North Ayrshire Council
Comhairle Siorrachd Àir a Tuath

Audit and Scrutiny Committee

A Special Meeting of the **Audit and Scrutiny Committee** of North Ayrshire Council will be held in the **Council Chambers**, **Ground Floor, Cunninghame House, Irvine, KA12 8EE** on **Wednesday, 27 November 2019** at **13:30** to consider the undernoted business.

1 **Declarations of Interest**
Members are requested to give notice of any declarations of interest in respect of items of business on the Agenda.

2 **North Ayrshire IJB Financial Position**
Submit report by the Director (Health and Social Care Partnership) on the financial position of the North Ayrshire IJB and the plans to mitigate the current projected overspend.

3 **Urgent Items**
Any other items which the Chair considers to be urgent.

Audit and Scrutiny Committee Sederunt

Marie Burns (Chair) Margaret George (Vice Chair) Joy Brahim Alan Hill Tom Marshall Donald Reid John Sweeney	Chair: Apologies: Attending:

NORTH AYRSHIRE COUNCIL

27 November 2019

Audit & Scrutiny Committee

Title:	**North Ayrshire IJB Financial Position**
Purpose:	To provide an update on the financial position of the North Ayrshire IJB and the plans to mitigate the current projected overspend.
Recommendation:	It is proposed that the Committee note the attached reports.

1. Executive Summary

1.1 The Audit and Scrutiny Committee agreed to receive regular reports on the financial performance of the North Ayrshire IJB. The Committee requested a further update on the financial position of the partnership following a reported overspend position during the 2019-20 financial year.

1.2 The attached reports and supplementary information provide an overview of the financial position for the IJB and additional information on service demands, together with information on the local and national challenges in delivering on the ambitions of health and social care integration.

2. Background

2.1 The Scottish Government integrated health and social care so that people have access to the services and support they need, so that their care feels seamless to them, and so that they experience good outcomes and high standards of support. Integration requires services to be redesigned and improved, with a strong focus on prevention, quality and sustainability. Audit Scotland observed in their report published in November 2018 that integration can work within the current legislative framework, but that Integration Authorities are operating in an extremely challenging environment. It is acknowledged that health and social care services are driving forward many improvements in the experience of care, every day and often in challenging and difficult circumstances, but that the pace of change needs to increase. Much of the change that needs to happen is to completely transform how we deliver health and social care services, moving away from traditional approaches and looking after people for longer in their own homes. This is a huge cultural change for staff, communities and our partners and requires a realignment of expectations of the services we can continue to provide and how we provide those. The North Ayrshire HSCP is delivering the

Thinking Different, Doing Better experience to clearly communicate the challenges we face and the case for change.

2.2 The IJB approved a balanced budget for 2019-20 in March 2019. That budget was underpinned by a requirement to deliver savings of £6.1m and to manage a number of in-year unfunded pressures. Whilst the budget and savings plans are completely aligned to the IJB's Strategic Plan and the ambitions within that to change how we deliver health and social care services, we have never underestimated the challenge we face in terms of delivering service change across all services at pace whilst continuing to meet new demand for services. So many of the delegated services, particularly for social care, are demand led and for some services these are very specialist and high cost. This leads to a greater risk of being able to plan for and respond to in-year demands for services. Some of this is being reflected in the challenges being faced by health and social care systems across the country. The recent Auditor General's report reports a potential £1.8 billion shortfall in funding across Scotland by 2023-24. Whilst we await the quarter two position, by the end of quarter one this year, 22 of the 31 Integration Joint Boards were projecting overspends totalling £87 million.

2.3 The IJB approved a Financial Recovery Plan in September this year, at which time we were projecting a year-end overspend across the partnership of £2m. The Financial Recovery Plan includes actions to address the areas of overspend to help work towards financial balance for this year. In the main the actions outlined in the plan will deliver a recurring benefit and assist with providing a sustainable position for future years. It is therefore important that officers in the HSCP continue to work on delivering against those actions.

2.4 The IJB was presented with an update on the financial position last week where it was noted, with disappointment, the deterioration of the position to a projected overspend of nearly £3m. The partnership has made significant progress in a number of areas for social care including reducing Care Home placements and bringing children back from residential placements. However, we also face some significant challenges in meeting unprecedented demand for packages of care to facilitate hospital discharge and managing community waiting lists for services. In addition, our current limited availability of local kinship and foster carers alongside decisions taken, sometimes outwith our control by Children's Hearings and Courts, has led to some children being placed in very expensive care placements.

2.5 Whilst we are still confident of delivering the savings that have been agreed by the IJB, some delays have impacted on our ability to fully realise the extent of these savings in-year. For example, the delay in the opening of Trindlemoss and the delay associated with the process around the implementation of the Adult Support tender has, in both instances, meant that we have lost at least four months' worth of savings.

2.6 Whilst the IJB understand the responsibility to plan and deliver services from within the delegated budget, we recognise the challenges in recovering an overspend of nearly £3m by this point in the financial year and the impact of the short-term decisions and actions that would require to be taken to fully recover

this position. These actions would inevitably have longer term consequences, both financially and for individual people's outcomes and would not necessarily address the areas where we continue to have financial and operational pressures. These actions would also have unintended consequences on other areas of the care system we have responsibility for, including acute hospitals which are already at breaking point. None of this would align with our strategic ambition to shift the balance of care and improve outcomes for people in North Ayrshire and could result in the loss of trust between communities and the partnership as well as undermining our ability to deliver on areas of positive transformational change.

2.7 North Ayrshire Council continue to hold £1.5m on behalf of the IJB to allow the repayment of the outstanding debt of £5.1m to the Council over the next few years. Last financial year (2018-19) the partnership successfully delivered financial balance and made the first instalment towards reducing the debt, this positive outcome was partly supported by an underspend in the Health element of the budget which was utilised to offset social care overspends. In 2019-20 there are significant challenges in balancing the delegated Health budget. With a programme of service change including closure of wards (Elderly Mental Health and Learning Disabilities) which are delivering care on a Pan Ayrshire basis and therefore rely on other areas having plans for alternative care for individuals. We have seen significant delays in delivering these service changes which has had an impact on the health element of the IJB budget.

2.8 The IJB recognise that it is unlikely at this stage that we will be able to fully recover the full £3m overspend alongside managing continuing demand for services, therefore we are working towards reducing this as far as practically possible. It is important that we continue to progress the actions set out in the financial recovery plan as these are targeted not only at reducing the overspend for this year but also to address recurring overspends in future years. This is with an expectation that realistically we will not be in a position as planned to make this year's full instalment of £1.5m against the outstanding debt with the Council. The IJB do not want to be in a position of further adding to the £5.1m outstanding debt and therefore will focus on ensuring the final outturn is managed to at least £1.5m

3. Proposals

3.1 It is proposed that the Committee notes the current position and that the pressures experienced are not unique to North Ayrshire. The Committee is asked to note the impact of delays in delivering savings this year and the plans in place to reduce the projected position.

4. Implications

Financial:	The implications are outlined in the attached reports.
Human Resources:	The implications are outlined in the attached reports.
Legal:	The implications are outlined in the attached reports.
Equality:	The implications are outlined in the attached reports.
Environmental & Sustainability:	The implications are outlined in the attached reports.
Key Priorities:	The implications are outlined in the attached reports.
Community Benefits:	The implications are outlined in the attached reports.

5. Consultation

5.1 The attached report outlines the consultation that has taken place.

Stephen Brown
Director Health & Social Care Partnership

For further information please contact **Caroline Cameron** on **01294 324954**.

Background Papers

Appendix 1 – IJB Financial Monitoring Report – Period 6
Appendix 2 – Supplementary Demand Pressure Information
Appendix 3 – Integration Authorities Financial Position at Q1 2019-20
Appendix 4 – Audit Scotland – *NHS in Scotland 2019* (October 2019)
Appendix 5 – Scottish Government - *Medium Term Health and Social Care Financial Framework* (October 2018)
Appendix 6 – Health and Sport Committee – *Looking ahead to the Scottish Government – Health Budget 2020-21* (October 2019)
Appendix 7 – Council Budget Engagement Resources – NAHSCP

NORTH AYRSHIRE
Health and Social Care Partnership

Integration Joint Board
21 November 2019

Subject:	**Budget Monitoring – Month 6 (September 2019)**
Purpose:	To provide an update on financial performance to September 2019, including the projected outturn for the 2019-20 financial year.
Recommendation:	It is recommended that the IJB: a) Note the projected year-end overspend of £2.969m; b) Note the changes in funding as detailed in section 2.11 and Appendix E; and c) Note the potential impact of the Lead Partnerships.

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
MH	Mental Health
CAMHS	Child & Adolescent Mental Health Services
BRAG	Blue, Red, Amber, Green
UNPACS	UNPACS, (UNPlanned Activities) – Extra Contractual Referrals
CRES	Cash Releasing Efficiency Savings
NES	NHS Education Scotland – education and training body
NRAC	NHS Resource Allocation Committee

1.	**EXECUTIVE SUMMARY**
1.1	The report provides an overview of the financial position for the partnership and outlines the projected year-end outturn position informed by the projected expenditure and income commitments, these have been prepared in conjunction with relevant budget holders and services. It should be noted that although this report refers to the position at the September period end that further work is undertaken following the month end to finalise projections, therefore the projected outturn position is as current and up to date as can practicably be reported.
1.2	The projected outturn is a year-end overspend of £2.969m for 2019-20 which is an adverse movement of £0.661m from the previous reporting period. There is scope for this position to fluctuate due to in-year cost and demand pressures and assumptions in relation to funding and the achievement of savings. A financial recovery plan was approved by the IJB in September to work towards delivering financial balance. Progress against the plan will be closely monitored as the IJB may be required to approve additional actions later in the financial year if the planned impact is not realised.

1.3	There has been as adverse movement in the position which mainly relates to a review of the assumptions for care at home, an increase in fostering, children's residential placements, care home respite and South Lead Partnership services. The main areas of pressure continue to be learning disability care packages, care homes, care at home, looked after children, and adult in-patients within the lead partnership. Alongside the specific actions outlined in the financial recovery plan services will continue to deploy tight financial management controls to support bringing expenditure back into line with budget.
1.4	It is essential that the IJB operates within the delegated budget and commissions services from the Council and Health Board on this basis as financial balance needs to be achieved. North Ayrshire Council continue to hold £1.486m on behalf of the IJB to allow the repayment of the outstanding debt of £5.139m to the Council over the next 3-4 years. This resource is not currently included in the projected outturn position, any overspend position at the year-end would impact on the ability of the IJB to make the planned debt repayment.
2.	**CURRENT POSITION**
2.1	The report includes an overview of the financial position including commitments against the available resource, explanations for the main budget variances, an update on progress in terms of savings delivery and action required to work towards financial balance. The funding in relation to Frank's Law (free personal care for under 65's) and the Carers Act had previously been held outwith services, during this period the budget has been allocated to the relevant service areas. This impacts on the projection for each service area but not the overall financial position as the funding was already factored into the projected outturn.
	□INANCIAL PER□ORMANCE
2.2	Against the full-year budget of £242.394m there is a projected overspend of £2.969m (1.2%). An integrated view of the financial position should be taken; however, it is useful to note that this overall position consists of a projected overspend of £3.069m in social care services offset by a projected underspend of £0.100m in health services. The Integration Scheme outlines that there is an expectation that the IJB takes account of the totality of resources available to balance the budget in year. Appendix A provides the financial overview of the partnership position. The sections that follow outline the significant variances in service expenditure compared to the approved budgets with detailed analysis provided in Appendix B.
2.3	**Community Care and Health Services**
	Against the full-year budget of £67.878m there is a projected overspend of £1.275m (1.9%) which is a favourable movement of £0.213m due to the allocation of Frank's Law and Carers funding. The main reasons for the projected overspend are: a) Care home placements including respite placements – projected to overspend by £0.090m (£0.077m favourable movement). Permanent placements will continue to be managed to bring the budget back into line. The projection can

vary due to factors other than the number of placements e.g. the impact of interim funded places and outstanding requests for funding, this will require to be monitored closely. The overspend in permanent placements is partly offset by a projected over-recovery of Charging Order income of £0.200m which is based on income received to date and improved processes to track the charging orders.

b) Independent Living Services are projected to overspend by £0.230m which is due to an overspend on physical disability care packages within the community and residential packages. There will be further work undertaken with the implementation of the Adult Community Support framework which will present additional opportunities for reviews and payment only for the actual hours of care delivered. The favourable movement of £0.038m is due to the allocation of funding from Frank's Law.

c) Packages of care are projected to underspend by £0.090m which is a favourable movement of £0.006m. This is due to delays in new packages offsetting the use of supplementary staffing for existing packages, this has improved from the 2018-19 position.

