children's health and social care services and criminal justice social work.

How IAs are structured

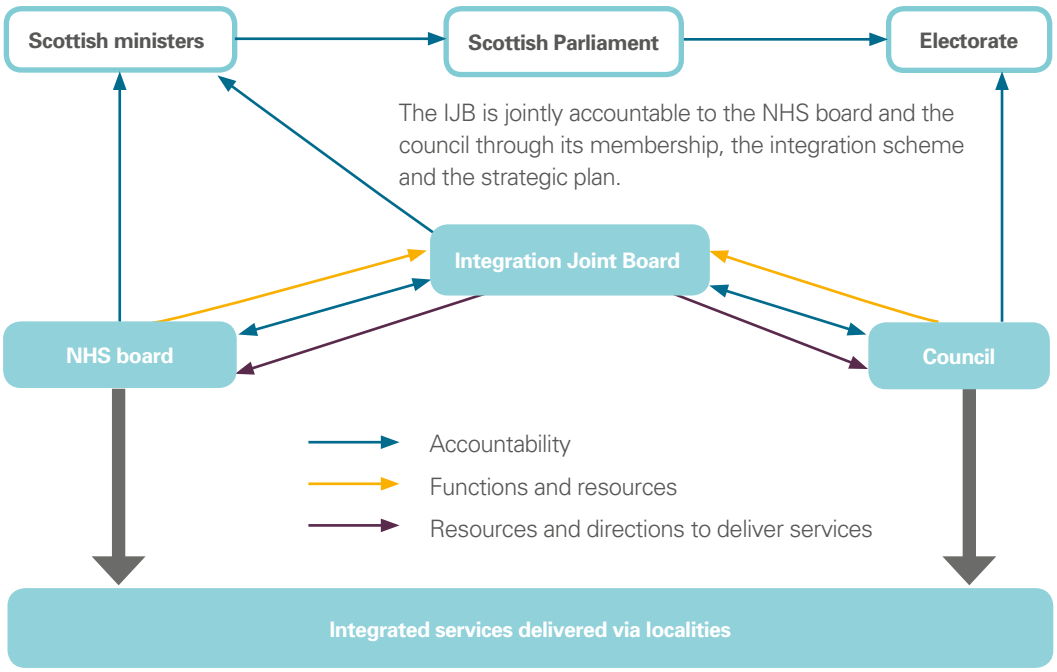
21. IAs will be responsible for overseeing certain functions that are delegated from the local NHS board and council(s). IAs can follow one of two main structural models (Exhibit 4, page 14).

22. All areas, apart from Highland, are planning to follow the body corporate model, creating an Integration Joint Board to plan and commission integrated health and social care services in their areas. IJBs are local government bodies, as defined by Section 106 of the Local Government (Scotland) Act 1973. Partners will need to understand the implications of differences between how councils and NHS boards carry out their business, so they are able to fulfil their duties. For example:

- IJBs must appoint a finance officer. The finance officer, under the terms of Section 95 of the Local Government (Scotland) Act 1973, has formal responsibilities for the financial affairs of the IJB.

Exhibit 4
Integration authorities will follow one of two main models

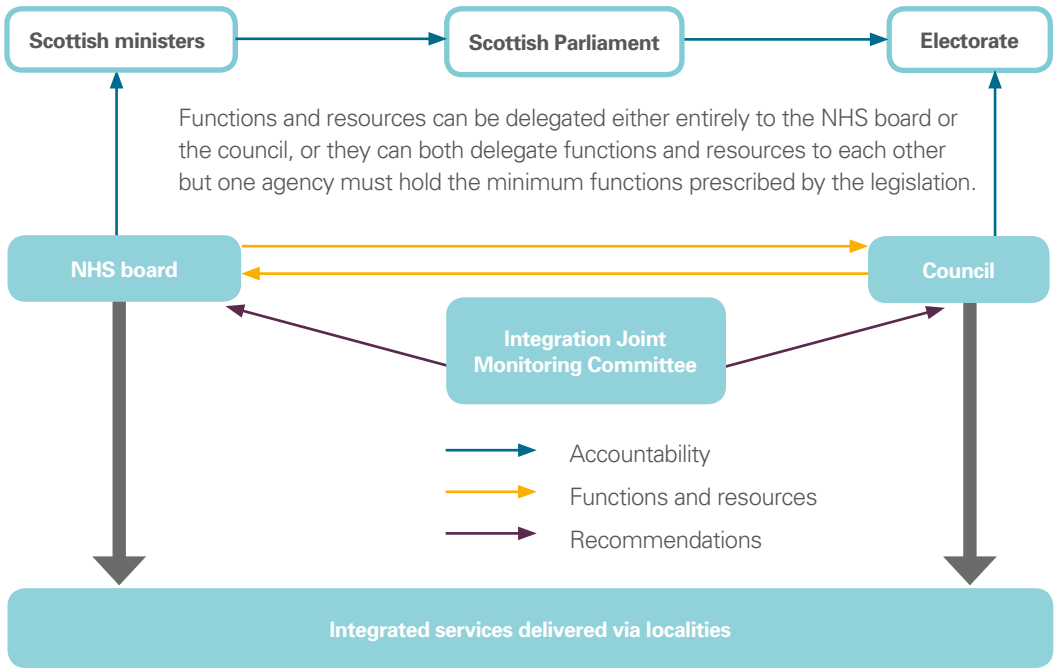
Body corporate or Integration Joint Board model



Body corporate

- NHS boards and councils delegate health and social care functions to an Integration Joint Board (IJB)
- The Act allows for partners to work jointly, for example, for two councils to work with their local NHS board to create a single IJB

Lead agency model



Lead agency

- NHS boards and councils delegate some of their functions to each other
- Carrying out of functions is overseen and scrutinised by an Integration Joint Monitoring Committee

Source: Audit Scotland

- The way local government bodies make decisions differs to NHS boards. Local government bodies in Scotland must take corporate decisions. There is no legal provision for policies being made by individual councillors.

- A statutory duty of Best Value applies to IJBs.

23. NHS boards and councils delegate budgets to the IJB. The IJB decides how to use these resources to achieve the objectives of the strategic plan. The IJB then directs the NHS board and council to deliver services in line with this plan. Only Highland has chosen the lead agency model, continuing arrangements established in earlier years for integrated services.[12] Under powers first set out in the Community Care (Scotland) Act 2002, NHS Highland is the lead for adult health and care services, with Highland Council the lead for children's community health and social care services. This provides continuity with lead agency arrangements in place in Highland since 2012. The council and the NHS board cannot veto decisions taken by the lead agency. Instead, as required by the legislation, they have established an integration joint monitoring committee (IJMC). The IJMC cannot overturn a decision made by the council or NHS board, but it can monitor progress in integrating services and make recommendations.

24. Whichever model is chosen, the underlying objective remains the same. The IA is expected to use resources to commission coordinated services that provide care for individuals in their community or in a homely setting and avoid unnecessary admissions to hospital.

Membership of Integration Joint Boards (IJBs)

25. For the IAs that follow the body corporate model, board members of IJBs are a mix of voting and non-voting members. Councils and NHS boards are each required to nominate at least three voting members. The NHS board and council can nominate more members, but both partners need to agree to this and the number from each body needs to be equal. The NHS board nominates non-executive directors to the IJB, and the council nominates councillors. Where the NHS board is unable to fill their places with non-executive directors, it is able to nominate other members of the NHS board. At least two of the NHS members should be non-executive directors. The IJB should also include non-voting members, including a service user and a representative from the voluntary sector (Exhibit 5, page 16).[13]

26. Initially, IJBs are not expected to directly employ staff, operating only as strategic commissioning bodies.[14] This may change over time as the Act allows IJBs to employ staff, but this needs to be approved by Scottish ministers, rather than decided locally. A chief officer and finance officer provide support for the IJB, but they are employed by either the council or NHS board and seconded to the IJB. The finance officer, under the terms of Section 95 of the Local Government (Scotland) Act 1973, has formal responsibilities for the financial affairs of the IJB.

Scrutinising integrated health and social care

27. Various scrutiny bodies have an interest in the integration of health and social care:

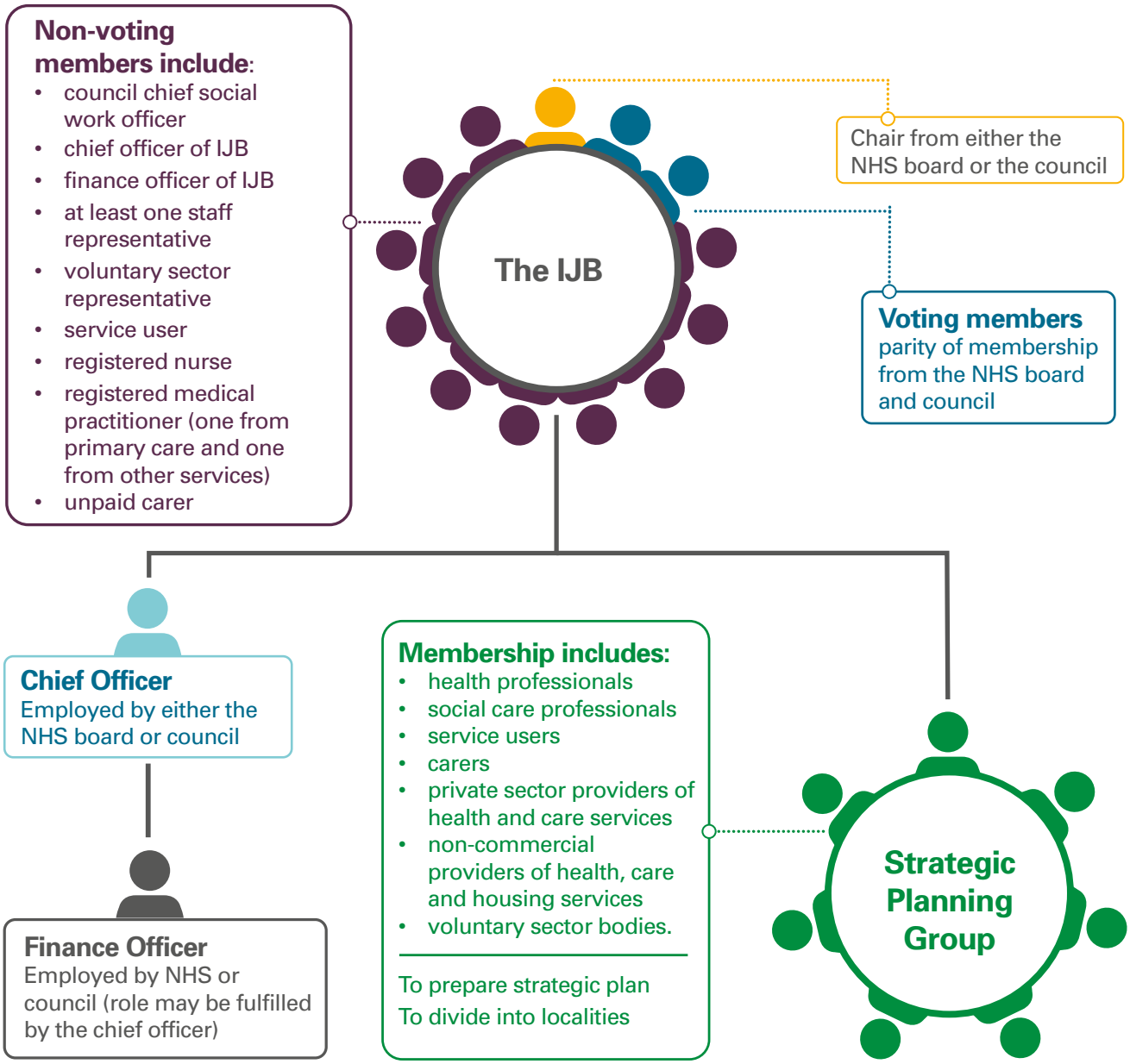
- The Accounts Commission is responsible for appointing auditors to IJBs and so has an interest in financial management and governance arrangements. As local government bodies, IJBs are also covered by the duty of Best Value as set out in the Local Government in Scotland Act 2003. The Accounts Commission has the power to audit the extent to which local government bodies are discharging their Best Value duty.

- Health and social integration is a significant national policy development. Therefore, the Auditor General for Scotland (alongside the Accounts Commission) has an audit interest in the extent to which it is being implemented at a national and local level, and in its impact on NHSScotland.

- The Care Inspectorate and Healthcare Improvement Scotland are responsible for scrutinising and supporting improvement in health and care services. Both organisations inspect individual services and work together to perform joint inspections of health and care services. These organisations will inspect the planning, organisation or coordination of

Exhibit 5

Organisation chart for a typical IJB



Source: Audit Scotland

integrated health and social care services. From April 2017, the Care Inspectorate and Healthcare Improvement Scotland are required by legislation to assess progress in establishing joint strategic commissioning and the early impact of integration.

Implications for the public, voluntary and private sectors

28. The significant changes under way will have an impact on everyone who needs to access, provide or plan health and social care services. Integration is part of the Scottish Government's focus on developing person-centred care. This is aimed at improving services, ensuring people using health and social care services can expect to be listened to, to be involved in deciding upon the care they receive and to be an active participant in how it is delivered. The aim is that this will result in improved outcomes for people, enabling them to enjoy better health and wellbeing within their homes and communities.

29. Health and social care integration is complex and it is important that IAs engage with the public on an ongoing basis so that they understand the purpose of integration and are able to influence the way services change. People may not see a significant difference in the services they receive immediately, but the reforms are focused on making better use of all health and social care services. Therefore there are implications for how people use services, for example GP, A&E and community-based services. If the reforms are to be successful, IJBs, NHS boards and councils need to involve people in decisions about the implications for local services. To help with this, there is a requirement that a service user and unpaid carer are members of the IJB and that IJBs consult and engage with local people as they develop their strategic and locality plans. It is also important that IAs are clear about how they link into the wider community planning process.

30. It is not only statutory services that need to change, other providers need to be involved. Voluntary and private sector providers employ two-thirds of the social services workforce and provide many social care services across Scotland. They are significant partners in developing integrated services, with the voluntary sector represented on the IJB as a non-voting member. Our previous report *Self-directed support* [PDF] highlighted some of the ways that councils have started to change how they work with the voluntary and private sectors.[15] There are lessons here for IJBs.

Localities

31. The Act requires IAs to divide their area into at least two localities, but they can choose to create more. Localities have an important role in reforming how to deliver services. They bring together local GPs and other health and care professionals, along with service users, to help plan and decide how to make changes to local services. A representative from each locality is expected to be part of the IA's strategic planning group, helping to ensure that specific local needs are taken into account. Localities also have a consultative role. When an IA is planning a change that is likely to affect service provision in a locality significantly, it must involve representatives of the local population in that decision.

32. As part of their role in planning services, localities are expected to plan expenditure on integrated health and social care services in their area, based on local priorities and to help shift resources towards preventative and community-based health and care services.

Outcomes and performance measures

33. IAs are required to contribute towards nine national health and wellbeing outcomes (Exhibit 6). These high-level outcomes seek to measure the quality of health and social care services and their impact in, for example, allowing people to live independently and in good health, and reducing health inequalities. This is the first time that outcomes have been set out in legislation, signalling an important shift from measuring internal processes to assessing the impact on people using health and social care services. IAs are required to produce an annual performance report, publicly reporting on the progress they have made towards improving outcomes.

The Scottish Government is providing resources to help support integration

34. The integration of health and social care is a complex reform and the Scottish Government is providing support to help organisations as they establish the new arrangements. The Scottish Government will provide more than £500 million over the three years from 2015/16 to 2017/18 to help partnerships establish new ways of working that focus on prevention and early intervention in a bid to reduce

Exhibit 6

National health and wellbeing outcomes

IAs are required to contribute to achieving nine national outcomes.

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

Source: National Health and Wellbeing Outcomes, Scottish Government

long-term costs. This money is not directly to support integration, but to continue initiatives that were already under way to improve services. The money is made up as follows:

- £300 million is an integrated care fund to help partnerships achieve the national health and wellbeing outcomes and move towards preventative services
- £100 million to reduce delayed discharges
- £30 million for telehealth
- £60 million to support improvements in primary care
- £51.5 million for a social care fund.

35. The Scottish Government has provided guidance to partnerships, covering issues such as strategic commissioning of health and care services, clinical and care governance, and the role of housing services and the voluntary sector. The timescales to implement the Act are tight. For some partnerships, guidance came too late. For example, the Scottish Government issued its guidance on localities in July 2015, yet localities play an important part in strategic plans and many partnerships had already begun the strategic planning process by then. The Scottish Government plans to issue further guidance on performance reporting late in 2015. However, for some areas this is coming too late – the three Ayrshire IJBs will present their first performance reports on or before 2 April 2016 and are developing these in advance of the guidance being issued.

36. The Scottish Government is supplementing this formal guidance with a series of support networks for IJB chairs and finance officers, such as regular learning events, and through the work of the Joint Improvement Team (JIT), including support for IJBs in developing their strategic plans.[16] Healthcare Improvement Scotland and the Care Inspectorate are currently developing a support programme for IAs, tailoring training and development events to fit local needs.

37. IAs are also being supported by the Information Services Division (ISD) of NHS National Services Scotland. ISD is creating a single source of data on health, social care and demographics. It is making this information available to NHS boards, councils and IAs to help them to gain a better understanding of:

- the needs of their local population
- current patterns of care
- how resources are being used.

38. This is the first time this detailed information on activity and costs will be routinely available to partnerships to help them with strategic planning. It will also help inform decisions on how to better use resources to improve outcomes for service users and carers. ISD is also providing data and analytical support through a Local Intelligence Support Team initiative, where partnerships can have an information specialist from ISD working with them in their local area.

Part 2

Current progress

Integration authorities are being established during 2015/16

39. Thirty-one IAs are being established, with one for each council area and a shared one between Clackmannanshire and Stirling. All partners submitted their draft integration schemes to Scottish ministers by the April 2015 deadline. Some, such as East Dunbartonshire, already plan to extend the scope of services being integrated and will resubmit their integration scheme for approval. By October 2015, 25 integration schemes had been formally approved, with the remainder expected to be agreed by the end of 2015.

40. By October 2015, six IAs had been established and taken on operational responsibility for budgets and services (Exhibit 7, page 21). The remaining IAs plan to be operational just before the statutory deadline, in March and April 2016.

Most integration authorities will oversee more than the statutory minimum services, and their responsibilities vary widely

41. The Act requires councils and NHS boards to integrate adult health and social care services. But it also allows them to integrate other services, such as children's health and social care services and criminal justice social work services.

42. The scope of the services being integrated varies widely across Scotland. Almost all the IAs will oversee more than the minimum requirement for health services, mainly by including some aspects of children's health services. But there is a wide range in responsibilities for other areas, such as children's social work services, criminal justice social work services, and planned acute health services (Exhibit 8, page 22). These differences in the scope of services included create a risk of fragmented services in some areas. Good clinical and care governance arrangements will be important to ensure that vulnerable people using integrated and non-integrated services experience high standards of care.