d) Care at home is projected to overspend by £0.893m which is an adverse movement of £0.298m. The movement is due to updating the assumptions re how much of a reduction can be achieved through reviews by the year-end, with a realistic estimate that hours can be reduced by 50 per week. This reduction will allow for capacity to be freed up in the internal service to facilitate hospital discharge and manage waiting lists and a reduction in cost from commissioned services. The overspend for in-house services relates to providing additional hours to cover a service that a provider handed back and the in-house service had to increase capacity to ensure the safety of vulnerable service users within the community of the North Coast locality and also the need to facilitate patient discharges from Crosshouse Hospital. The projection assumes that the number of hours currently being invoiced will reduce further following an internal review of the hours provided and an ongoing contractual issue with a commissioned provider. In addition previously unfunded costs relating the Care at Home service are now reported within the overall position for CAH to be managed within that delegated budget. The service currently has, between hospitals and community a managed waiting list of individuals waiting on a care at home package or an increase in their existing care package.

e) Long Term Conditions (Ward 1), projected overspend of £0.274m (adverse movement of £0.004m) which is mainly due to an overspend in employee costs to ensure staffing levels are at a safe level. This is a recurring pressure for which funding requires to be identified. This will be reviewed during 2019-20 along with other wards. Ward 2 is projected to be £0.020m underspent (adverse movement of £0.006m) but this is subject to continuing to receive £0.504m of funding from East HSCP for their patients, East have indicated their intention to reduce the number of commissioned beds, this is not anticipated to be implemented during 2019-20.

f) Community Care employee costs are projected to overspend by £0.193m (favourable movement of £0.115m) due to supernumerary / unfunded posts and the non achievement of payroll turnover. Some of these posts have been

	allocated to care at home and others have still to be allocated to the appropriate service to manage the costs within the delegated budget. g) Locality services employee costs are projected to overspend by £0.161m (favourable movement of £0.015m) due to a projected shortfall in payroll turnover targets. h) Carers Act Funding is projected to underspend by £0.268m based on the currently committed spend. This could fluctuate depending on the volume of carers' support plans undertaken and the level of demand/services identified from these plans. This underspend will be used in the first instance to fund the projected overspend on care home respite placements. i) Intermediate Care (excluding Models of Care) is projected underspend by £0.089m due to vacancies. j) Intermediate Care and Rehab Models of Care is projected to overspend by £0.247m (favourable movement of £0.013m) which represents the full year funding impact of the model. The projected overspend is based on the posts which are currently filled, with an assumption that any vacancies would be held until a longer term decision on funding investment is taken. k) Aids and adaptations – are projected to underspend by £0.200m per the approved recovery plan.
2.4	**Mental Health Services**
	Against the full-year budget of £75.958m there is a projected overspend of £0.860m (1.1%) which is a favourable movement of £0.415m due to the allocation of Frank's Law and Carers funding. The main reasons for the projected overspend are: • Learning Disabilities – projected overspend of £0.977m (favourable movement of £0.387m), of which £0.531m is in relation to community care packages, £0.272m for direct payments and £0.361m for residential placements. The projection assumes that savings of £0.368m will be made before the year end, that the level of invoice variations will be higher than previously assumed and some slippage with planned new packages. These overspends are partially offset by vacant posts. • Community Mental Health – is projected to underspend by £0.043m (favourable movement of £0.012m) mainly due to vacancy savings (after allocating £0.090m of payroll turnover) and an overall underspend in care packages. • Addictions – is projected to be underspent by £0.110m (favourable movement of £0.015m) due to vacant posts. • Lead Partnership for Mental Health – overall projected overspend of £0.036m (favourable movement of £0.001m) which consists of:

	Overspends: • Adult inpatients £0.600m (adverse movement of £0.020m) - mainly due to the delay in closing the Lochranza ward on the Ailsa site. The ability to close Lochranza is dependent on discharging at least two patients from South Ayrshire. South HSCP have been advised that the Lochranza ward will close, the projection also assumes subsequent redeployment costs. • Psychiatry £0.025m (favourable movement of £0.020m) – overspend primarily due to agency costs. Agency staff are used in the absence of being able to recruit permanent posts. • UNPACS £0.282m (£0.040m adverse movement) – based on current placements which increased by one and an increased charge from the state hospital for the period April to August 2019. • Elderly inpatients £0.100m - due to holding vacancies in relation to reconfiguring the wards. This resulted in using supplementary staff in the interim. *Underspends:* • CAMHS £0.270m (no movement) – due to vacancies and delays with recruitment. This is after applying £0.150m of payroll turnover. • Psychology £0.200m (£0.040m favourable) – due to vacancies. This is after applying £0.150m of payroll turnover. • Adult Community Mental Health £0.098m (£0.029m favourable movement) - due to vacancies. • MH Pharmacy £0.160m (£0.006m favourable movement) – due to continued lower substitute prescribing costs. • MH Admin £0.139m (favourable movement of £0.014m) - due to vacancies.
2.5	**Children □ □ustice Services**
	Against the full-year budget of £35.744m there is a projected overspend of £1.415m (4%) which is an adverse movement of £0.346m. The main reasons for the projected overspend are: a) Residential Schools and Community Placements – projected overspend of £1.386m (adverse movement of £0.124m). The projection is based on the current number of placements and estimated discharge dates for each placement. There are 20 placements and 2 secure placements. The reported projection assumes 2 discharges by December with the remaining 18 assumed to be still in a placement at the year end. There is no provision for any increase in placements. The adverse movement relates to a child being placed in a secure placement, one child in remand and another with an extended discharge date due to a decision made by the Children's Panel. Whilst there has been

some progress in reducing the overall number of external placements the financial benefit of this has been offset by unplanned secure and remand placements as well as decisions made by the Children's Panel.

b) Looked After Children Placements – projected overspend of £0.083m (adverse movement of £0.201m) due to the current demand for fostering, adoption and kinship placements. There were an additional 9 in house foster placements and 2 external placements in the last month. The external placements were made as there were no internal foster carers available. Unless additional internal foster carers are recruited there will be a continued need to use external foster placements.

c) Early Years – projected to underspend by £0.048m (favourable movement of £0.030m) mainly due to the level of vacancies in heath visiting. This is after allocating £0.200m of payroll turnover and accounting for £0.175m of potential additional costs for the regrading of the HV posts.

d) Children with Disabilities Residential Placements – projected underspend of £0.093m (adverse movement of £0.084m) as one placement is no longer funded on a shared basis with education. This budget requires to be maintained at a level to fund the investment in the new ASN residential facility.

2.6 **Management and Support Costs**

Against the full-year budget of £8.776m there is a projected underspend of £0.635m (7.2%) which is an adverse movement of £0.861m. The adverse movement is due to reallocating the funding for Frank's Law to the relevant service areas. The remaining underspend relates to the potential delay in commitment for pressure funding set aside in the 2019-20 budget, the most significant element of this is linked to the delay in opening of the Trindlemoss development. The requirement for this funding will need to be closely monitored and may require to be delegated to services as and when required.

2.7 **Primary Care and Prescribing**

Prescribing is the responsibility for the Health Board to fund and under the terms of the Integration Scheme the Health Board continues to underwrite the prescribing position across the three Ayrshire IJBs. At month 6 prescribing is projected to be £1.383m overspent (adverse movement of £0.276m). This is not included in the projected outturn due to the NHS underwriting the overspend.

2.8 **Savings Progress**

a) The approved 2019-20 budget included £6.134m of savings.

RAG Status	Position at Budget Approval £m	Position at Period 6 £m
Red	-	0.215
Amber / Red	-	1.738
Amber	2.980	0.874
Green	3.154	3.307
TOTAL	**6.134**	**6.134**

	b) The projected year-end outturn position assumes: i) £0.215m of the Red savings in relation to reducing LD sleepovers will not be delivered as planned and this is reflected in the overall projected outturn position; and ii) The £0.328m risk of savings relating to Trindlemoss is partially reflected (£0.178m) in the projected overspend position as there is ongoing work to establish the deliverability of the saving given that the savings were based on the service being operational from September. If progress is made to deliver the savings this would improve the overall outturn position (LD sleepovers) or prevent the overspend increasing further (Trindlemoss). Some savings have been reclassified as Amber / Red as the budget has been removed from the service area but these areas are overspending. The projected financial position assumes that all remaining savings on the plan will be delivered. Progress with savings delivery requires to be closely monitored to ensure the impact on the financial position can be assessed and corrective action taken where necessary. It is essential that if a saving cannot be achieved by the year end that there are plans in place to achieve it moving into 2020-21. Appendix C provides an overview of the savings plan, this highlights that at this stage a total of £2.461m of savings have been delivered successfully. The Transformation Board is in place to provide oversight and governance to the programme of service change. A focus of the Board is to ensure plans are in place to deliver savings and service change, with a solution focussed approach to bringing programmes back on track.
2.9	**□inancial Recovery Plan**
	The Integration Scheme requires the implementation of a recovery plan if an overspend position is being projected, to take action to bring overall service delivery back into line with the available resource. The previously approved financial recovery plan is included in Appendix D. This includes specific targeted actions with a focus on addressing the pressure areas, the actions will not only improve the projected overspend this year but will also address recurring overspends in service areas moving into future years. The plan requires the IJB support as whilst many of the actions are operational management decisions there may be some resistance from service users and communities to any changes to care packages and services. The plan will be monitored closely and is underpinned by more detailed plans with clear actions for high risk service areas. One of the most significant risk areas is Learning Disabilities, a more detailed plan with all actions including tracking progress with reviews is co-ordinated between the service and finance and transformation team. Weekly cross-service progress meetings are being held to track progress and to ensure progress at pace. The overall recovery plan will be an iterative document to remain under review. Progress with the plan will be monitored against to ensure it has the required impact

	and this will feature in future reporting to the IJB. The plan was agreed in September therefore at this stage the full impact is not known. Given the potential impact so far it is proposed that the further actions below are undertaken: 1) **Care at Home** – review feedback from the Thinking Differently Doing Better sessions to identify the main 'themes' that can be taken forward to maximise capacity, including visits, assessment and review process, electronic communication with staff. 2) **Learning Disability** – continue the focussed work with weekly progress updates. Hold a development session with the learning disability team to ensure that progress made to date is embedded moving forward. Progress the responder service on a geographical cluster basis with Trindlemoss being the piloted area. 3) **In house fostering –** grow the number of in-house foster carers through a recruitment campaign (advertising, radio and social media campaign). Review the terms and conditions for foster carers. 4) **Children's Residential Placements –** work with housing colleagues to develop alternatives for older children in care to ensure local capacity can be used to reduce the numbers of external placements. There is a risk that if the planned impact is not achieved that further actions will require to be added to the plan and these may include actions that would impact on the quality and performance of front-line services. The plan also highlights areas where a future policy decision may be required by the IJB to support delivery, where required this will be brought back to the IJB.
2.10	**□inancial Risks**
	The 2019-20 budget setting paper noted unfunded pressures which could present a risk to the projected outturn position. This included: a) Paid as if at work is a pressure relating to health employed staff and the payment of a holiday pay element for regular additional payments, e.g. overtime. The cost across the Health Board is estimated to be £1.4m but is unclear at this stage what the cost will be for each service, for North Ayrshire this is estimated to be around £0.2m. When the cost pressure value is known the partnership will look to services to fund from within existing resources where possible. b) There is a potential pressure in relation to GP practices in difficulty. This is a dynamic pressure which we will look to manage in-year. If this cannot be achieved, then the default position would be to fund the North fair share of this (circa £0.2m) from any underspend in the Primary Care Improvement Fund (PCIF). In addition to these pressures there is a potential reduction to the funding available for Ward 2 in Woodland View as East HSCP are reviewing the number of beds they want to commission from the ward. It is unlikely that this will be implemented during 2019-20 due to the limited notice given re the intent to reduce.

	The IJB may be asked to take further decisions during 2019-20 in relation to managing the above pressures.
2.11	**Budget Changes**
	The Integration Scheme states that "*either party may increase it's in year payment to the Integration Joint Board. Neither party may reduce the payment in-year to the Integration Joint Board nor Services managed on a Lead Partnership basis….without the express consent of the Integration Joint Board".* Appendix E highlights the movement in the overall budget position for the partnership following the initial approved budget. ***Reduction Requiring Approval:*** There are no specific reductions that the IJB are required to approve. ***Future Planned Changes:*** Further areas which are outstanding and will be included in future reports include: 1) Transfer of hub funding to the Communities Directorate (approx. £57k) 2) The transfer of the Douglas Grant and Redburn rehab wards from acute services to the North HSCP. The operational management of these wards has already transferred to the partnership, but the due diligence undertaken on the budget has highlighted a funding shortfall. It has been agreed with NHS Ayrshire & Arran that the financial responsibility will not transfer until balance is found. In the meantime, we are managing services and working to reduce the projected overspend prior to any transfer.
2.12	**Lead Partnerships**
	North Ayrshire HSCP Services managed under Lead Partnership arrangements by North Ayrshire Health and Social Care Partnership are projected to be £0.035m (£0.036m MH over and £0.001m Children under) overspent. Full detail on the underspend is given in section 2.4 above.
	South Ayrshire HSCP Services hosted and/or led by the South Partnership are forecast to be £0.225 million overspent. The Community Equipment Store was funded with an additional £0.280m as part of the budget for this year, however it continues to be a source of pressure and represents the majority of the overspend. It should be noted that expenditure is volatile depending on the timing of purchases. This issue is being discussed by SPOG.
	East Ayrshire HSCP Services managed under Lead Partnership arrangements by East Ayrshire Health and Social Care Partnership are projected to marginally overspend by £0.288m in total. The overall Primary Care Lead Partnership projected overspend is £0.266m and this projected variance mainly relates to additional payments within Primary Medical Services to GP practices currently experiencing difficulty (mainly practices that the NHS Board is administering due to previous GPs handing back contracts). The GP practices in difficulty issue is extremely fluid however negotiations are progressing

	with practices with a view to them returning to independent contractor status. Additional Ayrshire Urgent Care Services costs resulting from increased rates being paid to attract GPs over certain periods can prove challenging to fill without financial incentives. These additional costs are partially offset by savings in Dental services. This reflects the month 4 position for East as the updated information for month 6 was not available to incorporate into the report.
	Further work is being taken forward to develop a framework to report the financial position and impact of risk sharing arrangements across the 3 partnerships in relation to hosted or lead service arrangements. This is to ensure the IJB are fully sighted on the impact for the North Ayrshire partnership. The IJB will be kept informed of progress with this work which is being progressed by the Ayrshire Partnership Finance Leads. At month 6 the impact of the Lead Partnerships has been calculated based on the average NRAC share which is the method that was used in previous years and has been agreed by the Ayrshire Finance Leads. The NRAC shares are: North 36.6%, South 30.5% and East 32.9%
2.14	**Set Aside** The Integration Scheme makes provision for the Set Aside Budget to be managed in-year by the Health Board with any recurring over or under spend being considered as part of the annual budget setting process. The 2019-20 set aside budget for North HSCP is £30.094m, based on expenditure in 2018-19. The acute directorate, which includes the areas covered by the set aside budget, is overspent by £6.4m after 6 months. 58 additional and unfunded beds were open at the 31st March 2019. Crosshouse and Ayr hospitals have experienced a high level of demand and delayed discharges, resulting in increased operational pressures and additional expenditure. During 2018-19 the North Partnerships use of the set aside resources was £30.094m against the NRAC 'fair share' of £28.697m which is £1.127m above the 'fair share'. There is an expectation that the North Partnership will move towards its 'fair share'. The Models of Care programmes including the Intermediate Care and Rehab investment and the Palliative End of Life proposals being developed represent agreed or potential investment in community services with a view to reducing acute beds. This is in effect a mechanism to reduce the set aside resources. Currently however the funding for the ICR model is not able to be released from the acute set-aside budget due to service pressures and the overall overspend in acute services.
3.	**PROPOSALS**
3.1	**<u>Anticipated Outcomes</u>**
	Continuing to implement and monitor the financial recovery plan will allow the IJB to take the action where required to ensure the partnership can deliver services in 2019-20 from within the available resource, thereby limiting the financial risk the funding partners, i.e. NAC and NHS AA. The transformational change programme will have the greatest impact on the financial sustainability of the partnership, the IJB require to have a clear understanding of

	progress with plans and any actions that can be taken to bring the change programme into line.
3.2	**Measuring Impact**
	Updates to the financial position will be reported to the IJB throughout 2019-20.
4.	**IMPLICATIONS**

□inancial:	The financial implications are as outlined in the report. Against the full-year budget of £242.394m there is a projected overspend of £2.969m (1.2%). The report outlines the action being taken and proposed action to reduce the projected overspend. There are a number of assumptions underpinning the projections which could change as we progress through the year. We will continue to work with services to ensure the most accurate and reliable position is reported. The financial recovery plan details planned actions to reduce the projected overspend, this plan will require to be closely monitored and reviewed to determine if further actions may be required to bridge the gap. The main areas of financial risk which may impact on this position are highlighted in the report. North Ayrshire Council hold £1.486m on behalf of the IJB to allow the repayment of the outstanding debt of £5.139m to the Council over future years. This resource is not currently included in the projected outturn position, any remaining overspend position at the year-end would impact on the ability of the IJB to make the planned debt repayment.
Human Resources:	None
Legal:	None
E□uality:	None
Children and □oung People	None
Environmental □ Sustainability:	None
□ey Priorities:	None
Risk Implications:	Within the projected outturn there are various over and underspends including the non-achievement of savings which need to be addressed. If the financial recovery plan does not deliver the required improvements to the financial position, there is a risk that further actions will require to be identified and service quality and performance may be compromised to achieve financial balance.

Community Benefits:	None

Direction Re□uired to Council, Health Board or Both	Direction to :-	
	1. No Direction Required	
	2. North Ayrshire Council	
	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	√

4.	**CONSULTATION**
4.1	This report has been produced in consultation with relevant budget holders and the Partnership Senior Management Team. The report is shared with the Director of Finance for NHS Ayrshire and Arran and the Executive Director Finance and Corporate Support for North Ayrshire Council.
5.	**CONCLUSION**
	It is recommended that the IJB: a) Note the projected year-end overspend of £2.969m; b) Note the changes in funding as detailed in section 2.11 and Appendix E; and c) Note the potential impact of the Lead Partnerships.

□or more information please contact:

Caroline Cameron, Chief □inance □ Transformation Officer on 01294 324954 or carolinecameron□ north-ayrshire.gov.uk

Eleanor Currie, Principal Manager – □inance on 01294 317814 or eleanorcurrie□ north-ayrshire.gov.uk

North Ayrshire Health & Social Care Partnership
Objective Summary Report as at 30th September

Appendix A

Partnership Budget - Objective Summary	2019/20 Budget									Over/ (Under) Spend Variance at Period 5	Movement in projected budget variance from Period
	Council			Health			TOTAL				
	Budget	Outturn	Over/ (Under) Spend Variance	Budget	Outturn	Over/ (Under) Spend Variance	Budget	Outturn	Over/ (Under) Spend Variance		
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
COMMUNITY CARE AND HEALTH	**54,873**	**55,931**	**1,058**	**13,005**	**13,222**	**217**	**67,878**	**69,153**	**1,275**	**1,488**	**(213)**
: Locality Services	25,271	25,507	236	4,517	4,421	(96)	29,788	29,928	140	721	(581)
: Community Care Service Delivery	26,035	27,391	1,356	0	0	0	26,035	27,391	1,356	1,169	187
: Rehabilitation and Reablement	1,765	1,531	(234)	1,925	2,034	109	3,690	3,565	(125)	(54)	(71)
: Long Term Conditions	1,443	1,168	(275)	4,574	4,788	214	6,017	5,956	(61)	(318)	257
: Integrated Island Services	359	334	(25)	1,989	1,979	(10)	2,348	2,313	(35)	(30)	(5)
MENTAL HEALTH SERVICES	**24,109**	**25,248**	**1,139**	**51,849**	**51,570**	**(279)**	**75,958**	**76,818**	**860**	**1,275**	**(415)**
: Learning Disabilities	18,240	19,325	1,085	511	403	(108)	18,751	19,728	977	1,364	(387)
: Commmunity Mental Health	4,504	4,558	54	1,611	1,514	(97)	6,115	6,072	(43)	(31)	(12)
: Addictions	1,365	1,365	0	1,345	1,235	(110)	2,710	2,600	(110)	(95)	(15)
: Lead Partnership Mental Health NHS Area Wide	0	0	0	48,382	48,418	36	48,382	48,418	36	37	(1)
CHILDREN & JUSTICE SERVICES	**32,134**	**33,519**	**1,385**	**3,610**	**3,640**	**30**	**35,744**	**37,159**	**1,415**	**1,069**	**346**
: Intervention Services	3,859	3,862	3	325	368	43	4,184	4,230	46	137	(91)
: Looked After & Accomodated Children	16,325	17,603	1,278	0	0	0	16,325	17,603	1,278	1,016	262
: Fieldwork	4,713	4,833	120	0	0	0	4,713	4,833	120	52	68
: CCSF	309	289	(20)	0	0	0	309	289	(20)	(45)	25
: Criminal Justice	2,627	2,627	0	0	0	0	2,627	2,627	0	0	0
: Early Years	394	358	(36)	2,868	2,856	(12)	3,262	3,214	(48)	(18)	(30)
: Policy & Practice	3,907	3,947	40	0	0	0	3,907	3,947	40	(87)	127
: Lead Partnership NHS Children's Services Area Wide	0	0	0	417	416	(1)	417	416	(1)	14	(15)
PRIMARY CARE	0	0	0	47,170	47,170	0	47,170	47,170	0	0	0
ALLIED HEALTH PROFESSIONALS				5,131	5,071	(60)	5,131	5,071	(60)	(50)	(10)
MANAGEMENT AND SUPPORT COSTS	6,899	6,436	(463)	1,877	1,705	(172)	8,776	8,141	(635)	(1,496)	861
CHANGE PROGRAMME	655	605	(50)	1,082	1,082	0	1,737	1,687	(50)	(50)	0
TOTAL	**118,670**	**121,739**	**3,069**	**123,724**	**123,460**	**(264)**	**242,394**	**245,199**	**2,805**	**2,236**	**569**
Return Hosted Over/Underspends East	0	0	0		0	(12)			(12)	(17)	5
Return Hosted Over/Underspends South	0	0	0		0	(11)			(11)	(16)	5
Receive Hosted Over/Underspends South	0	0	0		0	82			82	0	82
Receive Hosted Over/Underspends East	0	0	0		0	105			105	105	0
REVISED PROJECTED OUTTURN	**118,670**	**121,739**	**3,069**	**123,724**	**123,460**	**(100)**	**242,394**	**245,199**	**2,969**	**2,308**	**661**

2019-20 Budget Monitoring Report – Detailed Variance Analysis per service

Appendix B

	Budget £000's	Outturn £000's	Over (Under) Spend Variance £000's	
COMMUNITY CARE AND HEALTH	**67,878**	**69,153**	**1,275**	
Locality Services	29,788	29,928	140	**Older People permanent care homes** - projected overspend of £0.290m based on 815 placements. Respite care is projected to be online. **Income from Charging Orders** - projected over recovery of £0.200m' **Independent Living Services :** Direct Payment packages- projected overspend of £0.086m on 62 packages and a net decrease of 1 packages expected during the year.. Residential Packages - projected overspend of £0.014m based on 35 packages. Community Packages (physical disability) - projected overspend of £0.130m based on 50 packages **NHS Packages of Car**e - projected underspend of £0.090m due to use of supplementary staffing offset by slippage in other packages.
Community Care Service Delivery	26,035	27,391	1,356	**Care at home** - in house service - projected overspend of £0.271m based on the current level of contracted costs remaining until the year end. Care at home staff have been incurring additional hours as there are moratoria on four of the purchased care providers. - Purchased Care at home - projected overspend of £0.672m. This is after reducing the budget by £0.500m to reflect the agreed 19-20 saving. **Direct Payments** - projected underspend of £0.050m based on 29 packages continuing until the year end. **Transport costs** - projected overspend of £0.072m due to increase in staff mileage within care at home. **Admin costs** - projected overspend of £0.103m mainly due to mobile phone equipment. Supplies and Services - projected overspend of £0.125m in relation to uniforms and other supplies. **Voluntary Organisations** - projected overspend £0.088m mainly in relation to the Alzheimer service. **Income** - projected over recovery £0.053m mainly in relation to CM2000 non compliance charges.