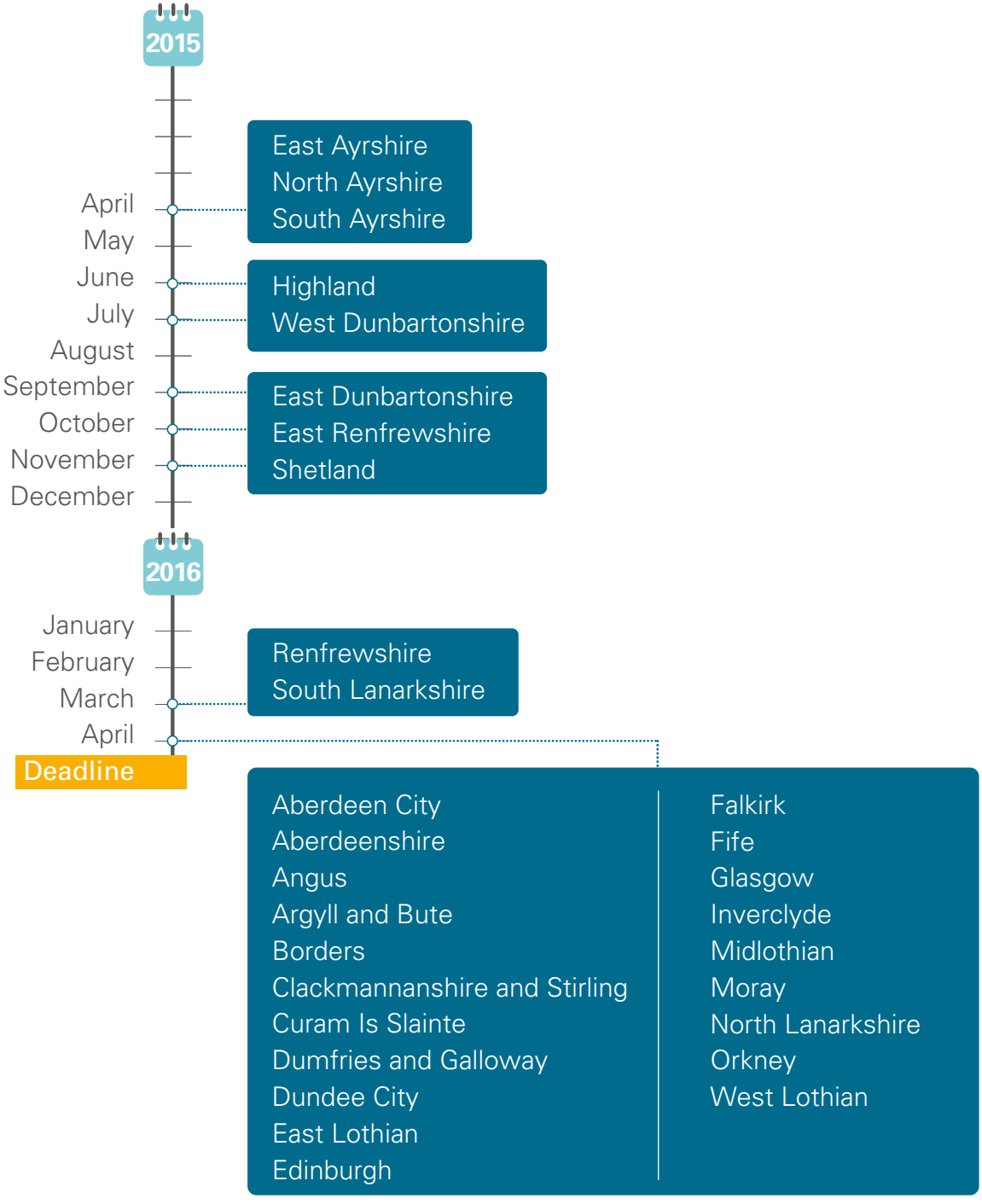
the scope of the services being integrated varies widely across Scotland

43. Among the variations the most notable are in Argyll and Bute IJB and Dumfries and Galloway IJB. These IJBs will oversee 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.

44. Various 'hosting' arrangements are also being implemented across the country. Where the area covered by an NHS board has more than one IJB it is often not practical or cost-effective to set up separate arrangements to deliver services for individual IJBs. This is particularly the case for specialist services, such as certain inpatient mental health services with small numbers of patients or staff. For example, North Ayrshire IJB hosts the following services on behalf of East Ayrshire and South Ayrshire IJBs:

Exhibit 7

Services will be delegated to IAs throughout 2015/16 with most delegating in April 2016



Notes:
1. The date of becoming operational is still to be agreed in Perth and Kinross.
2. Curam Is Slainte is the name for the partnership between NHS Western Isles and Comhairle nan Eilean Siar.

Source: Audit Scotland

Exhibit 8

Additional integrated services

Partnerships are integrating a wider range of services in addition to the statutory minimum.

Argyll and Bute	✓	✓	✓	✓
East Ayrshire	✓	✓	✓	–
East Renfrewshire	✓	✓	✓	–
Glasgow	✓	✓	✓	–
Inverclyde	✓	✓	✓	–
North Ayrshire	✓	✓	✓	–
Orkney	✓	✓	✓	–
South Ayrshire	✓	✓	✓	–
West Dunbartonshire	✓	✓	✓	–
Aberdeen City	–	✓	✓	–
Aberdeenshire	–	✓	✓	–
Curam Is Slainte	–	✓	✓	–
East Lothian	–	✓	✓	–
Midlothian	–	✓	✓	–
Moray	–	✓	✓	–
Shetland	–	✓	✓	–
Highland	✓	–	✓	–
Dumfries and Galloway	–	–	✓	✓
Angus	–	–	✓	–
Borders	–	–	✓	–
Clackmannanshire and Stirling	–	–	✓	–
Dundee	–	–	✓	–
East Dunbartonshire	–	–	✓	–
Edinburgh	–	–	✓	–
Falkirk	–	–	✓	–
Fife	–	–	✓	–
North Lanarkshire	–	–	✓	–
Perth and Kinross	–	–	✓	–
Renfrewshire	–	–	✓	–
South Lanarkshire	–	–	✓	–
West Lothian	–	–	✓	–

Key

- Children's social work services
- Criminal justice social work services
- Children's health services
- Planned acute health services

Notes:
1. Criminal justice social work services can include services such as providing reports to courts to assist with decisions on sentencing. Planned acute health services can include services such as outpatient hospital services.
2. The range of children's health services delegated varies by IA. They may include universal services (such as GPs) for people aged under 18, or more specialised children's health services such as school nursing or health visiting, or both universal and specialised services.
3. IAs may also be responsible for additional integrated services not listed here.
4. East Dunbartonshire plan to amend their integration scheme to include children's primary and community health services before 1 April 2016.
5. Where integration schemes have not yet been approved by ministers, the final integration scheme may vary from the information included here.

Source: Scottish Government, 2015 and Audit Scotland, 2015

- inpatient mental health services
- learning disability services
- child and adolescent mental health services
- psychology services
- community infant feeding service
- family nurse partnership
- child health administration team
- immunisation team.

IJBs are appointing voting board members and most have chief officers in post

45. Most IJBs are currently appointing board members. Our review of the 17 IJB integration schemes that Scottish ministers had approved at the time of our audit shows the following:

- Thirteen IJB boards will initially be chaired by a councillor, with the remaining four chaired by a non-executive from the local NHS board.
- Only three areas have chosen to nominate the minimum of three voting members each from the council and NHS board.[17] In 13 schemes, councils and NHS boards have each nominated four voting members. In Edinburgh, the council and NHS board each have five voting members.
- There are also local variations in the number of additional non-voting members. For example, East Renfrewshire has appointed an additional GP member to help provide knowledge on local service needs. In most cases, these variations do not add significantly to the number of IJB board members. But some IJBs have very large boards. For example, Edinburgh has 13 non-voting members, in addition to its ten voting members. The IJB board for Clackmannanshire and Stirling is expected to be even larger, reflecting the joint arrangements between the two council areas, with 12 voting members and around 23 non-voting members.

46. Almost all IJBs have now appointed a chief officer.[18] Edinburgh and Falkirk expect to have their chief officers in post by the end of 2015.[19] Chief officers are employed by either the NHS board or the council and then seconded to the IJB. Terms and conditions of employment vary between councils and NHS boards, so successful candidates choose their preferred employer, based on the packages offered.

Chief officer accountability

47. Accountability arrangements for the IJB chief officer are complex and while there may be tensions in how these arrangements will work in practice, we have attempted to set out the technical arrangements as clearly as possible. 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 NHS board and council for any operational responsibility for integrated services, as set out in the integration scheme.

Accountability to the IJB

- The chief officer is directly accountable to the IJB for all of its responsibilities. These include: strategic planning, establishing the strategic planning group, the annual performance report, the IJB's responsibilities under other pieces of legislation (for example, the Equalities Act and the Public Records Act), ensuring that its directions are being carried out, recommending changes and reviewing the strategic plan.

- Integration schemes can pass responsibility for overseeing the operation of specific services from the NHS board or council to the IJB. In these circumstances, the chief officer is accountable to the IJB for establishing the arrangements to allow it to do this. This includes setting up performance monitoring, reporting structures, highlighting critical failures, reporting back based on internal and external audit and inspection. If the council or NHS board passes responsibility for meeting specific targets to the IJB, the IJB must take this into account during its strategic planning, and the chief officer is accountable for making sure it does so.

Accountability to the NHS board and council

- All integration schemes should set out whether the chief officer also has operational management responsibilities. Where the chief officer has these responsibilities, they are also accountable to the NHS board and the council.

- Where the chief officer has operational management responsibilities, the integration scheme makes the chief officer the responsible operational director in the council and NHS board for ensuring that integrated services are delivered. The chief officer is therefore responsible to the NHS board and council for the delivery of integrated services, how the strategic plan becomes operational and how it is delivered. They are also responsible for ensuring it is done in line with the relevant policies and procedures of the organisation (for example staff terms and conditions).

- Although this is untested, the accountable officers for delivery should still be the chief executives of the NHS board and the council. But they must discharge this accountability through the chief officer as set out in their integration scheme. The chief executives of the NHS board and council are responsible for line managing the chief officer to ensure that their accountability for the delivery of services is properly discharged.

48. Although employed by one organisation only, most chief officers are line managed by the chief executives of both the council and the NHS board. This means that in some NHS board areas the chief executive is line managing several IJB chief officers. South Lanarkshire has adopted a more streamlined approach, where the chief officer reports to both the council and NHS board chief executive, but the organisation that employs the chief officer performs day-to-day line management.

Part 3

Current issues

There is wide support for the opportunities offered by health and social care integration

49. Integrated health and social care offers significant opportunities. These include improving the services that communities receive, the impact these services have on people, improving outcomes and using resources, such as money and skills, more effectively across the health and care system. The Scottish Government expects integrated services to emphasise preventative care and reduce both the level of hospital admissions and the time that some patients spend in hospital. A measure of success will be the extent to which integration has helped to move to a more sustainable health and social care service, with less reliance on emergency care.

50. Because integrated services with a focus on improving outcomes should result in more effective use of resources across the health and social care system, the Scottish Government expects integration to generate estimated annual savings of £138 - £157 million. The savings are as follows:

- Annual savings of £22 million if IAs can meet the current target to limit the delay in discharging patients to no more than two weeks and £41 million if they can reduce this further, to no more than 72 hours.
- Annual savings of £12 million by using anticipatory care plans for people with conditions that put them at risk of an unplanned admission to hospital. These plans provide alternative forms of care to try to avoid people being admitted to hospital.
- Annual savings of £104 million from reducing the variation between different IAs in the same NHS board area. The Scottish Government expects that IAs will identify the inefficiencies that cause costs to vary and, over time, reduce them.[20]

51. The Scottish Government estimated the initial cost of making these reforms to adult services to be £34.2 million over the five years up to 2016/17, and £6.3 million after this. It has not estimated the additional costs, or savings, from integrating other services such as children's health and social care or some criminal justice services.[21] It is unclear whether these anticipated savings will release money that IJBs can invest in more community-based and preventative care or how the Scottish Government will monitor and report progress towards these savings.

widespread support for the policy of health and social care integration, but concerns about how this will work in practice

52. There have been previous attempts at integration, as listed in Exhibit 2 (page 11). Our *Review of Community Health Partnerships* [PDF] highlighted that CHPs had a challenging remit, but lacked the authority needed to implement the significant changes required.[22] We also found limited progress with joint budgets across health and care services. This latest reform programme contains important new elements to help partnerships improve care. The Act:

- provides a statutory requirement for councils and NHS boards to integrate services and budgets, in contrast to previous legislation that encouraged joint working with resources largely remaining separate
- provides, for the first time, a statutory requirement to focus on outcome measures, rather than activity measures
- introduces a requirement for co-production as part of strategic planning. Co-production is when professionals and people who need support combine their knowledge and expertise to make joint decisions
- has clear links to other significant legislation, including The Children and Young People (Scotland) Act 2014 and the Community Empowerment (Scotland) Act 2015, where similar principles of co-production, engagement and empowerment apply.

53. Throughout our audit, we found there is widespread support for the policy of health and social care integration, but concerns about how this will work in practice. In this part of our report, we summarise the most important risks and issues we have identified through our audit. These are significant and need to be addressed as a priority nationally and locally to integrate health and care services successfully.

NHS boards, councils and IJBs need to be clear about how local arrangements will work in practice

Sound governance arrangements need to be quickly established

54. Good governance is vital to ensure that public bodies perform effectively. This can be a particular challenge in partnerships, with board members drawn from a wide range of backgrounds. Previous audit reports on community planning partnerships (CPPs) and CHPs have highlighted the importance of issues such as:

- a shared leadership, which takes account of different organisational cultures
- a clear vision of what the partnership wants to achieve, with a focus on outcomes for service users
- a shared understanding of roles and responsibilities, with a focus on decision-making
- an effective system for scrutinising performance and holding partners to account.

Members of IJBs need to understand and respect differences in organisational cultures and backgrounds

55. IJBs include representatives from councils, NHS boards, GPs, the voluntary sector, and service users. Everyone involved in establishing the new arrangements needs to understand, respect and take account of differences in organisational cultures so these do not become a barrier to progress. Members of the IJB need quickly to establish a shared understanding of their new role, how they will work together and measure success.

56. Voting members are drawn exclusively from councils and NHS boards and it is particularly important that they have a shared vision and purpose. There are important differences in how councils and NHS boards operate. Councils, for example, are accountable to their local electorate, while NHS boards report to Scottish ministers. There are also differences in how councils and the NHS work with the private sector. Councils have had many years of contracting services out to the voluntary and private sectors; for example, around 25 per cent of home care staff are employed in the private sector.

57. IJBs are aware of the need to establish a common understanding of the roles and responsibilities of board members. We found that many are planning opportunities for board development by providing training and support to board members. Other IJBs are also reinforcing this by developing codes of conduct to ensure that their board members follow the same standards of behaviour.

58. IJBs include representatives from a wide range of organisations and backgrounds. This inclusive approach has benefits, including a more open and inclusive approach to decision making for health and care services, but there is a risk that boards are too large. For example, the Edinburgh IJB will have 23 members and the Clackmannanshire & Stirling IJB will have around 35. As we have highlighted in previous audits of partnerships across Scotland, there is a risk that large boards will find it difficult to reach agreement, make decisions and ensure services improve.

IJB members will have to manage conflicts of interest

59. The design of IJBs brings the potential for real or perceived conflicts of interest for board members. The NHS board and council nominate all voting members of the IJB. Their role is to represent the IJB's interests. Voting members will also continue in their role as an NHS board member or councillor. As a result, there is a risk that they may have a conflict of interest, particularly where there is a disagreement as part of IJB business.[23]

60. There is a similar potential for a conflict of interest for senior managers. IJB finance officers, for example, are required to support the needs of the IJB, but may also have responsibilities to support their employer – either the local NHS board or council. Similarly, legal advisers to the IJB will be employed by the council or the NHS board and, at a time of disagreement, may have a conflict of interest.

61. There is also a particular issue for NHS board members. Some NHS boards have to deal with several IJBs, and this places significant demands on their limited number of non-executive members. As a result, the Act and its associated regulations allow for NHS executive members to be appointed as voting members of the IJB. This means that there is the possibility of individuals acting as IJB board members who commission a service, and as NHS board members, responsible for providing that service. IJBs need to resolve this tension as part of their local governance arrangements.

62. IJBs are taking action to manage these tensions. For example, they are providing training to alert board members to the need to act in the IJB's interests when taking part in IJB meetings, and declaring conflicts of interest when they arise. But underlying conflicts of interest are likely to remain a risk, particularly at times of disagreement between local partners.

Although IJBs will lead the planning of integrated services, they are not independent of councils and NHS boards

63. IJBs set out how they will deliver services in their strategic plans, which they develop through strategic planning groups. The legislation allows NHS boards and councils jointly to ask IJBs to change their strategic plans only if they think it hinders their work in achieving the national health and wellbeing outcomes. As such, NHS boards and councils cannot individually veto an IJB decision. However IJBs are not fully independent of NHS boards and councils which can influence them through the following:

- **Membership of IJBs**: Chairs, vice chairs and voting members are all nominated by NHS boards and councils.

- **The approval process to agree future budgets:** Guidance issued by the Scottish Government's Integrated Resources Advisory Group (IRAG) suggests that, for future years, each IJB develops a business case and budget request and submits this to the NHS board and council to consider.

- **Control of integration schemes:** NHS boards and councils can decide to resubmit their integration schemes, changing the terms under which the IJB operates, or replacing it with a lead agency approach.

64. IJBs may overcome the challenges of working with a large board, with different organisational cultures and tensions, but once difficult decisions have been made there are still complex relationships back to the NHS board and council to negotiate. As a result, it is not clear if IJBs will be able to exert the necessary independence and authority to change fundamentally the way local services are provided.

Only a few IJBs will oversee the operation of acute services in their area, potentially limiting their impact

65. Regulations allow NHS boards and councils to choose what role IJBs will have in relation to operational management of services, in addition to commissioning and planning services. This flexibility allows, for example, NHS boards to remain solely responsible overseeing the operation of large hospital sites. The alternative is a more complex arrangement where responsibility for overseeing the operation of an A&E department is shared across several IJBs. Where the IJB has no operational management of hospital services, the IJB will receive regular performance reports from the NHS board on hospital services, so the IJB can assess whether the NHS board is delivering services in line with the IJB strategic plan. From the 17 schemes we reviewed that establish IJBs, we found the following:

- All 17 IJBs oversee the operation of non-acute integrated services, such as district nursing.

- To date, only Argyll and Bute, and Dumfries and Galloway IJBs will oversee the operation of the acute hospital integrated services in their areas, and

the chief officer will operationally manage these services. In Argyll and Bute, this continues an arrangement that existed previously and arises because the NHS board contracts most acute services from NHS Greater Glasgow and Clyde. Argyll and Bute CHP received information from the NHS board as part of the contract monitoring process. The IJB and NHS Greater Glasgow and Clyde are in the process of agreeing the information the chief officer and IJB board members will receive on the operational performance and delivery of these services.