	Budget £000's	Outturn £000's	Over (Under) Spend Variance £000's	
Rehabilitation and Reablement	3,690	3,565	(125)	**Employee costs -** projected underspend £0.154m due to vacancies. **Intermediate Care and Rehab Models of Care** - projected to overspend by £0.247m which is the full year funding impact. **Aids and Adaptations** - projected underspend of £0.200m per the approved recovery plan
Long Term Conditions	6,017	5,956	(61)	**Ward 1 -** projected overspend of £0.274m due to the use of supplementary staffing. **Ward 2 -** projected underspend of £0.020m assuming £0.504m of funding transfers from East HSCP in relation to Kirklandside patients. **Elderly CMHT -** underspend of £0.055m due to vacancies. **Carers Act unding** - projected underspend of £0.268m based on the committed spend. This could fluctuate depending on the volume of carers' assessments undertaken and the level of demand/services identified from these assessments. This underspend will be used in the first instance to cover the projected overspend on care home respite placements.
Integrated Island Services	2,348	2,313	(35)	**Outwith the threshold for reporting**
MENTAL HEALTH SERVICES	**75,958**	**76,818**	**860**	
Learning Disabilities	18,751	19,728	977	**Residential Packages-** projected overspend of £0.361m based on 41 current packages. **Community Packages (inc direct payments) -** projected overspend of £1.287 based on 294 current packages less 5% invoice variances. The projection assumes savings of £0.490m will be achieved and that any new packages or increases to current packages will be cost neutral. The direct payments projection is based on 41 current packages with a net increase of 2 to the year end less £0.102m recovery of unspent balances. **Employee costs -** projected underspend £0.084m mainly due to vacant posts
Community Mental Health	6,115	6,072	(43)	**Outwith the threshold for reporting**
Addictions	2,710	2,600	(110)	**Employee costs -** projected underspend £0.110m due to vacant posts **ADP** - projected online position as any underspend will be carried forward into 2020/21.

	Budget £000's	Outturn £000's	Over (Under) Spend Variance £000's	
Lead Partnership (MHS)	48,382	48,418	36	**Adult Community** - projected underspend of £0.098m due to vacancies. **Adult Inpatients**- projected overspend of £0.600m due to a delay in closing the Lochranza wards. Assumes a 5th bed is sold from October. **UNPACs** - projected overspend of £0.282m which includes the charges from the state hospital (April - August 2019). **LDS -** assumed online pending completion of the relocation of services to Woodland View. **Elderly Inpatients** - projected overspend of £0.100m due to use of supplementary staffing. This could fluctuate pending the finalisation of the elderly mental health bed redesign. **Addictions** - projected underspend of £0.025m due to vacancies. **CAMHS** - projected underspend of £0.270m due to vacancies. **MH Admin** - projected underspend of £0.139 due to vacancies.. **Psychiatry** - projected overspend of £0.025m due to agency costs. **MH Pharmacy** - projected underspend of £0.160 mainly within substitute prescribing. **Psychology**- projected underspend of £0.200 due to vacancies. **Action 15** - assumed online position
CHIDREN'S AND JUSTICE SERVICES	**35,744**	**37,159**	**1,415**	
Intervention Services	4,184	4,230	46	**Outwith the threshold for reporting**

	Budget £000's	Outturn £000's	Over (Under) Spend Variance £000's	
Looked After & Accom Children	16,325	17,603	1,278	**Looked After Children placements - projected overspend of £0.083m based on the following:-** **Fostering -** projected overspend of £0.041m. Budget for 339 placements, currently 331 placement but projecting 338 placements by the year end. **Adoption -** projected overspend of £0.015m. Budget for 74 placements, currently 74 placements. **Fostering** - projected overspend of £0.153m. Budget for 120 placements, currently 134 placements **Fostering Extra** - projected underspend of £0.104m. Budget for 32 placements, currently 25 placements but projecting 24 placements by the year end. **Private fostering -** projected overspend of £0.033m. Budget for 11 placements, currently 12 placements. **IMPACCT carers** - projected underspend of £0.016m. Budget for 4 placements, currently 2 placements. **Residential School placements including community packages -** projected overspend of £1.386m. The projection is based on the current number of placements and estimated discharge dates for each placement based on the support from the mainstreamed Challenge Fund project. There are currently 23 placements. The projection assumes 3 discharges in December with the remaining 20 assumed to be still in a placement at the year end. There is no provision for any increase in placements.
Fieldwork	4,713	4,833	120	**Employee costs** - projected overspend of £0.106m in relation to non achieved payroll turnover. Various minor overspends on transport and the out of hours service.
CCSF	309	289	(20)	**Outwith the threshold for reporting**
Criminal Justice	2,627	2,627	0	**Outwith the threshold for reporting**
Early Years	3,262	3,214	(48)	**Outwith the threshold for reporting**
Policy & Practice	3,907	3,947	40	**Outwith the threshold for reporting**
Lead Partnership (CS)	417	416	(1)	**Outwith the threshold for reporting**

	Budget £000's	Outturn £000's	Over (Under) Spend Variance £000's	
PRIMARY CARE	47,170	47,170	0	**Outwith the threshold for reporting**
ALLIED HEALTH PROFESSIONALS	5,131	5,071	(60)	**Employee costs -** projected underspend £0.060m due to vacancies.
MANAGEMENT AND SUPPORT	8,776	8,141	(635)	**Projected underspend** - this underspend relates to pressure funding awarded as part of the 2019-20 and the pressures have not yet arisen. This funding will be closely monitored and delegated to services as and when required.
CHANGE PROGRAMME CHALLENGE FUND	1,737	1,737	(50)	**Outwith the threshold for reporting**
TOTAL	**242,394**	**245,249**	**2,805**	

Threshold for reporting is + or - £50,000

2019-20 Savings Tracker **Appendix C**

Description	Responsible Senior Management Lead	Deliverability Status at budget setting	Approved Saving 2019□20 £	Deliverability Status Month 6	Net Saving Achieved at Period 6 £
Health and Community Care					
Roll out of multidisciplinary teams - Community Care and Health	Helen McArthur	Amber	55,000	Amber □Red	0
Day Centres - Older People	Helen McArthur	Green	38,232	Green	38,232
Deliver the Strategic Plan objectives for Older People's Residential Services	Helen McArthur	Green	130,350	Amber	0
Care at Home - Reablement Investment	Helen McArthur	Amber	500,000	Amber □Red	0
Assessment and Self Directed Support	Isabel Marr	Green	150,000	Amber □Red	0
Packages of Care	Isabel Marr	Amber	150,000	Green	150,000
Mental Health and Learning Disabilities					
Integration of the Learning Disability team	Jan Thomson	Amber	56,000	Green	56,000
Mental Health - Tarryholme / Trindlemoss (Council element)	Jan Thomson	Amber	328,000	Amber	150,000
Trindlemoss (full year impact is £0.370m)□NHS element	Jan Thomson	Amber	250,000	Green	0
LD - Reduction to Sleepover Provision	Jan Thomson	Amber	215,000	Red	25,000
Reprovide Fergushill/Hazeldene at Trindlemoss & redesign commissioned services	Jan Thomson	Green	111,000	Green	0
Adult Community Support - Commissioning of Services	Jan Thomson /Julie Barrett	Green	388,000	Amber □Red	1,500
UnPACs - 7% reduction□	John Taylor	Green	200,000	Amber □Red	0
Substitute Prescribing - 5% reduction□	John Taylor	Green	135,000	Green	135,000
Review of Elderly Mental Health Inpatients□	William Lauder	Green	727,000	Green	0
See a 5th bed at Woodland View - MH inpatients□	William Lauder	Amber	90,000	Amber □Red	0

Children, □amilies and □ustice Services					
Fostering - reduce external placements.	Mae Henderson	Green	127,408	Green	127,408
Children's residential placements (CF)	Mae Henderson	Amber	355,000	Amber □Red	0
Partnership Wide					
Charging Policy	Lisa Duncan	Green	200,000	Green	200,000
Reduce business admin services	Julie Davis	Green	50,000	Green	50,000
ICF Project - Partnership Enablers	Michelle Sutherland	Amber	27,000	Green	27,000
ICF Project - Buckreddan care home	Michelle Sutherland	Amber	16,000	Amber	8,000
Uncommitted ICF Funding	Michelle Sutherland	Green	80,000	Green	80,000
Living Wage	n/a	Green	187,000	Green	187,000
Resource Transfer to South Lanarkshire	n/a	Green	40,000	Green	40,000
19/20 impact of 18/19 part year savings	Stephen Brown	Green	113,000	Green	113,000
Respite	n/a	Green	200,000	Green	200,000
Payroll Turnover Target	Stephen Brown	Amber	500,000	Amber	208,333
Lean Efficiency Programme	Stephen Brown	Green	50,000	Amber	0
Payroll Turnover Target - Mental Health □	Thelma Bowers	Amber	300,000	Green	300,000
Payroll Turnover Target - Other Services	Thelma Bowers	Amber	365,000	Green	365,000
			6,133,990		**2,461,473**

Ref	Service Area	Action	Service Impact	I□B Support	Included in P6 Position £000□s	Planned Impact £ 000□s	Responsible Officer
Health and Community Care:							
1	Care at Home	**Reduction in Care at Home Provision:** - reduce weekly hours of purchased provision by between 50 and 100 hours per week, by closing cases for clients admitted to hospital. - review care packages with any reduction in hours closed to offset the overspend. - continue to review the actions of Independent Providers in the use of CM2000 for maximum efficency - further roll out and embedding of reablement approach in CAH service to allow packages to be reduced	May lead to delays in care at home packages being delivered and may impact on hospital discharges and increase delayed discharges. May have impact on waiting list. Risk of this will be mitigated by ensuring resources are used efficiently, with a risk based approach to allocating resources.			200	Helen McArthur
2	Care Homes - Respite Placements	**Health and Community Care Service to enforce a policy and criteria in relation to emergency respite in commissioned care home settings**: - significant increase in emergency respite where in many cases residents are placed in long term care, action taken to fund long term placements in September - change of practice for social workers in relation to use of respite - provide clairty to commissioned care home providers that respite beds will be used for short term care to ensure expectations of service, care home and service user are aligned	Action has been taken to address current placements to ensure the service delivered is equitable, that the HSCP are appropriately financially assessing residents and that the commissioned care homes are funded for long term care placements. The appropriate use of emergency respite placements will be reinforced to the social work team. The longer term commissioning and use of respite provision for older people is being considered as part of the Care Home Strategy.	√	√	-	Helen McArthur
3	Equipment & Adaptations	**Temporary reduction (2019-20 only) in the e□uipment and adaptations budget**. - mirrors the reduction made in 2018/19 to assist with overall financial position, would not be sustainable on a recurring basis as provision of equipment fundamental to keeping people safe at home - priority for equipment provision will be: 1. support for end of life care 2. complete adaptations started or committed to in writing prior to tightened control of expenditure 3. maintain equipment and adaptations in situ and on which service users depend 4. provide essential equipment to support avoidance of hospital admission	Potential delays to equipment and adaptations for service users, this will be kept under review together with any waiting lists and impact on delivery of community based services, including monitoring the costs of any delays in supporting individuals to be supported in the community.		√	200	Helen McArthur

Ref	Service Area	Action	Service Impact	I□B Support	Included in P6 Position £000□s	Planned Impact £ 000□s	Responsible Officer
Mental Health and Learning Disabilities:							
4	Learning Disabilities	**Prioritised Review of Adult Community Packages:** - targeted reviews to be carried out immediately, reviews co-ordinated on a prioritised list with a focus on individuals moving service provider following the outcome of the tender exercise and with high cost packages being prioritised - will be supported with significant additional LD social work capacity with additional professional lead, additional social workers and the employment of agency staff to accellerate planned reviews - reviews will ensure the split of personal and non-personal care is appropriate and equitable (to ensure equity of provision and charging) - direct payments to be reviewed to progress claw-back of underspends - incorporates looking at clients where the service provided has been less than than commissioned to formalise re-alignment of care packages based on need.	Service users will be reviewed by a dedicated review team, the outcome should ensure that all reviews are up to date and appropriate and equitable levels of care are being provided. This process may cause some anxiety for service users as there is an expectation that significant reductions can be made to care packages. No reduction will be made to care packages unless deemed to be safe and appropriate by the service, however there may be some resistance to change from service users, their families and advocates.	√		750	Thelma Bowers
5	Learning Disabilities	**Trindlemoss development finalise the financial impact of the new service (LD day service, complex care unit and supported accommodation)**: - for 2019/20 require to plan to mitigate delay in savings being achieved - opportunities to further reduce cost of amalgamating day services - identifying supports required for service users in supported accommodation - policy in relation to eligibilty and prioritisation for supported accommodation, model of care blueprint for other supported accommodation coming online	The opening of the new service at Trindlemoss (originally planned August 2019) has been delayed due to delays in the building works, this has impacted on the timescales for service users and patients transferring. The service will require to be configured around the affordability of the care and support, taking into account the positive environment and the opportunities the shared accommodation space offers in terms of reducing existing high cost care packages.	√		tbc	Thelma Bowers
6	Learning Disabilities	**Sleepovers - develop policy in relation to 24 hour care for Adults in the Commnunity:** - policy decision to not provide one to one 24 hour sleepover service where there are: □supported accommodation alternatives available; □opportunities for service users to share a service (will be identified by geographically mapping services); or □where technology supports can be provided supported by a responder service. - Recovery plan action and financial impact is based on a plan to deliver a responder service from the Trindlemoss supported accommodation to support removal of sleepovers in the area	This will result in the removal of one to one 24 hour support from service users, an enhanced overnight service will be provided from Trindlemoss to support capacity for response. Individual service user safety will be a priority and the one to one support will only be removed where safe to do so.	√		128	Thelma Bowers
7	Learning Disabilities	**Transition Cases (Adults aged 65□):** - reviews undertaken jointly with LD and Older People's service which will deliver some savings, some work outstanding in relation to these reviews where changes to care packages have been identified - further action to scrutinise outcome of reviews and equity of service provision across client groups, particularly for high cost care packages which are not equitable with community care provided in Older People's services - requires a clear policy decision in relation to transitions of care and funding for community based supports *Note that there have been several reviews undertaken which indicate that savings will be made. These savings can be limited in some of the more complex care packages as care is required on a 24/7 basis.*	Service users are being reviewed with a view to reducing the cost of packages as the clients transition to the Older People's service. Some reviews for high cost community packages have identified individuals suitable for the criteria of long term care but resistance from service users to change from current care and support. If care packages cannot be reduced the IJB will be asked to agree a policy decision on the level of care provided in such cases.			134	