- In Dumfries and Galloway, the IJB will oversee the operation of all integrated services, including all acute hospital services. The chief officer will be responsible for managing the operation of these integrated services, receiving regular information from the council Chief Social Work Officer and the NHS board acute services management team. The geographical circumstances in Dumfries and Galloway help to make this arrangement possible, as there is only one IA in the NHS board area, with only one acute hospital.

There needs to be a clear understanding of who is accountable for service delivery

66. There is a risk that the complex interrelationship between IJBs and councils and NHS boards will get in the way of clear lines of accountability. Their respective roles appear to be clear: IJBs are responsible for planning and commissioning services; councils and NHS boards are responsible for delivering those services.

67. But this understanding of accountabilities could be tested when there is a service failure, either in the care of an individual or in meeting outcome targets. The consensus amongst those we spoke with during our audit is that responsibility would lie with the council or NHS board delivering the service. But it could also be argued 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. It is essential that the chief officer is clear about how this joint accountability will work in practice from the start.

68. Clear procedures also need to be in place for clinical and care governance. These are procedures for maintaining and improving the quality of services and safeguarding high standards of care. NHS boards use long-established clinical governance approaches within the NHS. Similarly, councils follow well-established approaches for social care. IJBs have a great deal of flexibility over this issue and are required only to consider what role they will have in supporting the councils' and NHS boards' clinical and care governance work and how integration might change some aspects of this.

69. The Act introduced a requirement that IJBs set out in their integration scheme how they will work with NHS boards and councils to develop an integrated approach to clinical and care governance. We found that, at present, most IJBs plan to retain existing arrangements, with NHS boards directly overseeing clinical governance and councils overseeing care governance. However, IJBs will need to have a role in monitoring clinical and care standards without duplicating existing arrangements. Perth and Kinross IJB has developed a new clinical and care governance framework that other IJBs are now considering. In addition, the Royal College of Nursing has developed an approach that helps IJBs, councils and NHS

boards review their clinical and care governance arrangements. The aim is to ensure consistent approaches within each integrated service, and that these are aligned to existing clinical and care governance arrangements in the NHS and councils.[24]

IAs need to establish effective scrutiny arrangements to help them manage performance

70. IAs need to establish effective arrangements for scrutinising performance, monitoring progress towards their strategic objectives, and holding partners to account. Using the nine statutory outcome measures, listed at Exhibit 6, will help IAs to focus on the impact of health and care services. But as well as simply monitoring performance, IJB members will need to use these to help redesign services and ensure services become more effective.

71. There is also a need for regular reporting to partner organisations. This is particularly important where most members of the local council or NHS board are not directly involved in the IJB's work. Aberdeenshire Council, for example, has 68 councillors, with only five sitting on the IJB. Those not directly involved need to be kept informed on how the budgets provided to the IJB have been used and their effectiveness in improving outcomes for local people.

Councils and NHS boards are finding it difficult to agree budgets for the new integration authorities

72. At this stage, IAs are establishing financial procedures that look to be sound. While there is a range of approaches to financial monitoring and dealing with overspends and underspends, the processes outlined in the integration schemes are reasonable.

73. There are, however, significant concerns about funding. Councils and NHS boards are having great difficulty in agreeing budgets for the new IAs. At October 2015, six months before they were required to be established and commissioning health and care services, the Scottish Government had only been informed of the agreed budgets for six IAs. This uncertainty about budgets is likely to continue until early 2016. The results of the UK spending review were not announced until November 2015, and the Scottish Government will only publish its financial plans on 16 December 2015.

74. NHS boards and councils have faced several years of financial constraints and this is expected to continue in the coming years. There is a risk that, if NHS boards and councils seek to protect services that remain fully under their control, IAs may face a disproportionate reduction in their funding, despite the focus on outcomes that all partners should have. We have reported previously on increasing pressures on health and care budgets. This risk of budget overspends is a significant risk for IJBs. Other specific factors add to these difficulties in agreeing budgets:

- **Set-aside budgets:** These relate to the budgets retained by NHS boards for larger hospital sites that provide both integrated and non-integrated services. There are difficulties in agreeing these set-aside budgets, despite the Scottish Government issuing specific guidance. The current difficulties relate to how to determine the integrated and non-integrated costs for these hospitals and how to allocate a fair share to each IJB within the NHS board area. More fundamentally, however, there is a risk that NHS

boards may regard this funding as continuing to be under their control, making it difficult for IAs to use the money to shift from acute hospital care to community-based and preventative services. As a result of these uncertainties, not all of the strategic plans published so far consider the set-aside budgets or plan for the level of acute services that will be needed in future years.

- **Different planning cycles:** NHS boards and councils agree budgets at different times. In North Ayrshire, for example, the council agreed its 2015/16 budget in December 2014, while the NHS agreed its budget in March 2015. NHS budgets and allocations can change during the financial year. This could bring further challenges for IJBs. Similar budget-setting cycles exist across Scotland. If councils and NHS boards continue with these cycles, then IJBs will be involved in protracted negotiations for budgets and ultimately cannot expect partners to approve their plans until just before the start of each financial year. In response, NHS Forth Valley has adapted its budgeting process to allow it to provide an earlier indication of the integrated health budget to its local IAs. In addition, as part of the community planning process, there is an expectation that community planning partners will share information on resource planning and budgets at an early stage, before formal agreement.[25] This should help IAs' financial planning.

Integration authorities need to make urgent progress in setting out clear strategic plans

Most IAs are still developing their overall strategic plans, but those that are in place tend to be aspirational and lack important detail

75. Strategic planning is central to the role that IAs will have in commissioning and helping redesign local health and care services. Scottish Government guidance emphasises the importance of localities in this process, and of strategic plans to reflect the different priorities and needs of local areas.

76. At the time of our audit, only six IAs had published their strategic plans. Some, such as Aberdeen City, Aberdeenshire and Moray, have developed draft plans in advance of the formal approval of the integration schemes. Difficulties with reaching agreement on budgets are an important factor hindering IAs from developing comprehensive strategic plans. This raises concerns about the readiness of IAs to make an immediate impact in reshaping local services. Our audit involved speaking to people involved with strategic planning, including IJB board members. Many of them felt it would be at least another year before most IAs have established plans that are genuinely strategic and can redesign future service delivery rather than simply reflect existing arrangements.

77. Even where strategic plans are in place, there tend to be weaknesses in their scope and quality. They often set out the broad direction of how to provide integrated health and social care services in their areas over the next three or so years, identifying local priorities for their area and for localities. But they can be unclear about what money and staff are available, particularly over the longer term, or how to match these to priorities. They lack detail on what level of acute services is needed in an area and how they will shift resources towards preventative and community-based care. They generally lack performance measures that directly relate to the national outcomes.

78. Strategic planning is even less developed at the locality level. There is a risk that strategic planning is not joined up with locality planning. Some IAs have completed strategic needs assessments, helping to identify the different needs and priorities of individual localities. They are using these to develop local priorities and budgets. There are also significant challenges in involving a wide range of service users, voluntary organisations, GPs and other clinicians and other professional staff in the planning process. These groups are represented at IJB board level, as non-voting members. But involving these groups more widely and actively at locality level is crucial to providing community-based and preventative health and social care services.

Most IAs have still to produce supporting strategies

79. In addition to their overall strategic plans, IAs need to establish supporting strategies for important areas such as workforce, risk management, data sharing, and how they will work with people who use health and social care services. They are required to set out a broad timetable for producing these in their integration schemes.

80. We analysed the timetables in the approved integration schemes available at the time of our audit. This reveals some significant variations (Exhibit 9, page 33). Some risk management and workforce strategies have been developed and are scheduled to be agreed well in advance of the IA becoming operational. In others, however, it will be up to 12 months after the IA becomes operational before these strategies are due to be agreed and can start to contribute to progress with integrating services.

81. This raises questions about the effectiveness of some IAs, at least in the first year of their operation. It is important that IA strategies are well thought through, built on an analysis of local needs and resources and meaningful consultation, clearly setting out how the IA will deliver against the aspirations of the Act. We did not look in detail at the strategies produced at this early stage. But there is a risk that strategies produced quickly lack the detail needed to show how IAs will take practical steps that:

- improve outcomes
- integrate services
- make best use of the funds, skills and other resources available to them.

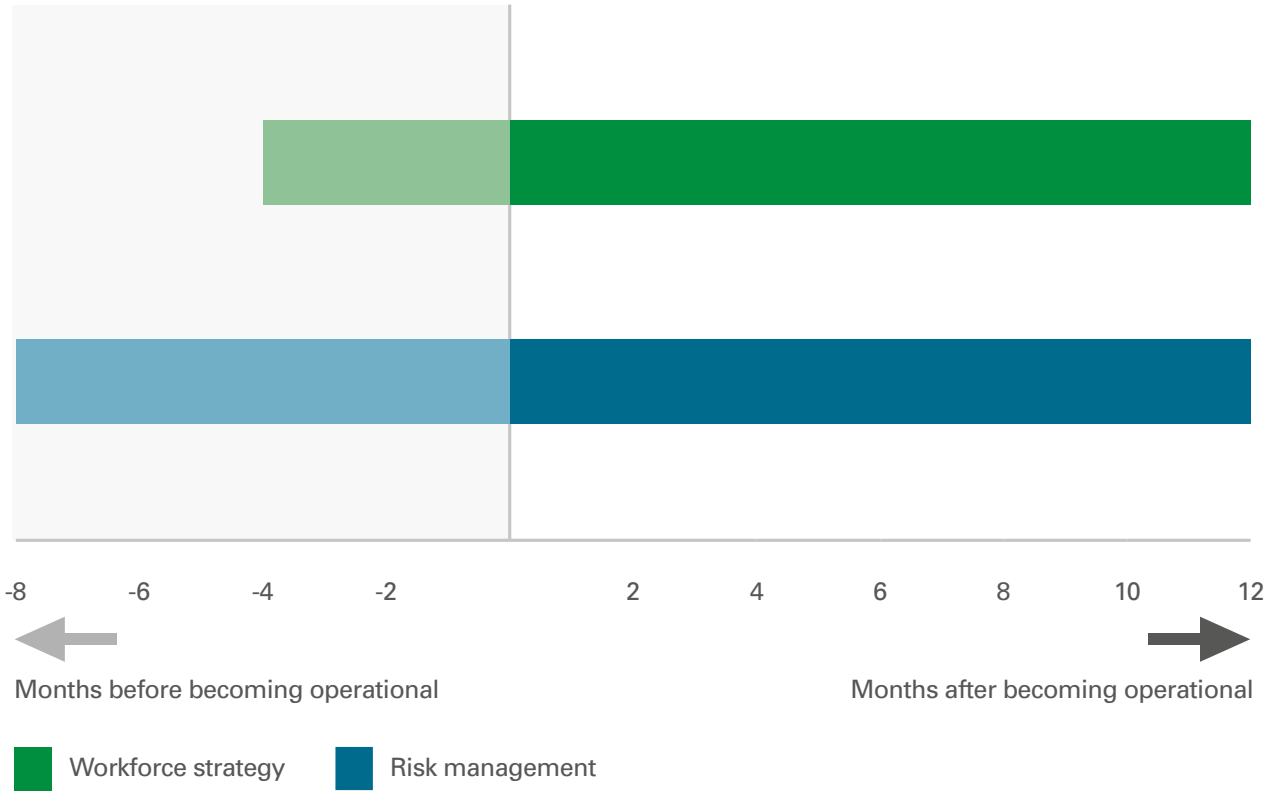
Equally, there are risks where the IA will not have plans in place until they have been operational for many months. It is important that IAs have clear strategic priorities and use these in developing:

- a workforce strategy, showing how they will redesign health and care services
- a risk management strategy to demonstrate that they are properly prioritising their work and their resources.

Exhibit 9

Range of timescales for supporting strategies

It will be up to a year before some IJBs have established workforce and risk management strategies.



Source: Audit Scotland analysis of available integration schemes

There is a pressing need for workforce planning to show how an integrated workforce will be developed

82. The health and social care workforce is critical to the success of integration. Health and social care services are personal services; it is important that staff have the skills and resources they need to carry out their roles, including providing emotional and physical support and clinical care.

83. At present, few IAs have developed a long-term workforce strategy. Developing a suitably skilled workforce is crucial to the success of integrated health and social care services. This is particularly challenging, given the wide range of people involved and the size of the workforce. NHS Scotland employs around 160,000 staff.[26] Social services employ almost 200,000, both directly employed council staff and others from the private and voluntary sector.[27] Furthermore, an estimated 759,000 people in Scotland are carers for family members, friends or neighbours.[28] IJBs need to work closely with professional and regulatory bodies in developing their workforce plans.

84. IJBs do not directly employ staff, but they are responsible for coordinating services from this varied mix of staff and carers. There will be implications for the skills and experience that staff will need to deliver more community-based support as services change. Developing and implementing workforce strategies to meet these needs will be challenging.

85. The following will add to these difficulties:

- **Financial pressures on the NHS and councils.** NHS boards and councils continue to face pressures from tightening budgets and rising demand for services. Most councils have responded to these pressures in part by reducing staff numbers and outsourcing some services to the private and voluntary sectors. These changes are less evident in the health sector. As a result, there are concerns that any future changes to the workforce will not affect health and care staff equally.

- **Difficulties in recruiting and retaining social care staff.** Over many years, councils have had difficulties recruiting and retaining care home and home care staff. Organisations in areas such as Edinburgh and Aberdeen, with high living costs, have had particular difficulties. There is a need to develop a valued, stable, skilled and motivated workforce. We found examples of organisations developing new approaches to making careers in caring more attractive. For example in Dumfries and Galloway and Aberdeen City they are considering creating caring roles that are part of a defined career path, to encourage more people into these roles.

- **The role of the voluntary and private sectors.** Voluntary and private organisations play an important role in providing care and support, but there are particular challenges in how IJBs can involve these diverse organisations as part of a coordinated workforce plan. The introduction of the national living wage will have a significant impact on the voluntary sector and their ability to provide the same level of support for health and care services. We will comment on this further in our audit of Social Work in Scotland.

86. GPs have a particularly important role but there are concerns over GPs having time available to contribute actively towards the success of integrated services. Most GPs are independent contractors, not employed by the NHS. GPs have a crucial role in patient referrals and in liaising with other health and care services. Ultimately, if there are concerns about the quality or availability of community-based services, there is a risk that GPs will refer patients to hospital to ensure they receive the care they need.

87. Throughout Scotland, there are difficulties in recruiting and retaining GPs. As a result, GPs are facing increasing pressures, at a time when a planned shift to community care and support can be expected to increase their workload. The Scottish Government has recognised this issue and has announced £2.5 million to fund a three-year programme to improve recruitment and retention of GPs and improve the number of people training to be GPs. It also has plans to revise GP contracts, to allow GPs to delegate some services to other healthcare professionals, freeing up GPs' time. However, it will be many years before these measures will have a significant impact.

The proposed performance measurement systems will not provide information on some important areas or help identify good practice

88. There is wide support for the Scottish Government's focus on health and wellbeing outcomes (set out earlier at Exhibit 6). In addition to the nine national outcomes, the Scottish Government developed core integration indicators to measure progress in delivering the national health and wellbeing outcomes and to allow national comparison between partnerships. These 23 measures, listed in Appendix 2, cover a mixture of outcome indicators – based on people's perception of the service they received – and indicators based on system or organisational information, such as people admitted to hospital in an emergency or adults with intensive care needs receiving care at home.

89. The Scottish Government has provided further support through the Information Services Division (ISD) of NHS National Services Scotland. It provided access to local data and technical support to help partnerships understand and plan for their areas' health and social care needs. The ISD data brings together health, social care and demographic information for the first time and is a significant step forward in providing partnerships with the information they need to plan locally and to measure the impact of their activity. Much of the data is already available for partnerships to use, and ISD plans to develop the data further including analysing the cost of end-of-life care.

90. Some IAs have been unable to make use of this resource as data-sharing agreements are not yet in place. ISD has access to health data but requires permission from councils to access the social work data they hold for their areas. Before councils can grant access they need to ensure they are not breaching data protection legislation and are doing this by agreeing data-sharing procedures. Most councils and NHS boards are making progress with this, but where information sharing has not been agreed IAs are having to plan without it.

91. National care standards were created in 2002 to help people understand what to expect from care services and to help services understand the standard of care they should deliver. Given the way that services have changed since then, in June 2014, the Scottish Government issued a consultation on new national care standards. The consultation proposed developing overarching standards, based on human rights, setting out the core elements of quality that should apply across all health and social care services.

92. The standards are an important part of integrating and scrutinising health and care services and it is important that they are in place quickly and publicised widely. However, overarching principles will not be finalised until April 2016; this will be followed by a consultation on specific and generic standards, with a view to them being implemented from April 2017.

93. While all these developments are clearly a step in the right direction, all partners need to consider the following issues:

- **The core integration indicators do not fully take account of all the expected benefits of the reform programme.** Overall, the Scottish Government's reform programme is expected to shift the balance of care to community-based or preventative services. However, demographic pressure will create increased demand for both hospital and community-

based services. It is not clear how the proposed indicators will measure progress in transferring from hospital to community care. There may be central data that the Scottish Government can use to track some of these changes but these should be set out clearly as part of measures to publicly monitor and report on progress. It is also unclear how the Scottish Government will track expected savings. An example is the expected annual savings of £104 million from reducing some of the variation evident in the cost of providing health and social care services across different parts of Scotland.[29] The core set of integration indicators does not attempt to give a national measure of reductions in cost variation or the savings that arise from this. Anticipatory care plans are projected to yield savings of £12 million a year, but there are no proposed indicators to assess if IAs are using them, or what impact they have on releasing resources such as skills and equipment.[30] This means the Scottish Government will not know if integration has freed up resources for other uses, in line with its expectations, or if it has achieved a shift from institutional to community-based care.

- **The process of linking measures and outcomes is incomplete and it may be difficult to measure success.** This means that the Scottish Government will be unable to see what progress is being made nationally, or to compare the different approaches adopted by IAs to identify which are most effective. For example, one of the measures seen as indicating success is 'reducing the rate of emergency admission to hospitals for adults'. (A reduction in this is seen as evidence of a positive impact on outcomes 1, 2, 4, 5 and 7, as listed at Exhibit 6.) But hospital emergency admission rates can reduce for many reasons. At present, it is up to individual partnerships to decide which additional local measures they will adopt to explore why hospital emergency admission rates are changing.

  Councils and NHS boards are required to set out in their strategic plans which local measures they will use. We compared plans for North Lanarkshire and North Ayrshire IAs, both relatively advanced in their performance management arrangements at the time of our audit. We found the following:

  – They will use different measures from each other. This has the benefit of allowing IAs to focus on their local priorities. However, it will make it difficult for the Scottish Government to compare performance across IAs to identify what approaches are working best (Exhibit 10, page 37).

  – In various places, both IAs have associated a different mix of indicators to an outcome from that set out in Scottish Government guidance. This occurs more frequently in North Ayrshire which developed its plans before the Scottish Government published its approach. But North Lanarkshire also has taken a different view on which indicators it will use to measure progress on some of the national outcomes, making it difficult for the Scottish Government to measure progress at a national level.

  – We have provided a more detailed comparison of the approaches used by North Lanarkshire and North Ayrshire IAs in a supplement to assist other IJBs when developing their plans (Exhibit 10, page 37).