Ref	Service Area	Action	Service Impact	I□B Support	Included in P6 Position £000□s	Planned Impact £ 000□s	Responsible Officer
8	Adult Community Packages	**Adult Resource Group no overall increase in care package provision:** - ARG in place for Mental Health and Learning Disability care packages for approval, ARG will no longer be permitted to approve any increase to existing or new care packages unless there has been a reduction in service elsewhere - will require social workers to proactively review caseload and use finite resource available to support whole client group - arrangements will remain in place until the service brings the overall expenditure on community care packages back into line	Service users assessed as requiring a service will have to wait until resource has been identified to fund the care package, this is equitable with waiting lists for other services where resources are limited. This may result in delays in supports being provided but will also ensure that the service is managing, directing and prioritising resources effectively.	√			Thelma Bowers
9	All	**Self Directed Support:** - exploring how to embed this alongside the asset based approach promoted through the HSCP *Thinking Different, Doing Better* experience into services to change how we deliver services and balance service user and community expectations - undertaking self-evaluation for North Ayrshire against good practice, this will include stakeholder engagement to develop future approach	Positive impact to embed Self Directed Support, with a view to being realistic in managing expectations of services and service users. Address a perceived inequity in how services are delivered and how embedded SDS is across social care services.	√		-	Stephen Brown
Children and □amilies:							
10	Looked After and Accomodated Children	**Children□s External Residential Placements bring forward planned discharge dates:** **-** overspend due to delays in bringing children back from expensive external residential placements due to timescales slipping, recovery action based on pulling forward all estimated timescales by one month and moving to planned level of 14 placements by March 2020 - scrutiny of detailed plans for individual children, to be reviewed alongside the internal children's houses to free up capacity to bring children back to NA sooner - close working with Education services as shared ambition and requirements to provide educational supports within NA - formalise and reinforce governance arrangements for approval of new external children's placements	Transformation plan to support more looked after children in North Ayrshire is focussed on delivering more positive outcomes for Children. Accellerating plans to move children to different care settings is challenging for the service as these are sensitive complex cases.			200	Alison Sutherland

Ref	Service Area	Action	Service Impact	I□B Support	Included in P6 Position £000□s	Planned Impact £ 000□s	Responsible Officer
Other:							
11	All	**Recruitment free□e non-front line posts:** **-** hold recruitment to all vacant non-front line care posts, eg support services, admin support - partnership vacancy scrutiny group remains in place and will ensure posts are not approved for recruitment until the new financial year	Minimal impact on front line services but depending on where vacancies arise during the rest of the year could have an impact on the capcitay of support services, in particular to respond to service requests. The HSCP vacancy scrutiny group will ensure consideration is given to the impact on services when recruitment is delayed for individual posts.			200	Caroline Whyte
12	All	**Moratorium non-essential expenditure:** - communication issued to all budget holders (social care and health) with an instruction to delay or cease any areas of discretional spend (areas including supplies and services, training, third party payments etc) - finance teams will liaise with budget holders as part of regular engagement and budgets will be removed non-recurringly to allow target reduction to be met	Minimal impact on front line services but is a short term one-off approach to reducing expenditure.			184	Caroline Whyte
13	All	**Systems improvements re care packages:** - Extension of CM2000 to adult services which will enable payment to care providers based on actual service delivered, being rolled out to some providers in advance of new tender - finance working with services to review areas where service delivered differs from that commissioned to improve systems and basis of financial projections, this work also supports ongoing reviews - action plan in relation to improving projections and actions identified from recent internal audit report re Community Based Care, including streamlining systems and processes to remove duplication, scope for error and reliablity of information	Significant work requried to review systems across social care services where different approaches are used for different service areas, some areas involve duplication of information and systems. Work will result in more assurance re the information reported, including financial projections and will also ensure the partnership has assurance that we only pay for the direct care delivered.		√	-	Thelma Bowers/ Helen McArthur/ Caroline Whyte
		TOTAL				**1,996**	
			Less achieved to date (Aids and Adaptations)			- 200	
						1,796	

2019-20 Budget Reconciliation

Appendix E

COUNCIL	Period	Permanent or Temporary	£
Initial Approved Budget			95,067
Resource Transfer	3	P	22,993
ICF Procurement Posts - Transfer to Procurement	3	T	(85)
FPC under 65's Scottish Government Funding	3	P	702
Transfer to IT WAN circuit Kilwinning Academy	4	P	(3)
Waste Collection Budget	4	P	27
CLD Officer from ADP Budget to E & C	4	T	(31)
Period 6 reported budget			**118,670**

HEALTH	Period	Permanent or Temporary	£
Initial Approved Budget (based on month 9 of 2018-19)			145,425
Adjustments to reflect month 10 -12 of 2018-19 including non-recurring amounts			(1,845)
Opening baseline budget for 19-20			**143,580**
Resource Transfer	3	P	(22,993)
Superannuation Uplift	3	P	2,994
Voluntary Redundancy Scheme	3	P	271
Post from acute - PA to Clinical Nurse Manager, Long Term conditions	3	P	15
Post from acute - Clinical Nurse Manager, Long Term Conditions	3	P	34
Functional Electrical Stimulation Equipment from acute			10
Pharmacy Fees	3	P	19
HPV Boys Implementation	3	P	18
Action 15 (anticipated increase)	3	P	930
Post from Acute -Specialist Pharmacist in Substance Misuse	3	T	12
Old age liaison psychiatrist from acute	3	P	108
Patient Transport Service	3	P	49
Infant feeding nurse	3	T	41
Assoc Medical Director responsibility payment to Medical Director	3	T	(24)
Associate Medical Director sessions to the Medical Director	3	T	(71)
Contribution to the Technology Enabled Care (TEC) project	3	T	(50)
Superannuation Uplift Overclaimed	4	P	(270)
Action 15 overclaimed	4	T	(485)
Prescribing Reduction	5	P	(550)
Medical Training Grade Increase	5	P	51
Admin Transfer from South HSCP	6	P	19
NMAHP Clinical Lead	6	T	16
Period 6 reported budget			**123,724**
GRAND TOTAL			**242,394**

SOCIAL CARE FINANCIAL FRAMEWORK 2019-20

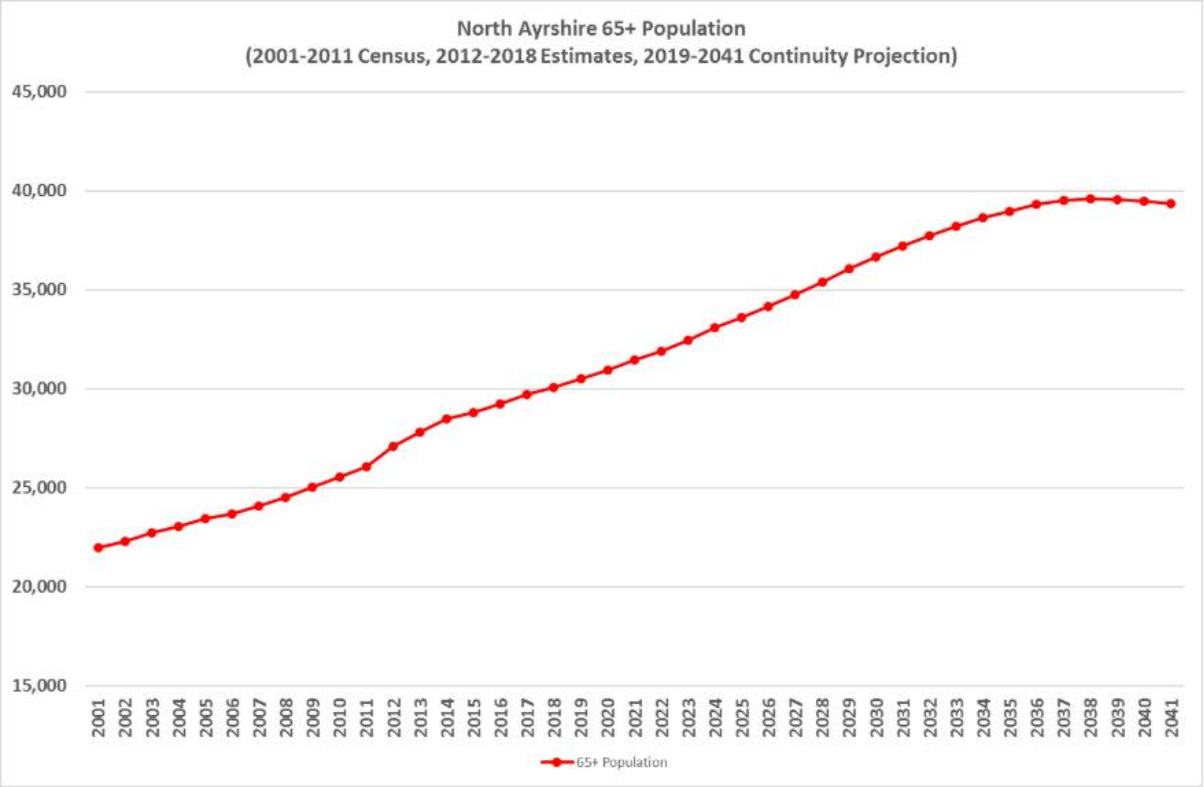
			SEPTEMBER 2019-20			AUGUST 2018-19				
Key Driver Activity	2019/20 Total Places/Hrs (BUDGET)	2019/20 Total £ (BUDGET)	2019/20 Total Places/Hrs (PROJECTED)	2019/20 Total £ (PROJECTED OUTTURN)	Average Annual Cost Per Client	2018/19 Total Places/Hrs (PROJECTED)	2018/19 Total £ (PROJECTED OUTTURN)	Increase/ (Decrease) number	Increase/ (Decrease) %	Increase/ (Decrease) £
LD - Community Packages	254	12,193,385	298	13,591,290	£45,608	296	13,110,979	2	1%	480,311
LD - Residential	35	2,391,786	41	2,753,094	£67,149	37	2,269,356	4	10%	483,739
LD - Direct Payments	27	862,000	42	1,192,360	£28,390	46	1,083,170	-4	-10%	109,190
MH - Community Packages	99	1,462,180	106	1,439,509	£13,580	101	1,448,533	5	5%	-9,024
MH - Nethermains	5	385,000	4	385,000	£96,250	4	385,000	0	0%	0
MH - Residential	24	912,245	24	981,324	£40,889	22	911,467	2	8%	69,858
MH - Direct Payments	12	145,174	17	170,972	£10,057	12	139,197	5	29%	31,776
Care Homes - Perm Nursing Places	584	13,106,488	542	12,964,477	£23,920	586	13,669,004	-44	-8%	-704,527
Care Homes - Perm Residential Places	257	4,295,880	274	4,640,677	£16,937	261	4,474,912	13	5%	165,765
Care Homes - Respite Places	6,595	512,194	9,905	769,301		9,040	578,552	865	9%	190,749
Care at Home - In-House	949,478	13,492,085	959,318	13,631,905	£12,148	916,984	12,425,137	42,333	4%	1,206,768
Care at Home - Purchased	397,194	6,676,835	442,176	7,432,973		410,605	6,717,500	31,571	7%	715,474
Care at Home - Direct Payments	35	488,967	27	382,315	£14,160	28	419,841	-1	-4%	-37,525
Community Care Packages -Physical Disabilities	40	981,476	46	1,152,528	£25,055	62	1,266,017	-16	-35%	-113,489
Residential Placements - Physical Disabilities	35	1,285,000	35	1,304,931	£37,284	31	1,124,960	4	11%	179,971
Direct Payments -Physical Disabilities	49	861,322	61	972,147	£15,937	65	838,802	-4	-7%	133,345
Kinship Care Placements	339	2,469,046	345	2,519,153	£7,302	320	2,302,410	25	7%	216,743
Adoption	74	735,000	73	738,161	£10,112	71	713,002	2	3%	25,159
Fostering	120	2,500,000	117	2,539,143	£21,702	130	2,631,007	-13	-11%	-91,864
Fostering Xtra	32	928,160	24	790,732	£32,947	30	810,836	-6	-25%	-20,104
External Foster Care	14	705,371	10	624,380	£62,438	10	642,176	0	0%	-17,796
Fostering Respite	1,730	98,831	1,952	111,564		1,938	110,686	14	1%	878
Fostering Respite Xtra	834	47,633	1,028	58,737		687	43,629	341	33%	15,109
Supported Accommodation	3	43,000	6	74,000		6	76,964	0	1%	-2,964
Residential Schools - EBD	13	2,850,180	19	4,132,003	£217,474	24	3,971,741	-5	-26%	160,262
Residential Schools - CDIS	7	1,532,392	9	1,355,279	£150,587	10	1,569,280	-1	-11%	-214,001
Residential Units	-	3,657,980	-	3,756,225	£117,382		3,274,013	0	0%	482,212
Community Packages - children	154	443,023	154	448,373	£2,912	148	433,023	6	4%	15,350
Direct Payments - children	52	444,368	41	437,147	£10,662	43	379,748	-2	-5%	57,399