Exhibit 10

Integration authorities can use different information to measure progress towards national outcomes

National Outcome	Core integration indicator			Number of additional local indicators mapped to national outcome	
	Mapped to national outcome by both	Not mapped to national outcome by both		North Ayrshire	North Lanarkshire
People are able to look after and improve their own health and wellbeing and live in good health for longer	Percentage of people who say they are able to look after their health very well or quite well	• Premature mortality rate	NL	5	19
		• Emergency admission rate	AL		
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide	None	• Percentage of staff who say they would recommend their workplace as a good place to work	NA	8	8
Resources are used effectively and efficiently in the provision of health and social care services	None	• Percentage of adults supported at home who agree that their health and care services seemed to be well coordinated	NL	10	31
		• Readmission to hospital within 28 days	NL		
		• Proportion of last six months spent at home or in community setting	NL		
		• Falls rate per 1,000 population aged 65+	NL		
		• Number of days people spend in hospital when clinically ready to be discharged per 1,000 population	NL		

NL = North Lanarkshire map this to outcome

NA = North Ayrshire map this to outcome

AL = Neither map this to outcome

Source: Audit Scotland analysis of performance frameworks

- **It is important that there is a balance between targeted local measures and national reporting on impact.** This has the benefit of providing flexibility so that local partnerships can focus their efforts on priority areas. It is important that local partnerships set ambitious targets. The reforms bring the opportunity to have local outcome measures that local people recognise as responding to specific issues in their community. However, the Scottish Government and IAs need to resolve tensions between introducing better local measures and the need for clarity at national level about the impact that IAs are having. An increasing focus on local measures means it is timely to review whether existing national measures are fit for purpose.

The role of localities still needs to be fully developed

94. Localities are intended to be the key drivers of change, bringing together service users, carers, and health and care professionals to help redesign services. The Act requires IAs to establish at least two localities within their area. Scottish Government guidance, issued in July 2015, suggests that localities should be formed around natural clusters of GP practices. Naturally, the number and size of localities vary. Edinburgh, for example, has established four localities, with an average population of around 120,000. By contrast, Shetland has seven localities, each with an average population of around 4,000. Under the Act, localities need to be involved in both planning services and play a consultative role about service change in their local area. This raises an issue about the scale and size of localities – the optimal scale for locally planning services may not be the same as that for consulting on service change.

95. With IAs still focusing on their overall budgets and governance arrangements, the arrangements for localities are relatively underdeveloped. Some have now agreed priorities and budgets for individual localities, but in most cases, work at locality level has initially focused on networking with stakeholders and on needs assessments. Localities are key to the success of integration, therefore IJBs must focus on how localities will lead the integration of health and care.

96. We found that GPs are becoming involved in locality planning. But, in many areas, there are concerns about their ability to remain fully involved in locality planning. Some GPs are also sceptical, given earlier experiences with LHCCs and CHPs, which failed to provide a fundamental shift towards preventative and community-based services. In response, the Scottish Government is piloting a new approach in ten health centres across the country. These centres will form 'community care teams' and test different ways of delivering healthcare. It is important that there is a clear link between the work of these teams and locality planning arrangements to avoid confusion.

There will be a continuing need to share good practice and to assess the impact of integration

97. The 31 IAs are putting different arrangements in place to deliver integrated health and social care services. This high level of variation is permitted by the Act and, in allowing IAs to respond to their local context and priorities, has many advantages. However, at some point, the Scottish Government and individual IAs will need to review their initial arrangements and consider how these might evolve to reflect good practice in other parts of Scotland. We hope that this report, and our subsequent audits, will contribute towards this wider review.

Part 4

Recommendations

We have made recommendations to help organisations address potential risks to the success of health and social care integration. We will monitor progress as part of our future work on integration.

The Scottish Government should:

- work with IAs to help them develop performance monitoring to ensure that they can clearly demonstrate the impact they make as they develop integrated services. As part of this:
  - work with IAs to resolve tensions between the need for national and local reporting on outcomes so that it is clear what impact the new integration arrangements are having on outcomes and on the wider health and social care system
- monitor and publicly report on national progress on the impact of integration. This includes:
  - measuring progress in moving care from institutional to community settings, reducing local variation in costs and using anticipatory care plans
  - reporting on how resources are being used to improve outcomes and how this has changed over time
  - reporting on expected costs and savings resulting from integration
- continue to provide support to IAs as they become fully operational, including leadership development and sharing good practice, including sharing the lessons learned from the pilots of GP clusters.

Integration authorities should:

- provide clear and strategic leadership to take forward the integration agenda; this includes:
  - developing and communicating the purpose and vision of the IJB and its intended impact on local people
  - having high standards of conduct and effective governance, and establishing a culture of openness, support and respect
- set out clearly how governance arrangements will work in practice, particularly when disagreements arise, to minimise the risk of confusing lines of accountability, potential conflicts of interests and any lack of clarity about who is ultimately responsible for the quality of care and scrutiny.

This includes:

- setting out a clear statement of the respective roles and responsibilities of the IJB (including individual members), NHS board and council, and the IJB's approach towards putting this into practice
- ensuring that IJB members receive training and development to prepare them for their role, including managing conflicts of interest, understanding the organisational cultures of the NHS and councils and the roles of non-voting members of the IJB

- ensure that a constructive working relationship exists between IJB members and the chief officer and finance officer and the public. This includes:
  - setting out a schedule of matters reserved for collective decision-making by the IJB, taking account of relevant legislation and ensuring that this is monitored and updated when required.
  - ensuring relationships between the IJB, its partners and the public are clear so each knows what to expect of the other

- be rigorous and transparent about how decisions are taken and listening and acting on the outcome of constructive scrutiny, including:
  - developing and maintaining open and effective mechanisms for documenting evidence for decisions
  - putting in place arrangements to safeguard members and employees against conflict of interest and put in place processes to ensure that they continue to operate in practice
  - developing and maintaining an effective audit committee
  - ensuring that effective, transparent and accessible arrangements are in place for dealing with complaints
  - ensuring that an effective risk management system in in place

- develop strategic plans that do more than set out the local context for the reforms; this includes:
  - how the IJB will contribute to delivering high-quality care in different ways that better meet people's needs and improves outcomes
  - setting out clearly what resources are required, what impact the IJB wants to achieve, and how the IA will monitor and publicly report their progress
  - developing strategies covering the workforce, risk management, engagement with service users and data sharing, based on overall strategic priorities to allow the IA to operate successfully in line with the principles set out in the Act and ensure these strategies fit with those in the NHS and councils
  - making clear links between the work of the IA and the Community Empowerment (Scotland) Act and Children and Young People (Scotland) Act

- develop financial plans that clearly show how IAs will use resources such as money and staff to provide more community-based and preventative services. This includes:
  - developing financial plans for each locality, showing how resources will be matched to local priorities
  - ensuring that the IJB makes the best use of resources, agreeing how Best Value will be measured and making sure that the IJB has the information needed to review value for money and performance effectively
- shift resources, including the workforce, towards a more preventative and community-based approach; it is important that the IA also has plans that set out how, in practical terms, they will achieve this shift over time.

Integration authorities should work with councils and NHS boards to:

- recognise and address the practical risks associated with the complex accountability arrangements by developing protocols to ensure that the chair of the IJB, the chief officer and the chief executives of the NHS board and council negotiate their roles in relation to the IJB early on in the relationship and that a shared understanding of the roles and objectives is maintained
- review clinical and care governance arrangements to ensure a consistent approach for each integrated service and that they are aligned to existing clinical and care governance arrangements in the NHS and councils
- urgently agree budgets for the IA; this is important both for their first year and for the next few years to provide IAs with the continuity and certainty they need to develop strategic plans; this includes aligning budget-setting arrangements between partners
- establish effective scrutiny arrangements to ensure that councillors and NHS non-executives, who are not members of the IJB board, are kept fully informed of the impact of integration for people who use local health and care services
- put in place data-sharing agreements to allow them to access the new data provided by ISD Scotland.

Endnotes

1 This included reviewing 18 approved integration schemes, 17 of which were for integration joint boards following the body corporate model and one of which was for Highland's lead agency model.

2 Clackmannanshire and Stirling, Dumfries and Galloway, East Renfrewshire, Edinburgh City, North Ayrshire and North Lanarkshire.

3 *Review of Community Health Partnerships* [PDF], Audit Scotland, June 2011.

4 *Reshaping care for older people* [PDF], Audit Scotland, February 2014.

5 *Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland,* Scottish Government, 2012.

6 *Scotland Performs*, Scottish Government, 2015.

7 *Projected Population of Scotland (2014-based),* National Records Scotland, 2015.

8 *Finance Committee. 2nd Report, 2013 (Session 4): Demographic change and an ageing population.* Scottish Parliament, 11 February 2013.

9 *Bed days occupied by delayed discharge patients*, ISD Scotland, May 2015.

10 *Review of Community Health Partnerships* [PDF], Audit Scotland, 2011.

11 After approval of its integration scheme, an IJB is established by parliamentary order. An IJB is operational when it has delegated responsibility from the NHS board and council for integrated budgets and services.

12 The lead agency is between Highland Council and NHS Highland. NHS Highland also has an IJB with Argyll and Bute Council.

13 Where the IJB spans across more than one council area, the minimum number of voting members is different. For IJBs of two council areas, at least two councillors from each council are required. For IJBs of more than two areas at least one councillor from each council is required. In both cases, the NHS board must nominate board members equal to the total number of councillors.

14 As IJBs have no plans to directly employ staff in this early stage of development, we are not commenting on related potential risks and issues. We are likely to return to this issue in more detail in future reports on integration.

15 *Self-directed support* [PDF], Audit Scotland, June 2014

16 The Joint Improvement Team is a partnership between the Scottish Government, NHSScotland, COSLA (Convention of Scottish Local Authorities) and the voluntary, independent and housing sectors.

17 East Dunbartonshire, Shetland and West Dunbartonshire.

18 Some areas, have a chief officer designate. This happens where, although recruitment for a chief officer is complete, until the IJB is established it cannot formally appoint the chief officer.

19 Falkirk currently has an interim chief officer in post and expects to make a permanent appointment to this role by the end of the year.

20 Public Bodies (Joint Working) (Scotland) Bill, Financial Memorandum, 2013.

21 Ibid.

22 *Review of Community Health Partnerships* [PDF], Audit Scotland, June 2011.

23 We explore these tensions more fully in our report *Arm's-length external organisations (ALEOs): are you getting it right?* [PDF], Audit Scotland, June 2011.

24 *RCN briefing 2: Clinical and care governance in an integrated world,* May 2015, Royal College of Nursing.

25 *Agreement on joint working on community planning and resourcing*, Scottish Government and COSLA, September 2013.

26 *NHS Scotland Workforce Information Quarterly update of Staff in Post, Vacancies and Turnover at 30 June 2015*, ISD Scotland, 2015. This figure refers to all staff in NHS Scotland, not just those working in integrated services.

27 *Scottish Social Service Sector: Report on 2014 Workforce Data*, Scottish Social Services Council, 2015.

28 *Scotland's Carers,* Scottish Government, March 2015.

29 Public Bodies (Joint Working) (Scotland) Bill, Financial Memorandum, 2013.

30 Ibid.

Appendix 1

Audit methodology

We reviewed a range of documents during our audit. Where available, this included:

- the Act and national guidance and regulations on implementing the Act
- 18 approved integration schemes[1]
- strategic and related financial plans
- minutes, papers and agendas for IJB meetings
- internal audit reports and local reports on integration arrangements
- financial audit information
- joint inspection reports from the Care Inspectorate and Healthcare Improvement Scotland.

We interviewed stakeholders in the following IA areas:

- Clackmannanshire and Stirling
- Dumfries and Galloway
- East Renfrewshire
- Edinburgh City
- North Ayrshire
- North Lanarkshire.

We drew on the work already carried out by:

- the Care Inspectorate
- Healthcare Improvement Scotland
- local auditors.

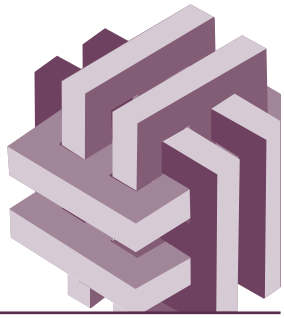
We also interviewed staff from:

- the Scottish Government
- the Joint Improvement Team
- the British Medical Association
- the Convention of Scottish Local Authorities
- NHS Information Services Division
- the Care Inspectorate
- Healthcare Improvement Scotland
- the voluntary sector.

Note: 1. We reviewed 17 integrations schemes establishing IJBs for Argyll & Bute, East Ayrshire, East Dunbartonshire, East Lothian, East Renfrewshire, City of Edinburgh, Eilean Siar, Inverclyde, Midlothian, North Ayrshire, North Lanarkshire, Renfrewshire, Shetland Isles, South Ayrshire, South Lanarkshire, West Dunbartonshire and West Lothian, and Highland's integration scheme setting out its lead agency approach.

Appendix 2

Scottish Government core integration indicators



Outcome indicators, based on survey feedback, available every two years, include:

- Percentage of adults able to look after their health very well or quite well.
- Percentage of adults supported at home who agree that they are supported to live as independently as possible.
- Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
- Percentage of adults supported at home who agree that their health and care services seemed to be well coordinated.
- Percentage of adults receiving any care or support who rate it as excellent or good.
- Percentage of people with positive experience of care at their GP practice.
- Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
- Percentage of carers who feel supported to continue in their caring role.
- Percentage of adults supported at home who agree they felt safe.
- Percentage of staff who say they would recommend their workplace as a good place to work.*

Outcome indicators derived from organisational/system data, primarily collected for other reasons, available annually or more often, include:

- Premature mortality rate.
- Rate of emergency admissions for adults.*
- Rate of emergency bed days for adults.*
- Readmissions to hospital within 28 days of discharge.*
- Proportion of last six months of life spent at home or in community setting.
- Falls rate per 1,000 population in over 65s.*
- Proportion of care services graded 'good' or better in Care Inspectorate Inspections.
- Percentage of adults with intensive needs receiving care at home.
- Number of days people spend in hospital when they are ready to be discharged.
- Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.
- Percentage of people admitted from home to hospital during the year, who are discharged to a care home.*
- Percentage of people who are discharged from hospital within 72 hours of being ready.*
- Expenditure on end-of-life care.*

* Indicates indicator is under development.

Health and social care integration

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Health and social care series

Changing models of health and social care

ACCOUNTS COMMISSION

AUDITOR GENERAL

Prepared by Audit Scotland
March 2016

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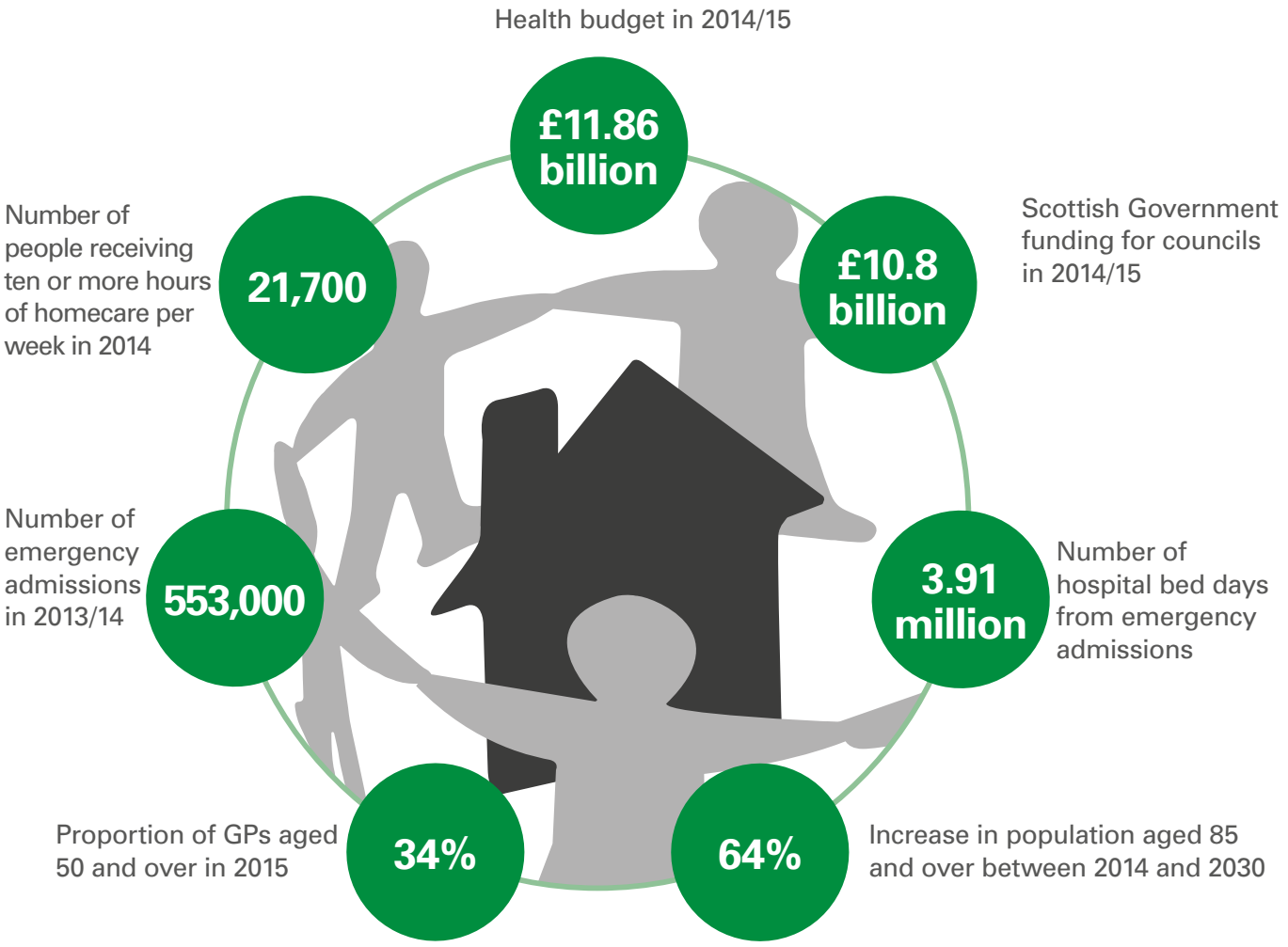
Contents

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


Health budget in 2014/15
£11.86 billion
Scottish Government funding for councils in 2014/15
£10.8 billion
Number of people receiving ten or more hours of homecare per week in 2014
21,700
Number of emergency admissions in 2013/14
553,000
3.91 million
Number of hospital bed days from emergency admissions
Proportion of GPs aged 50 and over in 2015
34%
64%
Increase in population aged 85 and over between 2014 and 2030

Summary

Key messages

1 The growing number of people with complex health and social care needs, particularly frail older people, together with continuing tight finances, means that current models of care are unsustainable. New models of care are needed. With the right services many people could avoid unnecessary admissions to hospital, or be discharged more quickly when admission is needed. This would improve the quality of care and make better use of the resources available.