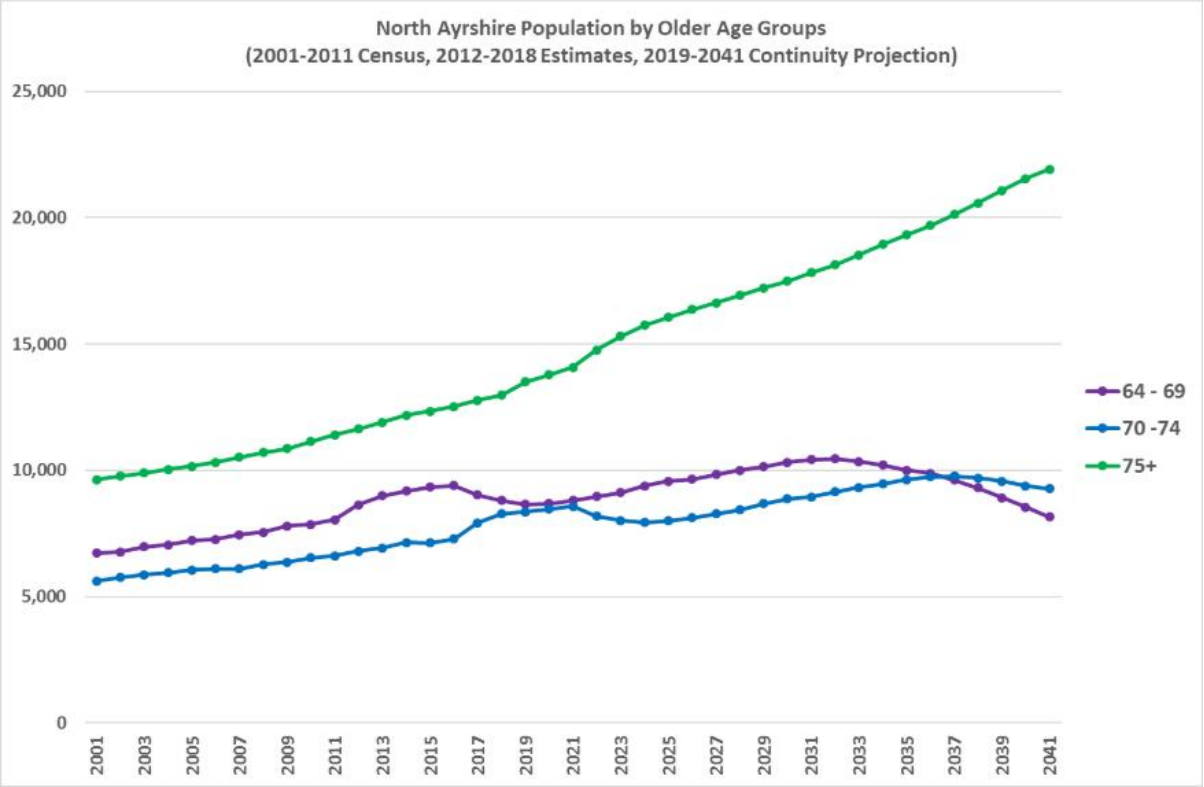
****Note - in some cases costs have increased due to the cost of services increasing - eg pay awards, inflationary increases in hourly rates**

POSITIVE MOVEMENT

NEGATIVE MOVEMENT/CHALLENGING AREA

North Ayrshire Population Pro ections – Older Age Groups





PROJECTED OVER 75'S INCREASE:

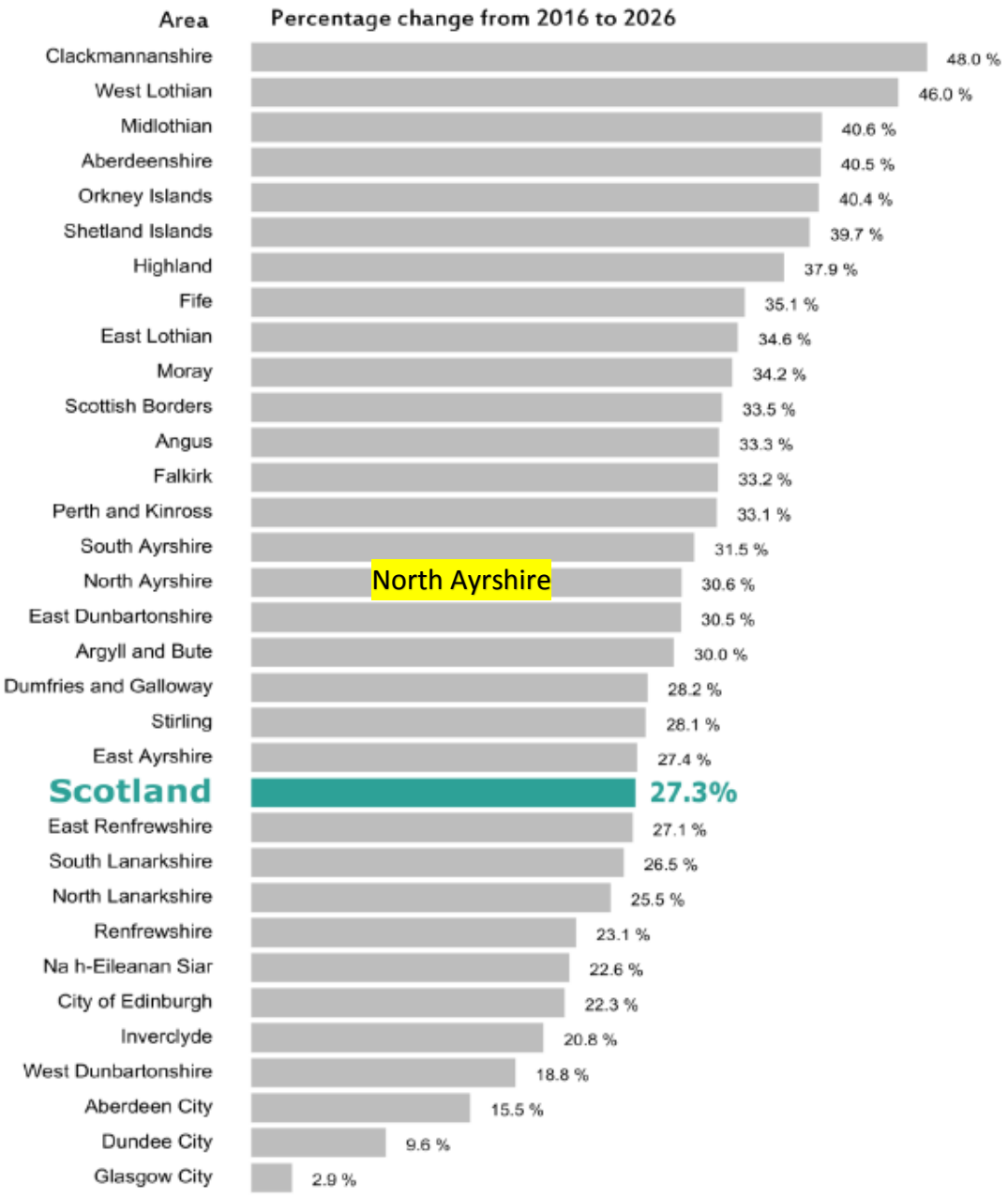
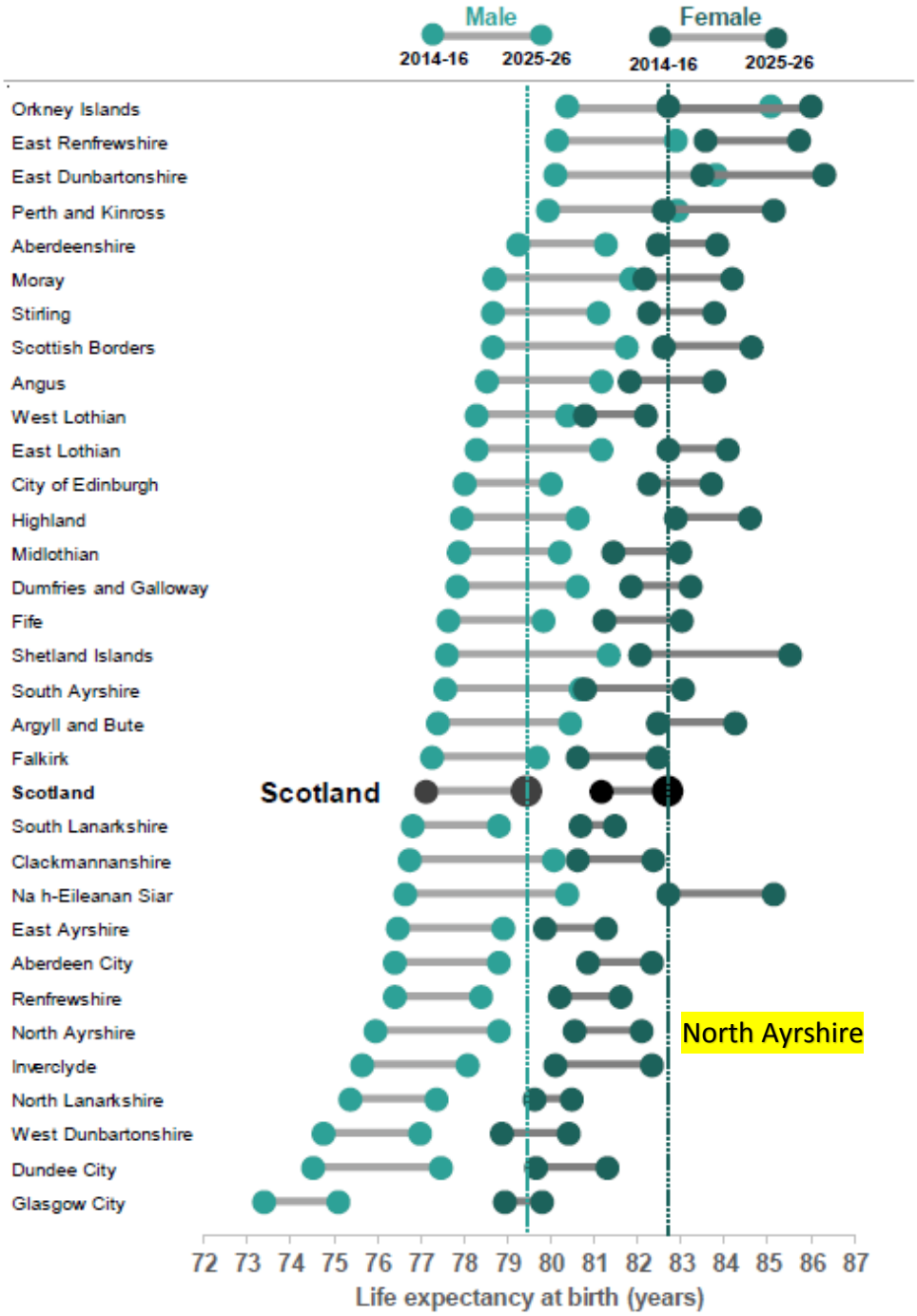


Figure 5: Estimated[1] and projected[2] life male and female expectancy at birth for council areas, 2014-16 and 2025-26



Appendix A North Ayrshire Older Age Groups Locality Population Estimates/Projections 2001-2041

North Ayrshire	Mid Year Estimates				Projections						
Age	2001	2006	2011	2016	2021	2026	2031	2036	2041	% Change 2016 - 2026	% Change 2016 - 2041
65-69	6,719	7,263	8,046	9,406	8,816	9,647	10,418	9,883	8,159	2.6	-13.3
70-74	5,623	6,095	6,615	7,292	8,571	8,131	8,951	9,735	9,279	11.5	27.2
75+	9,627	10,322	11,398	12,529	14,074	16,361	17,829	19,697	21,923	30.6	75.0
65+	**21,969**	**23,680**	**26,059**	**29,227**	**31,461**	**34,139**	**37,198**	**39,315**	**39,361**	**16.8**	**34.7**

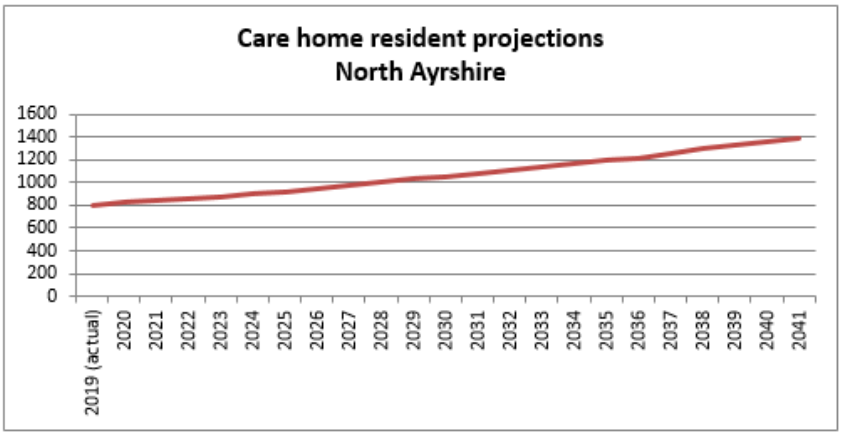
Age	% Increase 2001-2016	% Increase 2011-2016	Projected Change 2016-2021 (5yrs)	Annual Av Change 2016-2011
65-69	40%	16.9%	-6.3%	-1.26%
70-74	29.7%	10.2%	17.5%	3.5%
75+	30%	9.9%	12.3%	2.5%
65+	**33%**	**12.2%**	**7.6%**	**1.5%**

OLDER PEOPLE'S CARE HOMES

Projected number of care home residents - North Ayrshire

Projections to 2041 based on 2019 resident numbers and North Ayrshire population projections

	North Ayrshire		
	Female	Male	Total
2019 (actual)	578	227	805
2020	587	235	822
2021	597	241	838
2022	610	248	858
2023	623	256	879
2024	634	266	900
2025	647	275	922
2026	660	282	942
2027	681	293	973
2028	700	304	1003
2029	719	314	1032
2030	731	321	1052
2031	742	330	1072
2032	763	341	1103
2033	785	351	1136
2034	807	360	1167
2035	822	368	1190
2036	840	377	1218
2037	872	389	1261
2038	899	398	1297
2039	923	408	1331
2040	942	416	1358
2041	961	423	1384



Projection based on 'status quo' - straight population projection

Need to adjust for:

- future length of stay
- age of admission, eg older and frailer
- supported accommodation alternatives (sheltered or extra care housing)
- split between residential and nursing care
- alternative models - eg respite, step up step down, end of life
- investment in care at home and other community services
- impact of MDT working across health and social care

CHANGES AIM TO MITIGATE AGAINST AN INCREASE IN DEMAND

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CIPFA IJB CFO Section

Integration Authorities Financial Performance

Financial Year 2019/20 (Quarter 1)

OVERVIEW - BUDGET POSITION 2019/20

This is the first summary report which presents the overview of financial performance for all Integration Authorities (IA's) for quarter 1 of the financial year 2019/20. The position in respect of the NHS Highland Lead Agency arrangement is also included. The total budget for health and social care services in 2019/20 is currently forecast at £9,237m (Set Aside £812m; Non-Set Aside £8,396m; Reserves £29m). 26 IAs are reporting a set aside budget for 2019/20. This is expected to increase to 27 once Perth & Kinross is included.

FINANCIAL VARIANCES 2019/20 – YEAR-END OUTTURN AND YEAR TO DATE

IAs have different reporting approaches. At this stage of the financial year, 26 IAs report projected outturns for the year-end and 5 IAs report year to date (first quarter) positions.

Of the 26 IAs, representing £6,318m of the total budget, a year end overspend of £84.1m is projected. Projected outturns across these IAs vary as follows:

- 22 IAs are projecting overspends totalling £87m
- 1 IAs is projecting a break-even position
- 3 IAs are projecting underspends totalling £3m

This is the position before additional financial support from partners, the impact of financial recovery plans and the further use of reserves is taken into consideration.

Year-end Projected Outturn

- £40m non delivery of savings
- £15m demographics
- £9m staffing pressures
- £7m prescribing
- £2m price increases
- £11.1m other net cost pressures

Projected cost pressures - £84.1m

Year to Date Position

- £2.9m non delivery of savings
- £1.8m demographics
- £0.9m staffing pressures
- £0.7m prescribing
- £3.9m net underspends

Year to date cost pressures - £2.4m

Of the 5 IAs, representing £2,919m of the total budget, a year to date overspend of £2.4m is reported at the end of quarter 1.

The year to date positions across these IAs vary as follows:

- 3 IAs are projecting overspends totalling £3.6m
- 2 IAs are projecting underspends totalling £1.2m

SIGNIFCANT FACTORS 2019/20

The factors contributing to the variances reported by IAs are detailed on the schedule which accompanies this covering report.

The key highlights are summarised as follows:

- the challenge to deliver savings, in particular planned reductions in services not materialising due to inceased demand being experienced
- increased activity of acute services
- additional demand for services and the increasing complexity of health and social care needs across older people, adult and children's services
- the timeline to implement new models of service delivery taking longer than originally anticipated
- ongoing challenges associated with identifying further cost reduction and savings opportunties
- prescribing cost pressures; and
- staffing costs including the cost of locums.

As part of their financial strategies, 14 IAs are relying on the planned use of reserves totalling £29m at this stage of the financial year. The increase in costs is partly offset by underspends as a result of staff vacancies and slippage in the implementation of new funding, both of these provide non-recurring financial relief.

Work continues to be progressed to develop the set-aside monitoring arrangements.

IMPACT ON FUNDING 2019/20

It is currently estimated that the projected overspend totalling £86.5m will be addressed as follows:-

▪ Anticipated additional funding from NHS Boards	£26.7m
▪ Anticipated additional funding from Local Authorities	£6.4m
▪ Agreed financial recovery plan with no impact for partners	£16.4m
▪ Other	£7.0m

The funding impact of £30m remains 'not yet determined' or has still to be publicly reported in respect of 13 IAs.

A total of 4 IAs are in repayment arrangements with partners (£12.1m).

Repayment of Funding Advances

- £2.5m in 19/20
- £9.6m due 20/21 or later

UPDATE ON RESERVES

The net movement on IA's reserves is a decrease of £45m from 1st April 2019 of £158m to £113m (Earmarked £81m; Contingency £32m. The contingency reserve represents 0.4% of the total financial envelope of £9,237m. 9 IAs do not have a reserve. 4 do not have a contingency reserve. 1 IA has a negative reserve. For 17 IAs, the contingency reserves range from 0.03% to 1.2% of their available funding.

FUTURE REPORTS

IA's will continue to standardise presentation.

NHS in Scotland 2019

AUDITOR GENERAL

Prepared by Audit Scotland
October 2019

Auditor General for Scotland

The Auditor General's role is to:

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

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

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

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

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

Contents

Links

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Exhibit data

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

Audit team

The core audit team consisted of:
Leigh Johnston, Fiona Watson, Eva Thomas-Tudo, Agata Maslowska, Veronica Cameron and John Kirkwood with support from other colleagues and under the direction of Claire Sweeney.

Key facts

Workforce spending, 53 per cent of revenue spending

£6.9 billion

£13.4 billion

NHS budget for 2018/19

Reduction in capital funding from the Scottish Government over the last ten years

63 per cent

£65.7 million

Additional financial support from the Scottish Government needed by NHS boards in 2018/19

People in hospital who reported a positive experience of care

86 per cent

Two out of eight

Key national waiting times targets met by NHS Scotland in 2018/19

1.7 million

Accident and Emergency Department (A&E) attendances.
Increased by 2.8 per cent since last year

Summary

Key messages

1 Health remains the single biggest area of government spending, at £13.4 billion in 2018/19. This was 42 per cent of the 2018/19 Scottish Government budget and is growing. The healthcare system faces increasing pressure from rising demand and costs, and it has difficulty meeting key waiting times standards. Without reform, the Scottish Government predicts that there could be a £1.8 billion shortfall in the projected funding for health and social care of £18.8 billion by 2023/24. So far, the pace of change to address this, particularly through the integration of health and social care, has been too slow.

2 The Scottish Government has started to put in place foundations to support boards make the changes required. These include the publication of the *Health and Social Care: Medium-Term Financial Framework*, the *Waiting Times Improvement Plan* and the introduction of a national leadership development project. The new requirement for NHS boards to develop three-year financial and performance plans enables them to more effectively plan how services will be delivered in the longer term. It is, however, too soon to assess the impact of these initiatives.

3 Despite the existing pressures, patient safety and experience of hospital care continue to improve. Drugs costs have stabilised, and we have seen examples of new and innovative ways of delivering healthcare that involve a range of partners. These aim to increase the care provided in the community and expand multidisciplinary working, to improve access to care and treatment.

4 Achieving financial sustainability remains a major challenge for NHS boards. There have been increases in predicted deficits and additional financial support provided by the Scottish Government, and a continued reliance on one-off savings. Capital funding from the Scottish Government has decreased by 63 per cent over the last decade and the level of backlog maintenance remains high, at £914 million. High-profile, newly-built hospitals have come under significant scrutiny because of health and safety concerns.

5 The ambitions within the Scottish Government's 2020 Vision will not be achieved by 2020. The Scottish Government should work with NHS staff, partners and the public to develop its new strategy for health and social care. It should set out priorities that support large-scale, system-wide reform to increase the pace of change. Collaborative leadership is needed to focus on better partnership working, staff engagement and promoting positive workplace behaviours. Staff are at the heart of the NHS and it is vital that more is done to support them so that they can care for people in a safe, fulfilling and respectful environment.

Recommendations

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

- develop a new national health and social care strategy to run from 2020 that supports large-scale, system-wide reform, with clear priorities that identify the improvement activities most likely to achieve the reform needed
- develop and publish the national, integrated health and social care workforce plan and guidance, to inform future workforce planning
- improve the quality and availability of data and information, particularly in primary and community care. This will allow better performance monitoring, inform service redesign and improve care coordination by enhancing how patient information is shared across health and social care services
- incorporate the principles of the Community Empowerment Act within communication and engagement strategies.

The Scottish Government should:

- finalise and publish as a matter of urgency, the national capital investment strategy to ensure that capital funding is strategically prioritised
- report publicly on progress against the health and social care delivery plan. This should provide an update, and include measures of performance, on how services are being delivered differently to allow more people to be cared for closer to home
- develop a single annual staff survey that relates to behaviours, culture and staff experience, to identify areas for improvement and address behaviour that is contrary to NHS Scotland values.

The Scottish Government in partnership with NHS boards should:

- make sure that NHS boards' three-year plans are approved in time for the start of each financial year. The plans should be routinely managed and monitored and should include details of how boards intend to reduce their reliance on non-recurring savings
- ensure that the *NHS Scotland A Blueprint for Good Governance* is implemented in full and that areas for improvement are addressed, particularly around strengthening risk-management arrangements
- continue to monitor the effectiveness of the Scottish Government's NHS leadership development project and its impact on recruitment, retention and the support of senior healthcare leaders
- ensure that all NHS boards:
  - provide evidence that they actively promote positive workplace behaviours and encourage the reporting of bullying and harassment
  - have action plans in place to improve culture, address any issues identified and use the findings of the Sturrock review to inform their plans for cultural improvement.

Introduction

1. The NHS provides vital health services to the people of Scotland. People are living longer, many with chronic health conditions. There are greater expectations for the NHS to provide high-quality, timely and technologically advanced care. Pressures on the NHS in Scotland continue to be substantial and demand for services is at an all-time high. Between 2017/18 and 2018/19 the NHS in Scotland saw:

- an increase of 2.2 per cent in people waiting for outpatient appointments
- an increase of 2.8 per cent in Accident and Emergency Department (A&E) attendances
- an increase of 6.1 per cent in people waiting for inpatient appointments.