2 The Scottish Government has set out an ambitious vision for health and social care to respond to these challenges. There is widespread support for the 2020 Vision, which aims to enable everyone to live longer, healthier lives at home or in a homely setting. There is evidence that new approaches to health and care are being developed in parts of Scotland.

3 The shift to new models of care is not happening fast enough to meet the growing need, and the new models of care that are in place are generally small-scale and are not widespread. The Scottish Government needs to provide stronger leadership by developing a clear framework to guide local development and consolidating evidence of what works. It needs to set measures of success by which progress can be monitored. It also needs to model how much investment is needed in new services and new ways of working, and whether this can be achieved within existing and planned resources.

4 NHS boards and councils, working with integration authorities, can do more to facilitate change. This includes focusing funding on community-based models and workforce planning to support new models. They also need to have a better understanding of the needs of their local populations, and evaluate new models and share learning.

the shift to new models of care is not happening fast enough to meet the growing need

Recommendations

The Scottish Government should:

- provide a clear framework by the end of 2016 of how it expects NHS boards, councils and integration authorities to achieve the 2020 Vision, outlining priorities and plans to reach its longer-term strategy up to 2030. This should include the longer-term changes required to skills, job roles and responsibilities within the health and social care

workforce. It also needs to align predictions of demand and supply with recruitment and training plans

- estimate the investment required to implement the 2020 Vision and the National Clinical Strategy
- ensure that long-term planning identifies and addresses the risks to implementing the 2020 Vision and the National Clinical Strategy, including:
  - barriers to shifting resources into the community, particularly in light of reducing health and social care budgets and the difficulties councils and NHS boards are experiencing in agreeing integrated budgets
  - new integration authorities making the transition from focusing on structures and governance to what needs to be done on the ground to make the necessary changes to services
  - building pressures in general practice, including problems with recruiting and retaining appropriate numbers of GPs. The role of GPs in moving towards the 2020 Vision should be a major focus of discussions with the profession as the new GP contract terms are developed for 2017
- ensure that learning from new care models across Scotland, and from other countries, is shared effectively with local bodies, to help increase the pace of change. This should include:
  - timescales, costs and resources required to implement new models, including staff training and development
  - evaluation of the impact and outcomes
  - how funding was secured
  - key success factors, including how models have been scaled up and made sustainable
- work to reduce the barriers that prevent local bodies from implementing longer-term plans, including:
  - identifying longer-term funding to allow local bodies to develop new care models they can sustain in the future
  - identifying a mechanism for shifting resources, including money and staff, from hospital to community settings
  - being clearer about the appropriate balance of care between acute and community-based care and what this will look like in practice to support local areas to implement the 2020 Vision
  - taking a lead on increasing public awareness about why services need to change
  - addressing the gap in robust cost information and evidence of impact for new models.

NHS boards and councils should work with integration authorities during their first year of integration to:

- carry out a shared analysis of local needs, and use this as a basis to inform their plans to redesign local services, drawing on learning from established good practice
- ensure new ways of working, based on good practice from elsewhere, are implemented in their own areas to overcome some of the barriers to introducing new care models
- move away from short-term, small-scale approaches towards a longer-term approach to implementing new care models. They should do this by making the necessary changes to funding and the workforce, making best use of local data and intelligence, and ensuring that they properly implement and evaluate the new models
- ensure, when they are implementing new models of care, that they identify appropriate performance measures from the outset and track costs, savings and outcomes
- ensure clear principles are followed for implementing new care models, as set out in Exhibit 9 (page 30).

Information Services Division (ISD) should:

- ensure it shares and facilitates learning across Scotland about approaches to analysing data and intelligence, such as using data to better understand the needs of local populations.

Background

1. We have reported previously that NHS boards and councils are finding it increasingly difficult to cope with pressures facing health and care services. Our recent progress report on health and social care integration found that significant risks need to be addressed if integration is to fundamentally change the way health and care services are delivered. Evidence suggests that the new partnerships with statutory responsibilities to coordinate integrated health and social care services, integration authorities, will not be in a position to make a major impact during 2016/17. Many integration authorities have still to set out clear targets and timescales showing how they will make a difference to people who use health and social care services.

2. We have produced this report, building on our previous work on health and social care, to identify new local models of care and to help increase the pace of change. It aims to support new integrated authorities to implement new ways of working and address the challenges facing health and social care services.

3. We have produced two supplements to accompany this report:

- Supplement 1 [PDF] is a handbook for local areas and includes:
  - case studies referenced throughout the report
  - a system diagram of the types of new care models being introduced across Scotland
  - links to useful documents and checklists.
- Supplement 2 is a model of East Lothian's whole-system approach to introducing new ways of working and the data analysis and intelligence that local partners are using to inform their work.

About the audit

4. This audit builds on key pressures identified in the demand and capacity work undertaken as part of the NHS in Scotland 2013/14 audit. It assesses how NHS boards, councils and partnerships might deliver services differently in the future to meet the needs of the population. Our report highlights examples of some of the new approaches to providing health and social care aimed at shifting the balance of care from hospitals to more homely and community-based settings. It also considers some of the main challenges to delivering the transformational change needed to deliver the Scottish Government's 2020 Vision for health and social care and actions required to address them.

5. We gathered evidence for the audit by:

- analysing national and local information, for hospitals, councils and community-based services to identify pressures in the system, including performance, activity and financial data
- carrying out projection analysis to estimate the potential effect of increasing pressures in health and social care
- conducting desk-based research to identify examples of new care models outside Scotland
- working closely with one partnership area to illustrate the types of changes required and how this affects different parts of the health and social care system
- interviewing staff from NHS boards, councils, the Convention of Scottish Local Authorities (COSLA), the Scottish Government and other relevant organisations, such as professional and scrutiny bodies.

Part 1

Health and social care in Scotland

Health and social care services are facing increasing pressures

6. In recent years, 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. At the same time, NHS boards and councils are facing increasingly difficult financial challenges. There is general recognition that changes are needed and that NHS boards and councils need to support more people in the community.

health and social care services need to adapt to cope with the effects of the changing population

The proportion of older, frail people is increasing

7. The proportion of older people is growing more rapidly than the rest of the population; this is a major factor contributing to the pressures on health and care services. The biggest changes are predicted in the 75 and over population (Exhibit 1). From 2002 to 2020, data shows an increase of around 6,600 people aged 75 and over each year. From 2021 up to 2039, it is estimated there will be around 16,000 more people aged 75 and over each year.[1] The 85 and over population is estimated to double by 2034.

Exhibit 1

The projected population of older people in Scotland, 2014-30

The percentage of the population aged 75 and over is set to increase considerably over the next 15 years.

Source: *Projected population of Scotland (2014-based)*, National Records of Scotland, 2015

8. Although the population is ageing, overall healthy life expectancy (the number of years people might live in good health) has improved. Over time, this may help to reduce some of the pressure on health and social care services. Average healthy life expectancy increased between 2002 and 2008. It has remained at around the same level between 2009 and 2014. In 2014, average life expectancy for men was around 77 years and healthy life expectancy 60 years, and for women it was around 81 and

63 years.[2, 3] However, healthy life expectancy for men in the most deprived areas in Scotland still remains 18 years lower than those in the least deprived areas. GPs working in deprived areas face significant challenges in tackling health inequalities. GPs working in practices serving the 100 most deprived areas in Scotland (Deep End project) reported the following:

- They treat more patients with multiple health problems than GPs working in less deprived areas.[4]
- They are constrained by a shortage of consultation time with patients that limits the opportunity to provide appropriate treatment, advice and referral to suitable services.[5]

9. As people age they are more likely to have multiple conditions and become frail. Frailty is a decreased ability to withstand illness or stress without loss of function. For frail people, a minor injury or illness can result in a significant loss of function. Common conditions, such as dementia, also contribute to frailty.[6] In Scotland, an estimated ten per cent of people aged over 65 are frail and a further 42 per cent are at risk of becoming frail.[7]

10. Not all older people need support from health and care services, but for those that do, it is important that these services are well coordinated. They should focus on preventing ill health and where possible reduce the need for hospital-based care. Older people make more use of hospital services than the rest of the population, particularly unplanned care such as A&E services and emergency admission to hospital. Older patients are more likely to remain in hospital for longer. The majority of people who are nursed at home, and get help with daily living activities such as washing, dressing and eating, are aged 75 or older.[8]

The number of emergency admissions to hospital is increasing

11. The number of people admitted to hospital in an emergency is an important measure that can indicate problems in other parts of the health and care system, such as a lack of social care support in the local area. Of all admissions to acute hospitals, around 85 per cent are emergency admissions. Around 30 per cent of emergency admissions relate to surgical specialties, such as orthopaedic surgery or urology. The majority of these admissions are not preventable and these patients require hospital treatment. However, there is scope to reduce emergency admissions by providing more preventative and community-based services. This includes emergency admissions in medical specialties such as general medicine, geriatric medicine, psychiatry of old age, rehabilitation medicine, and GP beds. The number of people admitted to hospital in an emergency between 2005/06 and 2013/14 increased by almost 80,000 (17 per cent), to 553,000. The number of emergency admissions increased by 17 per cent for people aged 65-74, by 19 per cent for people aged 75-84 and by 39 per cent for people who were aged 85 and older (Exhibit 2, page 11). Older people are more likely to be admitted to hospital in an emergency than people aged under 65. In 2013/14, 71 per cent of emergency bed days were occupied by people aged 65 and over. Of these:

- 18 per cent were occupied by people aged 65-74
- 29 per cent were occupied by people aged 75-84
- 23 per cent were occupied by people aged 85 and older.

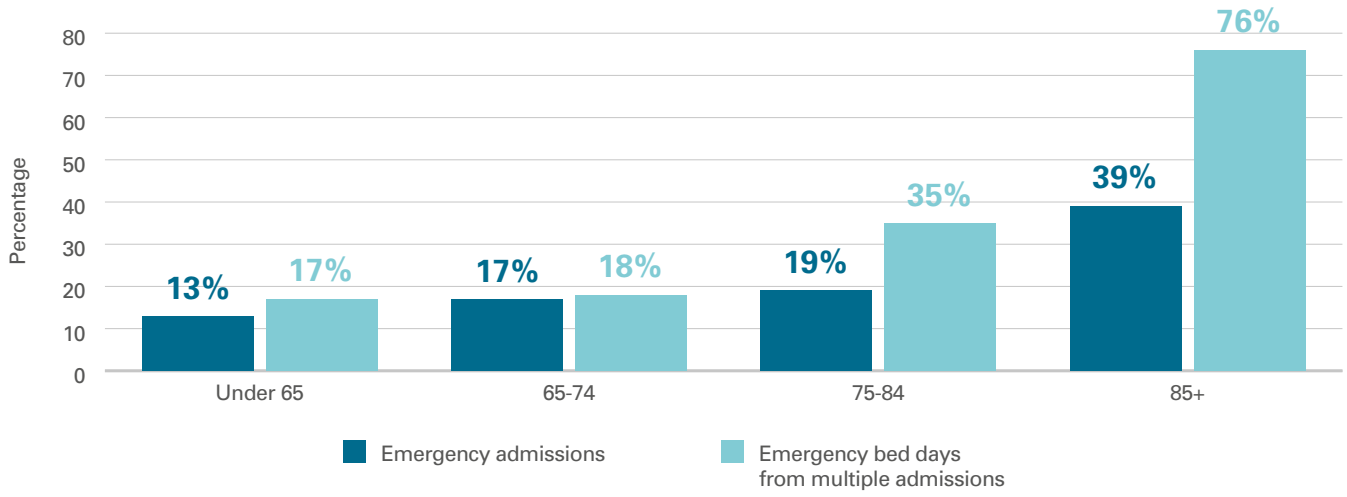
12. The number of emergency bed days for older people admitted to hospital three or more times in a year is increasing. Between 2005/06 and 2013/14, the number of bed days occupied by people aged 65 and over from multiple emergency admissions increased by 38 per cent to over 685,000 bed days. For people aged 65-74, the number of bed days increased by 18 per cent, for people aged 75-84 by 35 per cent, and for people aged 85 and older by 76 per cent (Exhibit 2).[9]

13. Although the overall number of emergency bed days has been reducing, the number of emergency admissions has been increasing along with the associated costs. Patients admitted to hospital in an emergency have a shorter length of stay, but most costs are incurred in the first few days when tests,

Exhibit 2

Increase in emergency admissions and multiple emergency admission bed days, by age group, 2005/06 to 2013/14

The number of older patients admitted to hospital in an emergency and the number of bed days for multiple emergency admissions (three or more admissions in one year) have increased considerably.



Source: SMR01 activity analysis provided to Audit Scotland by ISD, November 2015

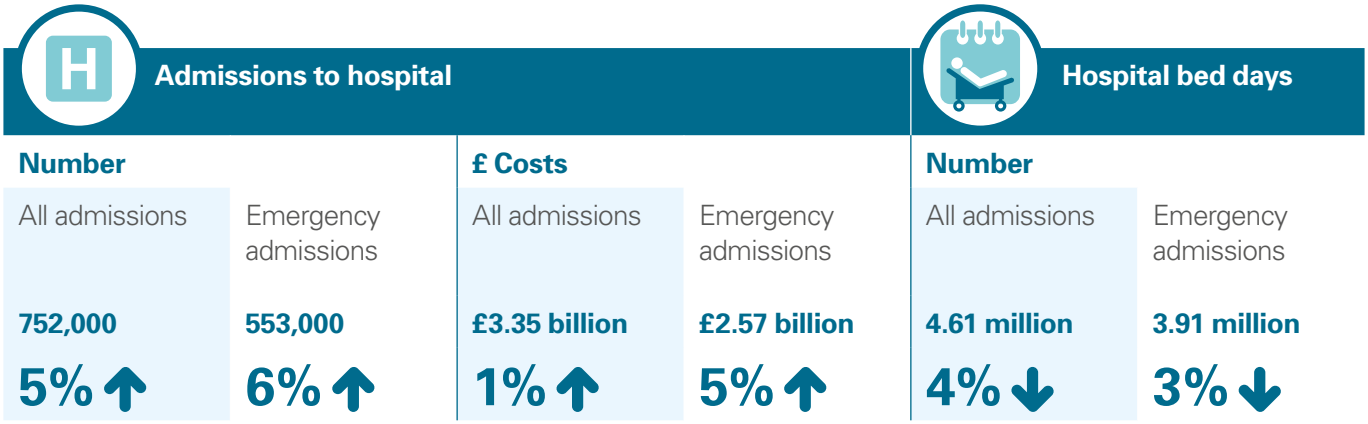
investigations or treatments are carried out. An emergency admission to hospital is more expensive than a planned admission. This means that although the percentage increases in the number of all admissions to hospital and in the number of emergency admissions are similar, the percentage increase in costs for emergency admission is higher (Exhibit 3, page 12).

14. There is more to be done to ensure that people are receiving the best care and treatment, rather than being admitted to hospital as an emergency, and to reduce hospital costs to allow more effective use of resources. An example is putting in place models of care to support older people in the community and prevent admission to hospital where possible. We highlight examples of this happening in some areas later in the report. To address the current challenges in relation to emergency admissions, a number of partners across the health and care system need to work well together. This includes GPs, community nurses and social care staff.

Exhibit 3

Changes in admissions to hospital and associated costs and bed days, 2010/11 to 2013/14

The total number of emergency bed days has been decreasing, but the number of emergency admissions has been increasing along with the associated costs.



Source: IRF–NHS Scotland and Local Authority Social Care Expenditure–Financial Years 2010/11–2013/14, ISD Scotland, March 2015; SMR01 activity analysis provided to Audit Scotland by ISD, November 2015

Health and social care services need to adapt to cope with the effects of the changing population

15. Pressures on health and social care services are likely to continue to increase over the next 15 years. It is difficult to know the extent of this growth but NHS boards and councils are finding it challenging to cope with the present demand for health and social care services. These increasing pressures have significant implications for the cost of providing health and social care services and challenges in ensuring that people receive the right care, at the right time and in the right setting. To address this, local partnerships need to redesign services to avoid unnecessary admissions to hospital. Where hospital admissions cannot be avoided, support needs to be put in place to get people home as quickly and as safely as possible. Local areas are developing approaches involving targeting both small numbers of individuals who use high levels of resources and prevention in the broader population.

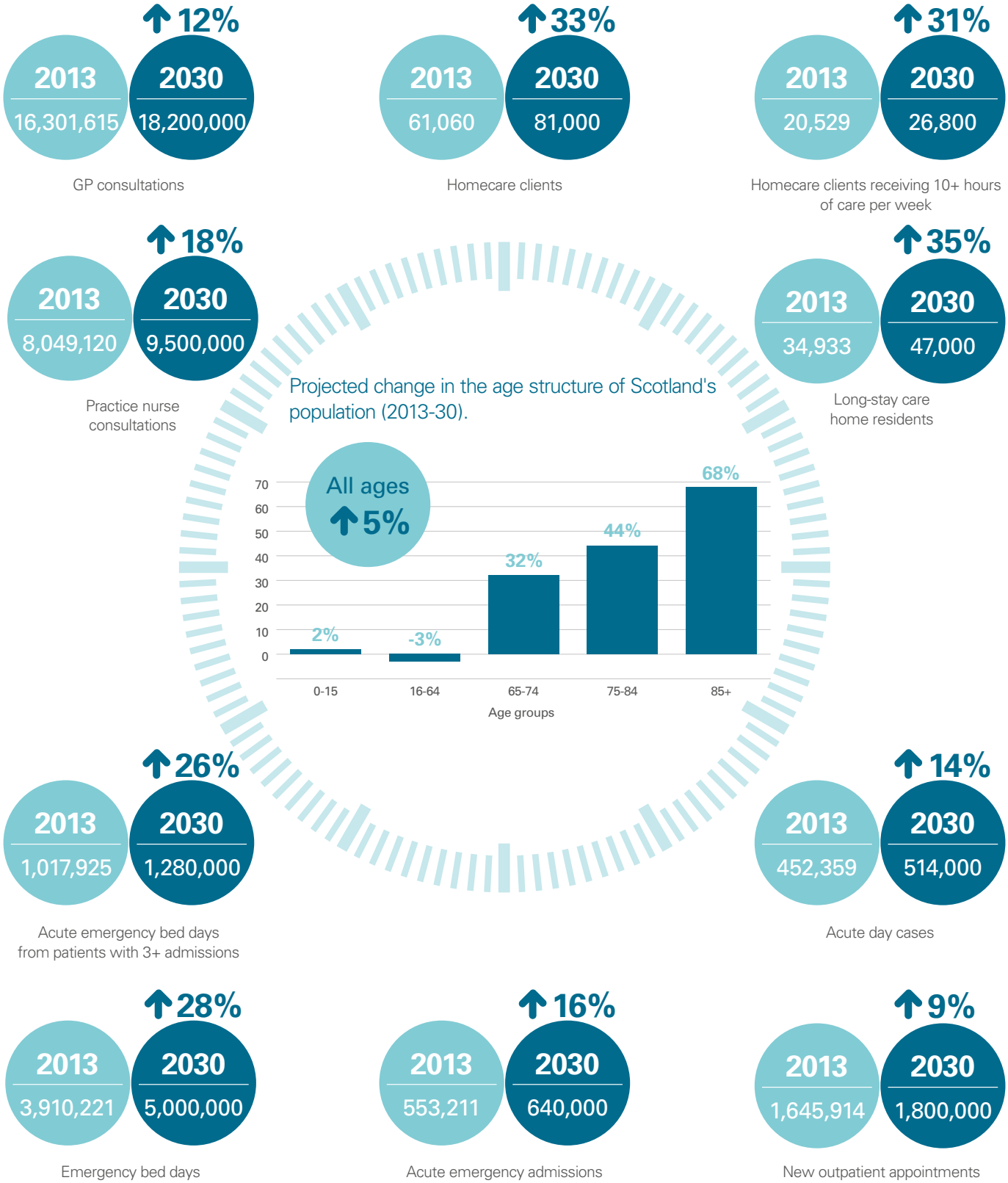
16. To help to explain the complexity of the health and social care system, and the potential impact changing demographics will have on services over the next 15 years, we have prepared Exhibit 4 (page 13). It shows projected rises in activity arising from a growing, ageing population. These are based on applying projected increases in the population to key measures that can indicate how well the system is working. The health and social care system is inter-related. If anything goes wrong in one part of the system, it can affect other parts of the system. The growing population will affect all parts of the health and social care system. If the population increases as predicted, and services continue to be delivered in the same way, the impact across the system is significant and highlights the need for change. Based on our projection analysis, in 2030, compared to 2013, there could be an additional:

- 1.9 million GP appointments and 1.5 million practice nurse appointments

Exhibit 4

Pressures on health and social care services, 2013-30

If current rates of activity continue, it is unlikely that health and social care services will be able to cope with the effects of the changing population unless they make major changes to the way they deliver services.



Note: Each indicator (eg, number of emergency admissions) is calculated as a rate of the population by using National Records of Scotland mid-year population estimates. The rate in 2013/14 is assumed to continue over the projection years. Over each of the projected years, the estimated rate is multiplied by the estimated projected population to find the number for that indicator.

Source: Audit Scotland analysis, 2016

- 20,000 homecare clients and 12,000 long-stay care home residents
- 87,000 emergency admissions to hospital and 1.1 million associated hospital bed days
- 62,000 hospital day cases and 154,000 outpatient appointments.

17. A number of factors will affect how much these pressures continue to increase, including: the ageing population; levels of deprivation and health inequalities; changes in healthy life expectancy; and the extent to which new ways of providing services are adopted, particularly preventative and community-based services. However, it is clear that health and social care services will need to be delivered differently to cope with the increasing pressures associated with the growing population.

NHS boards and councils are facing increasing financial pressures

18. The Scottish Government has estimated it would need an annual increase in investment of between £422 million and £625 million in health and social care services to keep pace with demand.[10] Its assumption is based on current service models remaining the same and demand increasing in line with the growth in the older population and changes in healthy life expectancy. This level of investment is not sustainable in the current financial climate. Budgets for health and social care services are reducing. Over the period 2010/11 to 2014/15:

- The health budget decreased by 0.6 per cent in real terms, that is allowing for inflation, to £11.86 billion.[11] The draft health budget is set to increase by 3.6 per cent in real terms in 2016/17. It includes £250 million of funding in NHS boards' budgets for integration authorities aimed at improving outcomes in social care.[12]
- Scottish Government overall funding for councils decreased by 5.9 per cent in real terms to £10.8 billion. Between 2010/11 and 2013/14, spending on social care services increased slightly by two per cent to around £3 billion.[13, 14] In 2016/17, Scottish Government funding for local government is set to decrease by 7.2 per cent.

GPs are central to developing new types of care, but pressures are building in general practice

19. GPs have a key role to play in coordinating care for patients, involving other professionals such as nurses, occupational therapists, physiotherapists and social workers as required. Owing to increasing pressures on GPs' time, new models of care will need to ensure patients are referred to the most appropriate professional based on needs, allowing GPs to focus on patients with complex needs.

20. There is currently a major gap in information about demand and activity for most community health services, including general practice services. Until 2012/13, the Information Services Division (ISD) of National Services Scotland collated practice team information (PTI). This will be replaced by a new system, Scottish Primary Care Information Resource (SPIRE). A phased roll out of SPIRE is due to start in March 2016 and complete by January 2017. It is essential to have good information on the patterns of use of general practice and demand for services to be able to design new models of care.

21. In the absence of published demand and activity data, a number of other indicators point to pressures building in general practice. These include patients' declining satisfaction with access to general practice, increasing patient visits to general practice, recruitment and retention issues, and dissatisfaction among GPs (Exhibit 5, page 16). These all have implications for the quality of care patients receive and their health outcomes. The National Audit Office has found that similar issues also exist in England.[15] The Scottish Government is in the process of negotiating a new contract for 2017 with GPs, partly to address some of these concerns.

The Scottish Government has set out an ambitious vision for health and social care

22. In September 2011, in recognition of the challenges facing health and social care, the Scottish Government set out an ambitious vision to enable everyone to live longer, healthier lives at home or in a homely setting by 2020.[16] This vision aims to help shape the future of healthcare in Scotland in the face of changing demographics and increasing demand for health services. Central to the vision is a healthcare system with integrated health and social care, and a focus on prevention, anticipation and supported self-management. Some of the main principles of the policy, particularly in relation to shifting more care and support into the community, are:

- focusing on prevention, anticipation, supported self-management and person-centred care
- expanding primary care, particularly general practice
- providing day case treatment as the norm when hospital treatment is required and cannot be provided in a community setting
- ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission
- improving the flow of patients through hospital, reducing the number of people attending A&E, and improving services at weekends and out-of-hours
- improving care for people with multiple and chronic conditions
- reducing health inequalities by targeting resources in the most deprived areas
- planning the workforce to ensure the right people, in the right numbers in the right jobs
- integrating adult health and social care.

Integration of health and social care is integral to delivering the 2020 Vision

23. Health and social care services in Scotland are currently undergoing reform. Under these arrangements 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 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 and

Exhibit 5

Indicators of building pressure in general practice

There is a lack of data on general practice activity and demand for services. But available indicators show pressures on general practice continuing to build.

General practice activity

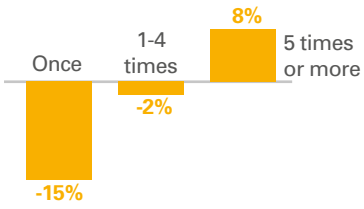
11% increase in patient contacts between 2003/04 and 2012/13 to 24.2 million

67% of contacts were with GPs in 2012/13

This increase is primarily driven by a rise in practice nurse contacts of **31%**

2003/04	2012/13
6.1 million	8.0 million

Change in patients contacting their GP practice 2011/12 to 2013/14



24.2 million GP contacts (2012/13)

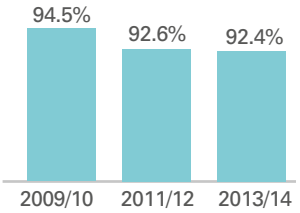
1.6 million A&E and Minor Injury Unit attendances (2012/13)

0.9 million Out-of-hours contacts (2014/15)

Patient experience 2013/14

1 in 6 patients found it difficult to get through to their GP practice on the telephone

The percentage of people able to see or speak to a doctor or nurse within 48 hours has decreased



78% of patients said they were able to book appointments 3 or more days in advance

2015 BMA survey of 1,800 GPs in Scotland

25% of GPs described their workload as unmanagable

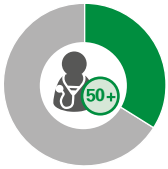
69% felt workload had a negative impact on their personal commitment to their career

a third would like to retire by 2020

17% of practices had at least one vacancy

Workforce

Around 1 in 2 community nurses were aged 50 and over, compared with 1 in 3 hospital nurses in 2015

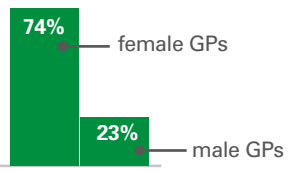


34% of all GPs were aged 50 and over in 2015, compared with 29% in 2005

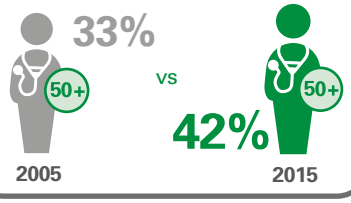
37% increase in female GPs over the ten-year period to 2015

15% decrease in male GPs over the ten-year period to 2015

Percentage of GPs working part-time in 2013



GP partners aged 50 and over



Source: *Health and Care Experience Survey 2013/14*, Scottish Government, May 2015; *Practice Team Information (PTI)*, ISD Scotland, October 2013; *GP Out of Hours Services in Scotland, 2014/15*, ISD, August 2015; A&E and minor incidents unit (MIU) activity data provided to Audit Scotland by ISD, January 2014; *Primary Care Workforce Survey 2013*, ISD Scotland, September 2013; *The UK nursing labour market review 2013*, Royal College of Nursing, September 2013; *The future of general practice - survey results*, British Medical Association (BMA), February 2015; *Community nursing staff in post and vacancies*, ISD Scotland, June 2015; *Nursing and midwifery staff in post*, ISD Scotland, September 2015; BMA press release, 13 March 2015; *Number of GPs in Scotland by age, designation and gender*, ISD Scotland, December 2015.

allowing people to receive care and support in their home or local community, rather than being admitted to hospital. The integration authorities will be responsible for delivering new National Health and Wellbeing Outcomes.[17] These focus on the experiences and quality of services for people using those services, carers and their families. Examples of the outcome indicators include the percentage of adults able to look after their health very well or quite well, and the percentage of people with a positive experience of the care provided by their GP practice.[18]

24. Our recent report on progress towards integration of health and social care services confirms that the new integration authorities are expected to be operational by the statutory deadline of 1 April 2016. However, there are a number of issues that the integration authorities need to address if they are to take a lead on improving local services. These include agreeing budgets, and setting out comprehensive strategic plans, clear targets and timescales to show how they will make a difference to people who use health and social care services. They will also need to deal with significant long-term workforce issues and ensure that complex governance arrangements, including the structures and processes for decision-making and accountability, work in practice.[19]

Part 2

New ways of providing health and social care

New approaches to delivering health and social care are emerging

25. We have identified a number of new models across Scotland that are designed to deliver more care to people in community settings in line with the 2020 Vision. We have identified different types of care models in local areas, including:

- community preventative approaches
- better access to primary care and routine hospital treatments
- enhanced community care models
- intermediate care models
- initiatives designed to reduce delayed discharges.

26. We have not reviewed all new models in all areas of Scotland. We have selected a number of examples in some areas of Scotland to illustrate the different types of models that exist and to highlight particular aspects of good practice (Exhibit 6, pages 20-21). These include ten primary and community care 'test sites' referenced in the Scottish Government's Programme for Government, published in September 2015.[20, 21] Some of these are at an early stage of development and others are more established. They include:

- local GP surgeries working together for faster appointments
- GPs and health professionals, such as nurses, physiotherapists and pharmacists, working together in multidisciplinary teams
- providing treatment that patients currently have to travel to hospital to receive.

new care models are emerging but there is a lack of evidence about what works

27. The Scottish Government intends to work closely with the ten test sites over the next two years to offer support and guidance and share learning.

28. We have produced a supplement to the report containing case studies (Supplement 1 [PDF]). There are hyperlinks throughout the report to the relevant case studies.

29. Most new care models are designed to relieve pressures on the acute sector but have an impact on different parts of the health and social care system. A high-level system diagram showing where the new models of care described in Exhibit 6 sit within the overall health and social care system is set out in Supplement 1 [PDF].

New models need to be implemented and evaluated properly

30. A common issue with many of the new care models being introduced across Scotland is a lack of evidence about the impact, implementation costs, efficiency gains or cash savings, and outcomes for service users. Some new ways of working are based on similar models from elsewhere, either another part of Scotland or other countries. But it is still important to monitor any new models to assess the impact on local systems and assess the costs, savings, outcomes and sustainability. This will help to assess the value for money of new models, whether the benefits justify the costs and if they should be rolled out more widely. For many of the new models that have been introduced in Scotland, it is too early to assess their impact. We were not able to carry out a cost benefit analysis for the care models described in Exhibit 6 owing to a lack of local cost information.

31. Many organisations highlighted the lack of time, resource and skills as a barrier to carrying out major change and also to properly evaluating new models. Senior managers in local bodies need to recognise that a successful change programme requires strong leadership and experience in change management to take forward major changes to services. Also, sufficient resources need to be included in the business case for changes to be properly implemented and evaluated.

More can be learned from the innovation of others

32. Although not all the models and approaches listed in Exhibit 6 will be directly transferable in their entirety to other areas, they each include aspects of innovation and improvement which can help inform how services could develop in other areas. In the following paragraphs we explore particular aspects of some of the models in more detail to provide a flavour of the new approaches being taken in some local areas.

Using a model of care focusing on the whole population to achieve a sustainable service

Population health models of care aim to improve the health of the entire population, rather than targeting specific age groups or certain conditions. Within this model the focus is on preventative measures and reducing inequalities. Case study 1 [PDF] provides details of a GP practice in Forfar developing a model of care focused on the whole population to improve access, health and wellbeing and to sustain services in the longer term in the light of the pressures we highlighted in Part 1.

33. The Nuka model of care from Alaska, also described in Case study 1 [PDF], has influenced the model the Forfar GP practice is developing. Native Alaskans create, manage and own the whole healthcare system. Multidisciplinary teams provide integrated health and care services in primary care centres and the community. These are coordinated with a range of other services and combined with a broader approach to improving family and community wellbeing.

Multidisciplinary teams working together to keep people at home

34. Recent work by the King's Fund suggests that collaboration through place-based systems of care offers NHS organisations the best opportunity for tackling the growing challenges facing them. This is where organisations work together to improve health and care for the local populations they serve.[22] There are examples of place-based care in Scotland in Tayside (Case study 2 [PDF]) and Glasgow (Case study 3 [PDF]).

Exhibit 6

New models of health and social care in Scotland

We have identified different types of new approaches to delivering health and social care in Scotland.

Community preventative approaches

These help people to stay in the community, in particular people with multiple conditions and complex needs. These approaches aim to help people self-care and to reduce people's demands for healthcare in the longer term. Examples of self-care include changing diet, taking more exercise or taking medicines at the right time.

- Two GP practices in Forfar are planning to merge into one of the largest practices in Scotland. Patients will be allocated to one of five multidisciplinary teams within the practice, each delivering a patient-centred model of care. Each multidisciplinary team will include GPs, nurses, healthcare assistants, an administrator and a named community nurse. The patients are encouraged to manage their conditions and self-care (Case study 1 [PDF]).
- The House of Care model is being tested in Lothian, Tayside and Glasgow. This approach encourages people living with multiple, long-term conditions to self-manage their care through joint planning, goal-setting and action planning.
- Patients with complex and/or multiple conditions from deprived areas in Glasgow may be eligible to be part of the CAREplus initiative. Inclusion allows patients longer consultations with a GP or nurse. This enables them to discuss their problems in more detail and make a list of priorities (Case study 3 [PDF]).
- The Links Worker Programme has placed community links practitioners in GP practices in deprived areas of Glasgow. They are not medically qualified, but link practices and patients with community-based services and resources such as lunch clubs and self-help groups based on individual patients' needs (Case study 3 [PDF]).

Improved access to primary care and routine hospital treatments

These approaches are designed to improve access to care for local people by health professionals working together, or in a different way.

- New community health hubs in Fife and Forth Valley: Patients will be able to get access to a range of services that they would normally have had to travel to an acute hospital to receive. A new type of doctor will be part of the healthcare team. They will be qualified GPs with an extra year of training to give them the skills they need to work across primary and acute care. This training began in autumn 2015.
- The new model of delivering healthcare for the Small Isles (Canna, Rum, Eigg, Muck and surrounding islands) is a combination of telehealth facilities and improving local skills to deal with healthcare needs. This is alongside a visiting service provided through NHS Highland's new rural support team, initially led by two GPs based on Skye. The rural support team includes GPs, nurse practitioners and paramedics.

Enhanced community care

This is a multidisciplinary team approach aimed at keeping people at home or in a homely setting, managing crisis situations and avoiding inappropriate admission to hospital. Some models also support quicker discharge from hospital.

- The Tayside Enhanced Community Support Service enables GPs, with the support of a multidisciplinary team, to lead the assessment of older people with frailty and at risk of unplanned hospital admission, and to respond to any increased need for health and social care support (Case study 2 [PDF]).

Cont.

Enhanced community care (continued)

- East Lothian service for the integrated care of the elderly (ELSIE): This whole-system approach offers access to multidisciplinary and multiagency emergency care at home, or the place people call home, to older people. The service offers a single point of contact for both people who are at risk of being admitted to hospital, and to actively facilitate the discharge of people from hospital (Supplement 2).
- Forth Valley's Advice Line For You (ALFY) is a nurse-led telephone advice line to help older people remain well at home. Nursing advice is available 24 hours a day, seven days a week (Case study 5 [PDF]).
- The Govan SHIP project aims to reduce demand for acute and residential care and improve chronic disease management. Four GP practices in Govan Health Centre provide a multidisciplinary approach to patients of any age who are known to be vulnerable (Case study 3 [PDF]).
- Community-based dementia care: In Perth and Kinross, the closure of a number of community hospital dementia beds allowed increased investment in community mental health teams that are looking after more patients in their own homes (Case study 8 [PDF]).

Intermediate care

This involves time-limited interventions aimed at promoting faster recovery from illness and maintaining the independence of people who might otherwise face unnecessarily prolonged hospital stays or inappropriate admission to hospital or residential care.

- The Glasgow Reablement Service provides tailored support to people in their own home for up to six weeks. It builds confidence by helping people regain their skills to do what they can and want to do for themselves at home (Case study 8 [PDF]).
- Bed-based intermediate care is provided across most health and social care partnerships. Step-up beds are for people admitted from home for assessment and rehabilitation as an alternative to acute hospital admission. Step-down beds are for people who are well enough to be discharged from acute hospital but need a further period of assessment and rehabilitation before they can return home.

Reducing delayed discharges

These approaches aim to increase the understanding of the reasons for delays in patients being discharged from hospital, and find ways to reduce this. A number of models combine reducing delayed discharges with providing enhanced care in the community to prevent people being admitted to hospital in the first place.

- Tayside Enhanced Community Support Service (as above)
- East Lothian Service for the integrated care of the elderly (ELSIE) (as above)
- The Glasgow 72-hour discharge model ensures patients who are considered fit for discharge from hospital are discharged within 72 hours. Their options for discharge are to go home, or home with support in place if needed. Another option is for people to go to a temporary care bed for a maximum of four weeks where they will be assessed and rehabilitated and a care plan will be developed and agreed for them.
- The East Lothian 'Discharge to Assess' service is delivered by physiotherapists and occupational therapists who provide early supported discharge and assess patients at home, rather than in an acute setting. This includes arranging equipment, active rehabilitation and developing packages of care. The service is an integral part of ELSIE (as mentioned in the above section: 'Enhanced community care').

Source: Audit Scotland

35. A number of areas across Scotland have recently introduced an enhanced community support model. This tends to involve multidisciplinary teams delivering an enhanced level of care, working together to keep people at home or in a homely setting, managing crisis situations and avoiding inappropriate admission to hospital. Tayside has combined this model of care with a local area-based approach that aligns consultant geriatricians to GP practices (Case study 2 [PDF]).

36. Most enhanced community support service models are targeted towards older people. However, in one area of Glasgow, three new linked approaches to delivering health and social care are facilitating an enhanced service for anyone in the local population who is judged to be vulnerable. This includes people with mental health problems or people who use services frequently and people with complex needs. Case study 3 [PDF] provides more detail of these three approaches and includes patient stories to illustrate the difference the new approaches have made to people using the service.

Nurse-led approaches that maximise the population's resilience

37. The Buurtzorg model of care from the Netherlands is an example of an effective nurse-led approach to delivering health and social care that maximises people's resilience (their ability to withstand stress and challenge) (Case study 4 [PDF]). Health and social care organisations can help to build people's resilience by: supporting them to look after themselves; providing preventative services that keep them well in the community; and by ensuring they know how to access help if things go wrong. Forth Valley has introduced some of the elements of this approach in its Advice Line For You (ALFY) model (Case study 5 [PDF]).

38. The ALFY model's *Your Plan* enables people to take responsibility for the challenges they face and to use their own skills and abilities, and friends, family and people who care for them, to develop resilience. This echoes the Buurtzorg service that promotes self-care, independence and the use of informal carers. The Buurtzorg model has improved the quality of patient care through round-the-clock access to a district nursing team by telephone or a home visit service. Results have shown:

- a correlated decrease in unplanned care and hospital admissions
- better patient satisfaction, when compared to other homecare providers in the Netherlands.[23]

Longer-term strategic approaches

39. We have found evidence of longer-term programmes supporting the 2020 Vision, where organisations have built on previous work, identified priority areas to focus on and are working on scaling up a number of models:

- The Scottish Ambulance Service's strategic approach to patient care involves closer working with primary care teams to ensure patients are referred to the most appropriate service, and to avoid admission to hospital wherever possible (Case study 6 [PDF]).
- The Scottish Centre for Telehealth and Telecare's Technology Enabled Care Programme encourages more use of established technology to help improve health and wellbeing outcomes (Case study 7 [PDF]).

Taking a whole-system approach

40. East Lothian partnership is taking a whole-system approach to understanding its local population and planning health and social care services and has the following long-term objectives:

- to increase the percentage of over 65s living at home
- to increase the percentage of spending on community care compared with institutional care
- to increase years of healthy life.

41. East Lothian recognises a number of challenges to providing health and social care services to its local population. East Lothian is developing intelligence about various parts of the health and social care system and using it to improve the way it delivers services. An analysis of East Lothian's population and primary care data shows:

- an ageing population with increasing levels of frailty and complex health needs
- increasing hospital admissions in some local areas from younger people with increasing long-term conditions and ill-health
- the groups of people who use a disproportionately high level of health services are those who are nearing the end of their life, are in care homes or have mental health needs
- relatively low numbers of people being admitted to hospital in an emergency, but high rates of occupied bed days and delays in discharge from hospital
- variety in the quality of access to GPs in different practices across East Lothian
- a predicted shortage of GPs owing to an ageing workforce
- preliminary information on the demand levels on GPs, such as the percentage of the practice population presenting to the GP each week.

42. To meet its objectives, East Lothian is focusing on:

- understanding the pattern of service use by high resource users and working out ways of intervening earlier to improve the support people receive and reduce unnecessary demand for services
- expanding ELSIE for people who are at risk of admission to hospital or have just been discharged from hospital to 24 hours a day, seven days a week
- supporting primary care services to meet demand to improve access for patients and to promote early intervention and prevention
- conducting a comprehensive bed modelling exercise to address the problem of delayed discharges, bring patients from Edinburgh hospitals closer to home and ensure efficiency and effectiveness of services.

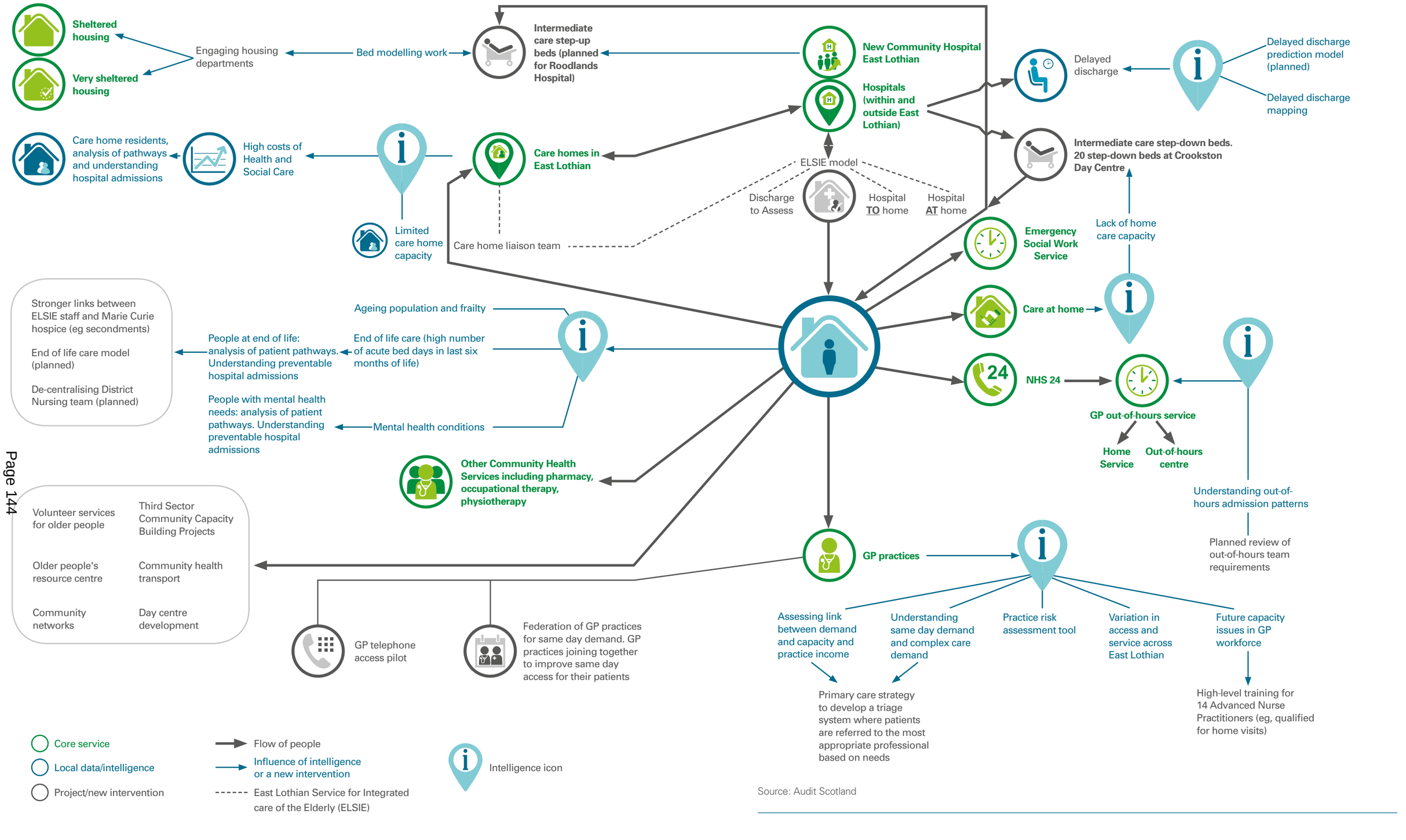
43. East Lothian is bringing together growing intelligence about its population, how people access services, and various strands of work which all aim to improve how it delivers services. This is allowing the partnership to build a comprehensive picture of the needs of its local population. It is also taking into account how changes to services affect different parts of the health and social care system and how these are linked. However, the partnership still has to fully evaluate the impact of new ways of working it has recently introduced. The different elements of East Lothian's whole-system approach to health and social care are summarised in Exhibit 7 (pages 24-25). An interactive version of this exhibit is set out in Supplement 2 and provides more detail on the overall approach.

Exhibit 7

East Lothian's whole-system model

In East Lothian intelligence on various parts of the health and social care system is being used to change the way that services are being delivered.

Exhibit 7 continued



Source: Audit Scotland

Part 3

Making it happen

The transformational change required to deliver the 2020 Vision is not happening

44. Public sector bodies have continued to deliver health and social care services in an increasingly challenging environment. This includes tightening budgets, changing demographics, growing demand for services, increasing complexity of cases and rising expectations from people who use these services. Alongside these pressures, NHS boards and councils are implementing major service reform to integrate adult health and social care services. It is clear that services cannot continue in the same way within the current resources available.

45. Transformational change is required to meet the Scottish Government's vision to shift the balance of care to more homely and community-based settings. NHS boards and councils need to significantly change the way they provide services and how they work with the voluntary and private sectors. Traditionally there has been an emphasis on hospital and other institutional care rather than the community-based and preventative approach outlined in the 2020 Vision. We have highlighted in previous reports that despite the Scottish Government's considerable focus and resources aimed at shifting the balance of care over a number of years, this has not changed to any great extent.[24] We will monitor trends in the balance of care as part of our ongoing work on health and social care integration.

the Scottish Government needs to provide stronger leadership by developing a clear framework to guide local development

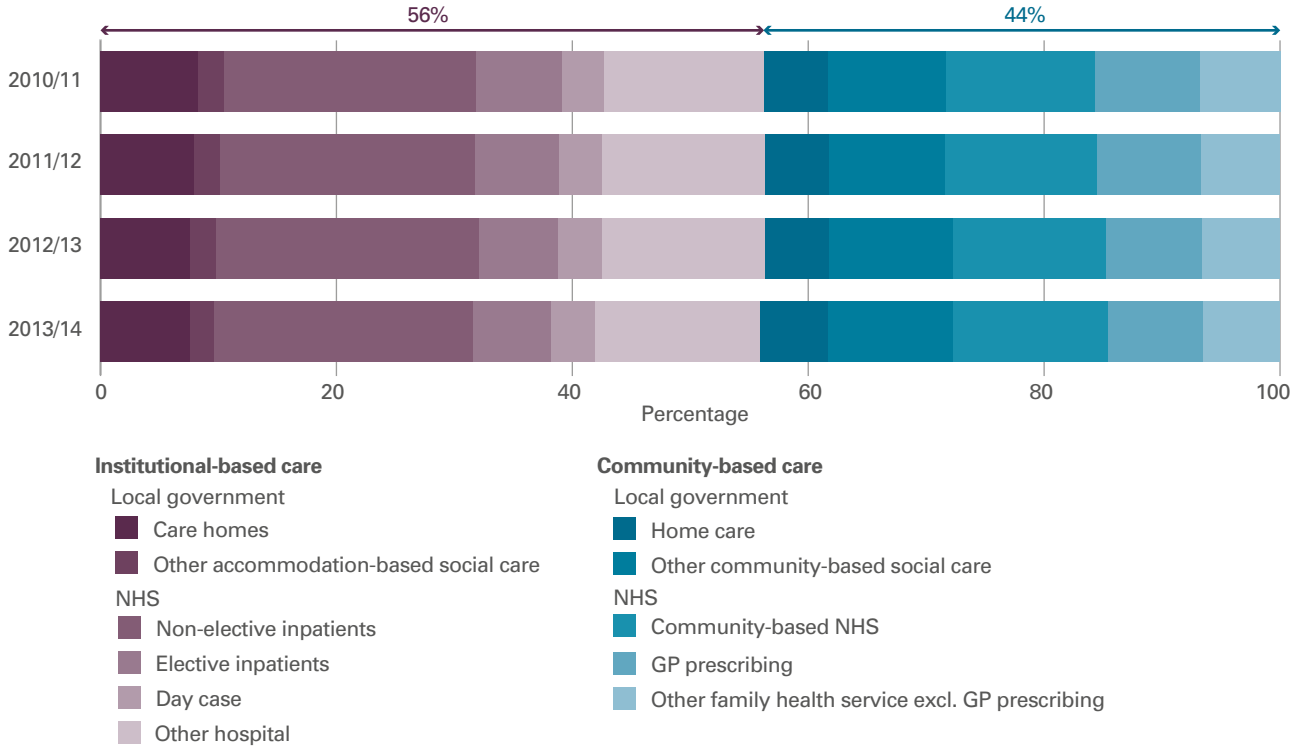
46. Over the four-year period from 2010/11 to 2013/14, the balance of expenditure on institutional services, such as hospitals and care homes, and on care at home or in community settings, has remained static. The percentage of total expenditure on adult health and social care (around £11.7 billion) has remained at 56 per cent for institutional-based care and 44 per cent for community-based care (Exhibit 8, page 27).

47. Our 2015 annual report on the NHS in Scotland highlighted that the Scottish Government has not made sufficient progress towards achieving its 2020 Vision of changing the balance of care to more homely and community-based settings.[25] In this audit looking at changing models of care, we found that there are many small-scale models and pilots across Scotland delivering new approaches to health and social care. However, there is limited evidence of transformational change happening on the scale required to meet the objectives of the 2020 Vision. Most initiatives are at a relatively early stage and have yet to be fully evaluated. This means the potential outcomes for service users and impact on resources are still to be fully established. Currently clear plans are lacking at a national and local level about what is needed to sustain new models of care. Examples include the funding, workforce and long-term planning requirements that are needed to ensure successful pilots are continued and scaled up.

Exhibit 8

Breakdown of adult health and social care expenditure, 2010/11 to 2013/14

The proportion of expenditure on institutional and community-based care has remained static.



Note: **Other accommodation-based social care** includes sheltered housing, hostels and supported accommodation. **Other community-based social care** includes meals, community service, prison social work, youth crime and youth work services. **Other hospital** includes maternity inpatients, special care baby units, outpatients and day patients. **Other family health service excl. GP prescribing** is General Medical Services expenditure.

Source: IRF–NHS Scotland and Local Authority Social Care Expenditure–Financial Years 2010/11–2013/14, ISD Scotland, March 2015

48. In June 2015, the Cabinet Secretary for Health, Wellbeing and Sport confirmed that the Scottish Government and NHS boards had not made sufficient progress towards delivering the 2020 Vision. At the same time, the Scottish Government announced plans to launch a new national conversation on the future of healthcare in Scotland. The Scottish Government decided to consider a longer-term plan, beyond 2020, to make more progress and increase the pace of implementing the vision and to expand the current focus of the vision.

49. The Scottish Government has engaged with staff, service users and other interested groups about improving the health of the population and its plans for health and social care services. It published a National Clinical Strategy in February 2016 setting out its plans for health and social care in Scotland over the next 10 to 15 years. The Scottish Government has published this strategy to help partners as they implement the 2020 Vision. The strategy also comments on the direction of travel beyond 2020. The new strategy describes a number of new proposals and changes to current services. GPs will focus on care that is more complex and the wider primary care team will develop extended skills and responsibilities. A new structure is proposed for a network of hospital services with more specialities planned and provided on a regional or national basis. There is also a strong focus on the need to reduce waste, harm and variation in treatment and making more use of technology to support and improve care.

The Scottish Government needs to provide stronger leadership and a clear plan for implementing the 2020 Vision

50. The Scottish Government's overall aim of enabling everyone to live longer, healthier lives at home, or in a homely setting, by 2020 is widely accepted. In May 2013, the Scottish Government set out high-level priority areas for action during 2013/14.[26] This lacked 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 (paragraph 22). 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.[27] The recently published National Clinical Strategy is intended to provide a clearer framework, but it does not detail how the high-level proposals will be implemented or contain any milestones or indicators or financial analysis.

51. The introduction of health and social care integration means there is now much more flexibility for partners to develop local solutions to local problems as they develop services and support systems to help people to live independently at home or in a homely setting. There is still an important role for Government to set the strategic direction and then to provide the support local partners need to ensure they are able to implement more effective models of care, if the pace of change is to increase.

52. In order for the 2020 Vision and the National Clinical Strategy to be realised, the Scottish Government needs to clarify:

- the immediate and longer-term priorities for local bodies to focus on
- a clear framework to guide local development of new care models, including the types of models to be tested, the resources required (such as funding and skills, job roles and responsibilities of the workforce), and how new models will be tested and rolled out in a coordinated way
- long-term funding plans to help implement the 2020 Vision and the National Clinical Strategy, to allow local bodies to plan and implement sustainable, large-scale changes to services
- how it will measure progress, for example by setting milestones and indicators.

The Scottish Government needs to identify priorities and risks

53. The Scottish Government needs to provide a clear plan now about what needs to be done to reach its longer-term strategy up to 2030. It should identify short, medium and long-term priorities for delivering its vision over the next 15 years. Examples include focusing on implementing high-impact changes to providing services in the short term, identifying the funding and other resources required for the medium term and achieving improved outcomes for the population in the long term. In its plans, the Scottish Government needs to identify and take into account specific risks to delivering its 2020 Vision and longer-term strategy. This should include the following:

- The risks we have highlighted in our report on health and social care integration. Up to late 2015, the focus has been on getting the structures and governance in place for health and social care integration. The Scottish Government will need to ensure that the new partnerships make the transition to focusing on what needs to be done on the ground to make the necessary changes to services.

- Health and social care budgets. Real-terms reductions in NHS and council budgets will pose risks to implementing new models and shifting more care into community-based settings. Council budgets have seen significant cuts in recent years and although new integrated health and social care budgets should allow funding to flow from NHS to social care budgets, it is not yet certain this will happen in practice. Councils and NHS boards are finding it difficult to agree budgets for the new integration authorities.

- The building pressures in general practice, including problems with recruiting and retaining the workforce. The new GP contract that will come into effect in Scotland in 2017 will be crucial in managing the role of general practice in helping to implement the changes required to meet the 2020 Vision. The role of GPs in moving towards the 2020 Vision should be a major focus of the discussions between the Scottish Government and the profession as the new contract terms are developed.

The Scottish Government should outline clear principles for implementing new care models

54. Various principles should be followed for new care models to be implemented, tested, evaluated and rolled out successfully. If local bodies are to expand and roll out new models, they must have thorough information on the costs involved for planning and ensuring the models are sustainable. The Scottish Government has not provided an estimate of the investment needed to implement its 2020 Vision and longer-term strategy, and whether it can be achieved within existing resources. It needs to model how much investment is needed in new services and new ways of working and if it can be achieved within existing and planned resources.

55. Staff implementing new models should have a business plan that clearly details how they will implement, monitor and review them. Exhibit 9 (page 30) summarises principles for implementing new care models. It draws on the information collated from our fieldwork and the learning shared by local bodies and other organisations. Links to toolkits and reports that may be useful for NHS boards, councils and integration authorities for implementing new models of care are included in Supplement 1 [PDF].

56. Few of the models outlined in Exhibit 6 have been fully costed or properly evaluated. In several cases, it is too early to assess the impact of new ways of working. However, sometimes this is due to the lack of good monitoring data or the lack of skills and resources to carry out an evaluation. Generally, there is a lack of evidence of community-based models having a major impact and clarity about what works. This is a common problem, not unique to Scotland, but a crucial one to address so that local areas can efficiently identify and implement the most effective models.[28]

Exhibit 9

Principles for planning, implementing, monitoring and reviewing new care models

New care models should be properly planned, implemented, monitored and evaluated to ensure value for money and sustainability.

Source: Audit Scotland

Mechanisms to support a significant shift in resources from acute to community settings are needed

57. Moving towards more community-based care is central to the 2020 Vision, but the balance of care is not shifting (Exhibit 8). To achieve the transformational change required to meet the 2020 Vision, the Scottish Government needs to

identify mechanisms that will drive a significant shift of resources from acute to community settings. Some local partnerships have found innovative ways to overcome barriers to improvement, but more can be done to facilitate change locally. The Scottish Government has an important role to play in supporting local bodies make these changes.

58. There are tools that can facilitate the transfer of resources across a local system, demonstrated in the examples seen in Tayside, Glasgow and Highland (Case study 8 [PDF] and Case study 9 [PDF]). Scotland could apply learning from other countries. For example, Canterbury, New Zealand, shifted the balance of care through strong leadership, a clear vision, and a collaborative and whole-system approach. An important factor was its focus on 'one system, one budget'. It prioritised spending 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 (Case study 10 [PDF]).

59. The Scottish Government needs to identify what balance of care it wants to achieve, what this will look like in practice and the financial implications of achieving this. The Scottish Government should challenge local partnerships to be clear about their specific ambitions in relation to the balance of acute and community care in their local areas, with clear timescales and milestones for achieving it.

60. The continued focus on targets in the acute sector is counterproductive to moving more funding into the community. NHS boards are under significant pressure to meet challenging hospital waiting time targets. This means that the acute sector continues to absorb considerable resources to meet these targets. A focus on short-term funding and increasing use of the private sector to help meet targets does not demonstrate value for money. The focus on annual targets does not help to achieve the longer-term aims and objectives of the NHS. Integration authorities are required to deliver outcome measures. This recent development with a greater focus on improving people's experiences of health and social care services is more helpful than focusing on narrow performance targets.

61. The Scottish Government needs to identify adequate and timely longer-term funding to support transformational change. It has provided multiple short-term funds to help local bodies implement change, but these do not provide the level of funding or certainty to make large-scale sustainable changes.[29] It has announced a £30 million transformational change fund to 'support creativity and transformation' in its draft budget for 2016-17.

62. In 2014, we reported on progress of the Scottish Government's policy of reshaping care for older people.[30] As part of this audit, we considered the impact of the £300 million Change Fund over four years, introduced by government in 2011/12 to support its policy. We found that the Change Fund had led to the development of a number of small-scale initiatives, but that they were not always evidence-based or monitored on an ongoing basis. It was unclear how successful projects would be sustained and expanded.[31]

63. Similar challenges in transforming services to have a greater focus on community-based care are also evident in England. There may be lessons to learn from the approach NHS England is taking to testing and rolling out new models of care, but it is too early to assess the effectiveness of its approach.

The Health Foundation and the King's Fund have recommended that existing disparate strands of funding for transforming services in NHS England should be pooled into one transformation fund. They also recommend that a single body, with strong, expert leadership, oversees the investment for transformational change and that ongoing evaluation should be a core activity of the fund. They advise that the fund must be properly resourced to support investment in the four key areas that are essential for successful transformation: staff time, programme infrastructure, physical infrastructure and double-running costs.[32]

There is a lack of coordinated, clear and accessible learning

64. The current fragmented approach to implementing new ways of working means that the learning within individual organisations, and the work carried out by various national bodies, is not being consolidated. The Scottish Government needs to coordinate new ways of working and information at a national level to ensure a more efficient and effective approach. The Scottish Government should draw on successful improvement models it has implemented in other areas, such as its patient safety programme.

65. Support for service change and improvement has been available to local bodies from a number of national organisations, such as the Quality, Efficiency and Support Team (QuEST) within the Scottish Government, Healthcare Improvement Scotland (HIS), ISD, the Scottish Centre for Telehealth and Telecare, and the Joint Improvement Team (JIT). However, the activities of these various organisations are not well coordinated. They all have slightly different roles and the learning from the work they do with local bodies is not drawn together. A significant amount of information is available on the various organisations' websites, but it is not always easy to navigate or identify the key information partners should use when they are considering implementing a new model of care. This information could be used to better effect to help increase the pace of change.

66. From April 2016, QuEST, HIS and JIT will combine into one integrated improvement resource. Its overall aim is to support and facilitate NHS boards, integration authorities and their partners to deliver care and support that will improve health and wellbeing outcomes for their populations.[33] This new integrated improvement resource is a positive step and will facilitate a more coordinated national approach and will make better use of improvement resources available to support partnerships.

The public's perception of health and social care services needs to change

67. The Scottish Government first set out its vision for a different health and social care system in 2011, but the system remains largely the same, and the public has not seen major redesign of local services in many parts of Scotland. NHS boards, councils and integration authorities will need to adopt innovative models of care and ways of working that are quite different from traditional services to provide opportunities for better care. They will need to exercise much more flexibility in how they use resources, such as money; assets, including buildings and equipment; and their workforce. This involves making difficult decisions about changing, reducing or cutting some services. Services cannot continue as they are and a significant cultural shift in the behaviour of the public is required about how they access, use and receive services. The introduction of health and social care integration provides an opportunity to engage more directly with communities about services and the need for change.

68. Local communities have strong ties to existing services which can make discussions about changes difficult, for example discussions about changing how hospital services are delivered. There are recent examples in NHS Tayside where the board consulted extensively with the public about closing community hospital beds. The board explained why it needed to close beds and the benefits of providing services differently. It also engaged with patients and their families about their needs and how they could best be met in the new care model in a more homely setting. By closing care of elderly and dementia beds in a number of community hospitals, NHS Tayside has been able to shift more resources into community teams. This has allowed many more patients to be supported in the community and they are now receiving care in their homes instead of being admitted to hospital (Case study 8 [PDF]). It is important that NHS boards, councils and partnerships involve staff and local people as they develop new models of care. The Nuka model of care illustrates the benefits of staff and local people being closely involved in developing their local services (Case study 1 [PDF]).

69. The Scottish Government cannot make the significant changes that are required on its own. Local bodies also need to work closely with staff to develop and implement new ways of working. Fifty-five per cent of staff in NHS Scotland responding to the 2015 national staff survey reported that they are kept well informed about what is happening in their NHS board. Only 28 per cent of staff reported that they are consulted about change at work.[34] A focus on local populations within integration authorities will have an important role in reforming how to deliver services. This should bring together local GPs and other health and care professionals, along with service users, to help plan and decide how to make changes to local services.

NHS boards and councils can do more to address barriers and facilitate change

70. Staff within NHS boards and councils still face many barriers to making the level of changes required. We highlighted in Part 2 some examples of new care models being introduced across Scotland. Staff leading these often faced difficulties getting these in place or rolling them out. But new models have been successfully implemented where staff have taken a strategic approach with clear plans, aims and outcomes. Some of the main challenges to implementing new models include:

- overcoming structural and cultural barriers when bringing together staff from different parts of an organisation or from different organisations
- freeing up staff time to develop and implement new care models
- securing funding for new approaches owing to limited evidence of what works
- having resources for a long enough period to be able to fully test new models to demonstrate any benefits and outcomes for service users
- lack of robust evaluation of new models and being able to identify the attributable impact of a particular approach alongside other services and programmes
- temporary funding and staffing preventing the models continuing or expanding
- shifting resources from acute to community-based settings to allow new care models to develop significantly in line with national policy.

Funding needs to be focused on new community-based models

71. At the same time as dealing with increasing demand, NHS boards are facing a tightening financial position and councils are experiencing budget cuts (Part 1). The NHS is finding it difficult to release funding from the acute sector to increase investment in the community. Councils are finding it difficult to fund the level of social care services required to meet current demand, and the demands on health and social care services are likely to continue to increase. Barriers to releasing funding to invest in new care models include the following:

- Some NHS boards are overspending against their planned hospital budgets owing to pressures on hospital services. This makes it more challenging to release any funding to invest in community-based services. For example, NHS Highland has overspent on its budget for Raigmore hospital over the last five years (£9.6 million in 2013/14) and NHS Fife has overspent on its acute services division budget for the last two years (£10.6 million in 2014/15).[35, 36] In August 2015, NHS Greater Glasgow and Clyde reported spending levels of £5.3 million over its projected acute services division budget. The board had aimed to be £1.7 million over of its budget at that point in the year to be able to achieve a breakeven position by the end of the financial year.[37]

- Investment in NHS community-based services has not increased at the same rate as investment in hospital-based services. Between 2010/11 and 2013/14, spending on community-based services increased by 4.9 per cent in cash terms, but reduced by 0.5 per cent in real terms. Spending on hospital-based services increased by 8.4 per cent in cash terms and by 2.8 per cent in real terms.[38]

- Making improvements in preventing hospital care can increase costs in the community. For example, new care models to prevent admission to hospital increase the costs in community-based health and social care services, such as additional homecare, but the savings in hospital care are often not realised or transferred.

- New community-based care models may place additional pressure on councils already struggling to cope with demand for social care services and are not sustainable without a shift in funding.

- Public and political resistance to closing local hospitals or wards makes it difficult to release significant amounts of funding to invest in radically changing the way services are delivered.

- Closing a small number of hospital beds, or one or two wards, releases limited cash as many of the overhead costs remain or are only slightly reduced. Examples of overhead costs include theatre costs, input from staff covering a number of wards or specialties, cleaning and porter costs, and heating and lighting costs.

72. We did find some examples of local areas overcoming these difficulties and finding innovative ways to direct more funding to community-based care models. In Tayside, closure of community hospital dementia beds has allowed increased investment in community-based teams that are looking after more patients in their own homes. In Glasgow, the reablement service is helping more people to live independently and freeing up more resources for homecare

services (Case study 8 [PDF]). In Perth and Kinross and Highland, local areas are using tools to manage scarce resources and competing demands (Case study 9 [PDF]). There are also lessons from other countries. In Canterbury, New Zealand, a long-term transformational programme and integrated system has increased investment in community-based care and shifted the balance of care (Case study 10 [PDF]). The introduction of health and social care integration brings opportunities for partners to overcome barriers to shifting resources to more community-based and preventative services.

Changing models of care have implications for the structure and skills of the workforce

73. NHS boards and councils face major challenges in ensuring that staff with the right skills are able to provide new community-based models of care to meet the needs of the population. Recruiting and retaining staff on permanent contracts remains a significant problem for the NHS and the social care sector. In the NHS, vacancy rates, staff turnover rates and sickness absence levels all increased during 2014/15. Our *NHS in Scotland 2015* [PDF] report stated that a national coordinated approach is needed to help resolve current and future workforce issues. It highlighted that the approach should assess longer-term changes to skills, job roles and responsibilities within the sector as well as aligning predictions of demand and supply with recruitment and training plans. This is necessary to help ensure the NHS workforce adapts to changes in the population's needs and how services are delivered in the future. We plan to carry out further work on the NHS workforce during 2016/17.

74. Over many years, councils have had difficulties recruiting and retaining care home and homecare staff. Organisations in areas such as Edinburgh and Aberdeen, with high living costs, have had particular difficulties. There is a need to develop a valued, stable, skilled and motivated workforce. We plan to publish a report on Social Work in Scotland in Summer 2016. This will examine issues with recruiting and retaining social work staff in more detail.

75. To shift to more community-based services and care in homely settings, the availability and development of community-based staff with the right skills is crucial. But the balance of community-based staff has not increased significantly in recent years. For example:

- Between 2009 and 2013, the estimated number of GPs in post in Scottish general practices increased by less than one per cent, from 3,700 WTE to 3,735 WTE. The Royal College of General Practitioners in Scotland has calculated that an additional 740 GPs are required in Scotland by 2020, based on predicted population growth.[39]

- Between 2009 and 2014, there have been some changes in the number of people in the social care workforce. Adult day care services staff decreased by nine per cent. The number of adult care home staff increased slightly (one per cent). Staff providing housing support and care at home services increased overall by four per cent, however decreased by three per cent between 2009 and 2013, and only increased again between 2013 and 2014 by six per cent.[40] Between 2010 and 2014 the number of people receiving homecare fell by nearly seven per cent to 61,740, while the total number of homecare hours rose by over seven per cent to 678,900. The number of people receiving ten or more hours of homecare per week, those with more complex needs, increased by four per cent to 21,700.[41]

76. A number of other workforce issues were raised in our fieldwork, including the following:

- Limited capacity in general practice to cope with increasing demand.
- An increasing workload for GPs and the wider primary care team from monitoring patients on long-term medicines.
- GPs do not have protected time for service development, research and strategic meetings. This makes it difficult for GPs to get involved in developing new care models.
- Fewer junior doctors are choosing general practice as a profession.
- Problems recruiting nurses in specialty areas linked to caring for frail and elderly patients.
- A need to train more nurses who currently work in hospitals so they can work in the community.

77. Some local areas are finding solutions to the workforce issues we describe above. We found examples of different groups of staff getting involved in new community-based care models to reduce the pressure on limited GP capacity. Different professions are also working together in multidisciplinary teams to provide more efficient and better quality care, for example in Glasgow, Grampian and East Lothian (Case study 11 [PDF]).

78. BMA Scotland has set out a new role for GPs. It has proposed that GPs should be the senior clinical decision-makers in the community, become more involved in making improvements across the system and focus on complex care in the community. This would mean GPs being less involved in more routine tasks and other health professionals in the wider community team taking on extended roles.[42] This is a proposal in the new National Clinical Strategy. A review of primary care out-of-hours services also recognises the importance of a multidisciplinary team approach and the contribution of the wider team. It proposes a new model for patient access to out-of-hours care.[43]

79. In June 2015, the Scottish Government announced it was providing a primary care investment fund of £50 million over three years to help address workload and recruitment issues in primary care. It is a modest amount and represents around 3.5 per cent of the Scottish Government's primary and community services budget.[44] The Scottish Government anticipates that it will provide an initial impetus to encourage GPs to try new ways of working over the next three years. But it is not clear how its effectiveness will be monitored.

80. Key elements of the three-year fund include the following:

- Primary Care Transformation Fund allocating £20.5 million to GP practices to test new ways of working to address current demand. The Scottish Government is developing a framework for the fund and is inviting health boards and integration authorities to develop proposals to test new ways of working in primary care. Information on the application process and selection criteria was made publicly available in February 2016.

- An investment of £16.2 million for Pharmacist Independent Prescribers to recruit up to 140 new pharmacists. The aim is that they will work with GP practices to help care for patients with long-term conditions and to free up GPs' time so they can spend it with other patients.

- A GP Recruitment and Retention Programme of £2.5 million to explore the issues surrounding recruiting and retaining GPs. The programme will implement proposals to increase the number of medical students who choose to go into GP training and encourage GPs to work in rural and economically deprived areas.

- A £6 million Digital Services Development Fund to help GP practices put digital services in place more quickly. This includes developing online booking for appointments and implementing webGP, an electronic consultation and self-help web service hosted on a GP practice's website.

- The balance of just under £5 million will be used to fund:

  – equipment to enable optometrists to screen people for glaucoma

  – changes to front-line services so that Allied Health Professionals, such as physiotherapists, can better support active and independent living

  – a leadership programme to equip GPs with the necessary skills to play a leading role in developing local integration work

  – additional research and training through the Scottish School of Primary Care.[45]

81. In February 2016, the Scottish Government announced a further £27 million investment over the next five years to develop the NHS workforce. This includes £3 million to train 500 advanced nurse practitioners and over £23 million to increase the number of medical school places and widen access to medical schools. A new entry-level programme will be introduced to support and encourage more people from deprived backgrounds to study medicine.

82. Many general practices are struggling to recruit and retain staff. During 2015, NHS boards had to support nine practices that were not able to continue as successful businesses and provide the services required to their local population. This may become an increasing problem in light of the building pressures we have outlined throughout this report what impact it has on. Where NHS boards have had to step, it is not clear what impact this has had on the performance of practices and the services provided to patients. The Scottish Government should monitor these practices for any improvements or deterioration in the way services are provided, and share any learning.

A better understanding of the needs of local populations is required

83. NHS boards, councils and partnerships need to have a good understanding of their local population and how people use different services so they can provide services that effectively meet local needs. This understanding can help to identify where resources, including money and staff, are being directed and if they are using these resources in the best way. It can also help to identify changes required to the way services are delivered and how resources can be redirected to priority areas.

84. We found that NHS boards, councils and partnerships are at varying stages with this kind of analysis and taking different approaches to it. However, integration authorities will all have to carry out needs assessments of their local population, and this is an important step in improving local analysis. The organisations that are making good use of their local data are starting to think differently about how they can best deliver and redesign services. They are identifying a small number of priorities to focus on, which is much more manageable than trying to fix everything at once. It is also more effective than having too many small-scale projects that are difficult to manage and unlikely to demonstrate a significant impact.

Health and social care data is improving

85. ISD is developing an extensive database of linked data on health and social care activity and costs and demographic information. It is making this information available to NHS boards, councils and partnerships to help them gain a better understanding of the needs of their local population, current patterns of care and how resources are being used. The Health and Social Care Data Integration and Intelligence Project (HSCDIIP), now known as Source, is a long-term project that aims to support integration authorities by improving data sharing across health and social care.[46] From April 2015, the central team has begun sharing local data in the form of an interactive dashboard that contains easy-to-read information summaries. This has required local areas to sign an information governance agreement to enable NHS boards and councils to view each other's data across a local population. Some partnership areas have taken some time to get these agreements in place and therefore gain access to the analysis. As at February 2016, five partnerships had finalised these agreements and undergone training for the software that will allow them to access and analyse the linked data for their local area (Angus, Borders, Dumfries and Galloway, East Renfrewshire, and Midlothian). This is the first time this linked data has been available and this is a valuable resource for partnerships.

86. ISD is also providing data and analytical support through a Local Intelligence Support Team (LIST) initiative. This allows partnerships to have an information specialist from ISD working with them in their local area. The central team can also provide additional support and tailored analysis. This includes forecasting costs, pathway analysis to show how individuals move from one service to another, and the resource associated with the use of different services at a local population level.

87. Some areas have made good use of the support provided by the Source team to better understand their population and also the data that has been made available to them. This includes Perth and Kinross, East Lothian, and West Dunbartonshire (Case study 12 [PDF]).

88. These examples demonstrate how detailed analysis of local data at a local area and individual level is crucial in understanding the needs of a population, how people are currently using services and how costs are incurred. This then provides local areas with the information they need to identify how services can be provided differently and more efficiently to provide better outcomes for people and reduce costs. Using this information to identify the individuals at most risk of their health deteriorating allows preventative measures to be put in place or for care to be provided in a more effective and efficient way. This has the potential to free up resources across the whole system. If local areas do not have this level of information, they will not be able to properly plan or transform services in the future.

89. ISD is in a good position, through the Source and LIST work, to share good practice about data analysis across all partnership areas. ISD held a conference in September 2015 to share early learning from across Scotland. ISD should continue to share good practice. This could include:

- hosting further national events
- publishing good practice examples on its website to illustrate how local areas are making good use of data
- developing toolkits to assist partnership areas to identify appropriate approaches to analysing and understanding local data.

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