2. Wide-scale reform is necessary to address the increasing pressures on the NHS and reduce demand for acute services. The Scottish Government has had a long-term commitment to delivering care closer to home. To achieve this, the successful integration of health and social care is vital. Effective collaboration with community partners will support better planning, design and coordination of patient-focused care and services.

3. In 2018/19, the NHS in Scotland received £13.4 billion from the Scottish Government. This funding is needed to support the increasing cost of healthcare delivery and to meet national policy directives such as integration and reducing waiting times. *The Health and Social Care: Medium-Term Financial Framework* (MTFF), published in October 2018, sets out the reforms required to ensure the financial sustainability of the NHS in Scotland. Without reform the Scottish Government predicts that there will be an increase in spending across health and social care in Scotland to around £20.6 billion by 2023/24.

4. Despite the significant challenges, the NHS in Scotland has a committed workforce that continues to provide high-quality, safe care. There have been significant improvements in key patient safety indicators, such as mortality rates in hospital, and patients' experiences of healthcare has also improved.

5. This report provides an overview of the NHS in Scotland and the realities of delivering healthcare in Scotland. It draws on a wide range of intelligence, interviews and data, to help understand the context, challenges and performance. It sets out the financial performance of the NHS in 2018/19, and the financial outlook for 2019/20 and beyond. This includes the new approach to longer-term financial planning and the new MTFF, and progress towards achieving the objectives of the Health and Social Care Delivery Plan (HSCDP). We report on the workforce, leadership and culture, governance and performance against national targets.

Part 1

How the NHS in Scotland is performing

Key messages

1 The NHS budget for 2018/19 was £13.4 billion, an increase of one per cent in real terms since 2017/18. Four NHS boards required a total of £65.7 million in additional financial support from the Scottish Government to break even. The NHS achieved £390.4 million in savings, less than one per cent below its target, but remains reliant on one-off savings. Fifty per cent of all savings were non-recurring.

2 The Scottish Government has started to put in place foundations to support financial sustainability. The introduction of new three-year financial and performance plans and break-even arrangements is an important step towards more effective longer-term planning.

3 The NHS in Scotland is facing growing pressures from population changes and increasing costs of delivering healthcare. NHS boards and the Scottish Government have implemented a range of initiatives to manage these pressures. Some progress has been made. For example, spending on drugs has stabilised.

4 The NHS capital budget decreased by 63 per cent over the last decade. The level of backlog maintenance remains high, at £914 million, with nine per cent being classified as high risk. High-profile new builds have come under significant scrutiny because of health and safety concerns.

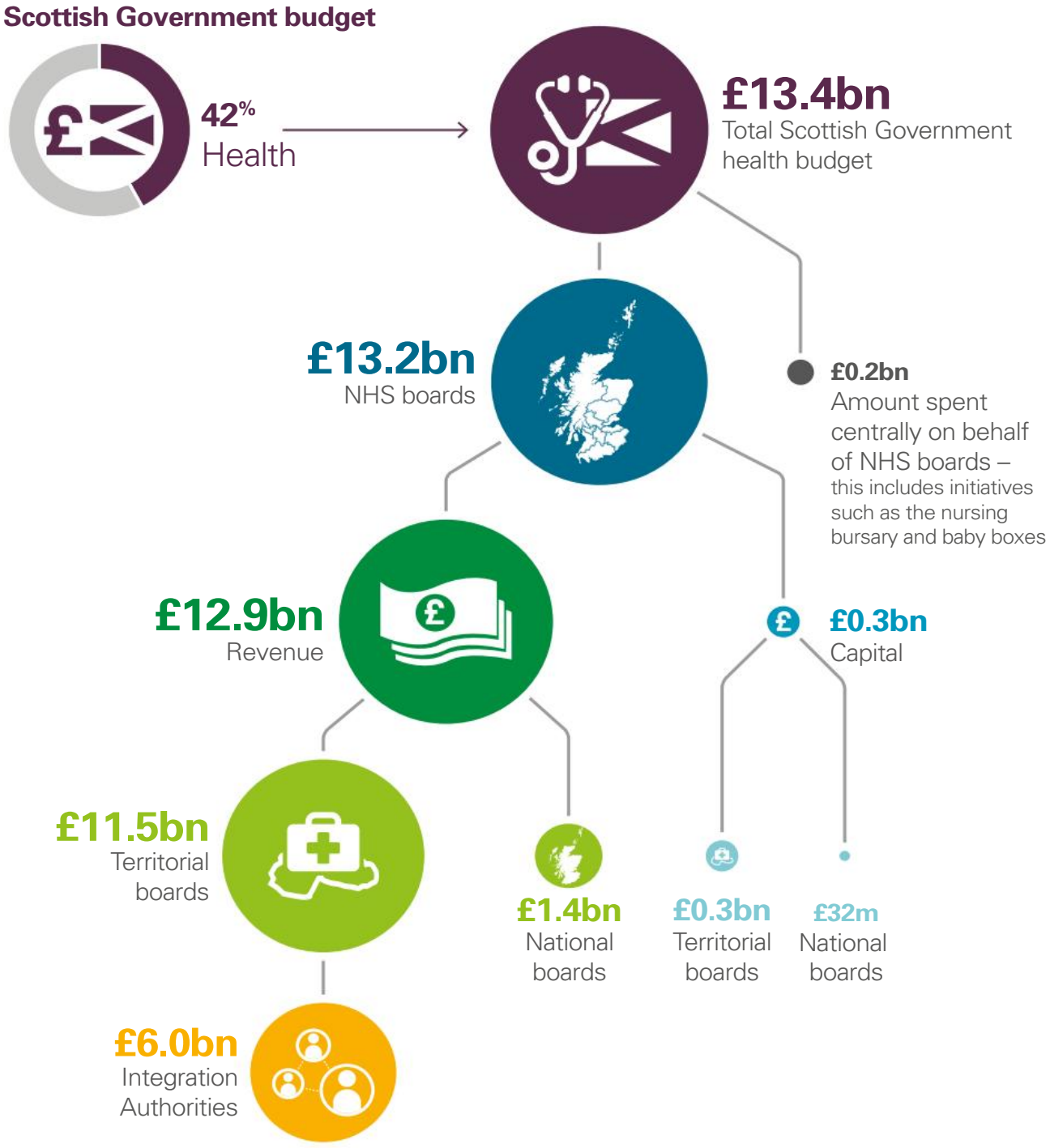
5 Patient safety is continuing to improve, with a significant reduction in hospital mortality rates. People's experience of hospital care is also improving. However, boards continue to struggle to meet key waiting times standards, with only two of eight national standards being met. But in seven of the eight standards, the number of people that were seen and treated on time increased. The Scottish Government has introduced several initiatives to improve access to care, such as the *Waiting Times Improvement Plan* (WTIP).

The NHS is starting to address some of its financial pressures, but major risks remain

6. In *NHS in Scotland 2018*, we reported that the NHS was not in a financially sustainable position. This meant that it was unlikely to be able to continue delivering services effectively or change how services are delivered with the available resources. NHS boards continue to struggle with financial pressures, which makes it harder to reform the health and social care system.

7. The Scottish Government health budget in 2018/19 was £13.4 billion. This was one per cent higher than the previous year, taking inflation into account. Of this, the amount allocated to NHS boards was £13.2 billion. The total revenue budget, for day-to-day spending, allocated to NHS boards was £12.9 billion. This has increased by 0.6 per cent in real terms since 2017/18 (Exhibit 1).

Exhibit 1
A breakdown of NHS funding in 2018/19



Source: Audit Scotland using NHS Consolidated Accounts

8. Health accounted for 42 per cent of the Scottish Government's budget in 2018/19. NHS boards delegate a significant proportion of their budgets to Integration Authorities (IAs) to fund health services such as primary and community care. In 2018/19, territorial boards delegated £6 billion to IAs, 52 per cent of their budget.

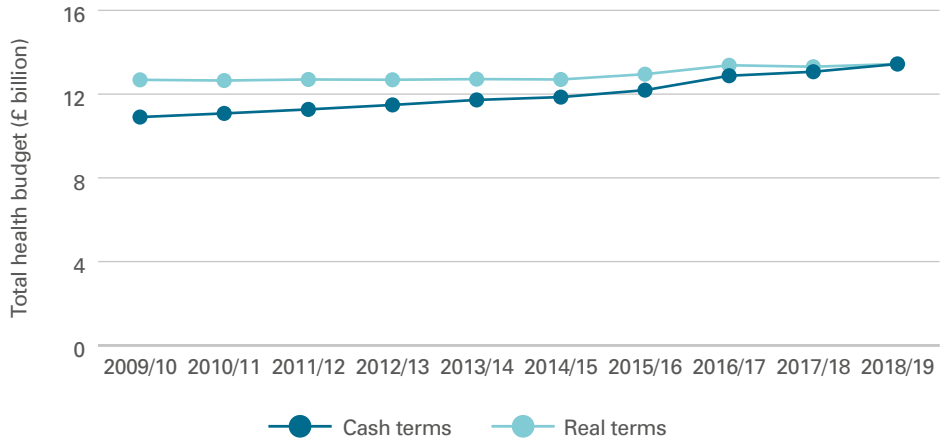
9. Over the last ten years, the health budget has increased by six per cent in real terms. Most of this increase has been in the last five years, with an increase of 5.8 per cent (Exhibit 2). Funding per head of population has increased at a slower rate. In 2018/19, health funding in Scotland was £2,471 per person. This compares to £2,424 in 2009/10, a two per cent increase in real terms.[1]

10. The Scottish Government's draft budget for 2019/20 states that health funding will increase to £14.2 billion, an increase of 5.4 per cent in cash terms. Revenue funding is planned to increase by 5.6 per cent and capital funding is set to decrease by 1.5 per cent in cash terms.[2]

Exhibit 2

Health funding trend since 2009/10

Health funding has increased in both real terms and cash terms since 2009/10.



Source: Scottish Government budgets

Without ongoing reform, there could be a rise in spending across health and social care services to around £20.6 billion by 2023/24

11. Last year, we reported that the publication of the MTFF aimed to better address the financial challenges of integrating the delivery of health and social care services. The framework acknowledges that there will be increases in demand for services, workforce pay and the cost of delivering healthcare services. It predicts that without reform there will be a £1.8 billion shortfall in the projected funding of £18.8 billion by 2023/24.[3]

12. In 2016, the Scottish Government published its five-year **HSCDP** (i). It set some ambitious targets intended to drive the integration of health and social care across the NHS in Scotland to help achieve the 2020 Vision.[4] Last year, we recommended that the Scottish Government should publish a report on progress

Exhibit 13

A timeline of major Scottish Government health and social care policies and publications
(page 31)

against the HSCDP. This has not yet been published and we recommend the Scottish Government do so as soon as possible. Further work is required to achieve the reform needed across health and social care. This work will not be completed in time to achieve the 2020 Vision.

13. NHS boards delegate funding to IAs for certain health services. This funding has increased each year since 2016/17, when IAs were established. In 2018/19, NHS territorial boards delegated 52 per cent of their budgets to IAs. This represents a 4.1 per cent increase in real terms from 2016/17.[5] IAs aim to shift spending and services from hospitals to community and social care. There is little evidence to date that this is happening.

At the beginning of 2018/19 the number of boards predicting a year-end deficit increased

14. Last year, we reported that the number of boards predicting year-end deficits had increased. These boards needed to make additional savings to offset any predicted overspend against their budget. There is a risk that boards will be unable to break even and will require additional financial support from the Scottish Government:

- In 2015/16, all territorial NHS boards predicted that they would break even or record a surplus by the end of the year.
- By 2016/17, three territorial boards predicted a year-end deficit, which increased to seven in 2017/18 and nine in 2018/19.
- The number of boards that required additional financial support from the Scottish Government, to break even at year end, were: one (2016/17), three (2017/18) and four (2018/19).
- The size of the predicted deficit also increased for 2018/19, from £99 million to £150 million, but decreased to £116 million for 2019/20. For 2021/22, however, the deficit is predicted to be significantly larger, at £207 million. Most of this deficit relates to NHS Lothian, which predicts a deficit of almost £90 million, and NHS Greater Glasgow and Clyde, which predicts a deficit of £61.5 million.[6]

The NHS in Scotland met its financial targets in 2018/19, but required £65.7 million in additional financial support from the Scottish Government to achieve this

15. In 2018/19, all NHS boards broke even, staying within the limits of their revenue and capital budgets, and delivered a surplus of £4.6 million.[7] However, this was only possible because four boards received additional financial support from the Scottish Government, totalling £65.7 million.[8] This was an increase from £50.7 million in 2017/18, but was £8.8 million lower than initially forecast. The four boards that required additional support were:

- NHS Ayrshire and Arran – £20 million
- NHS Borders – £10.1 million
- NHS Highland – £18 million
- NHS Tayside – £17.6 million.

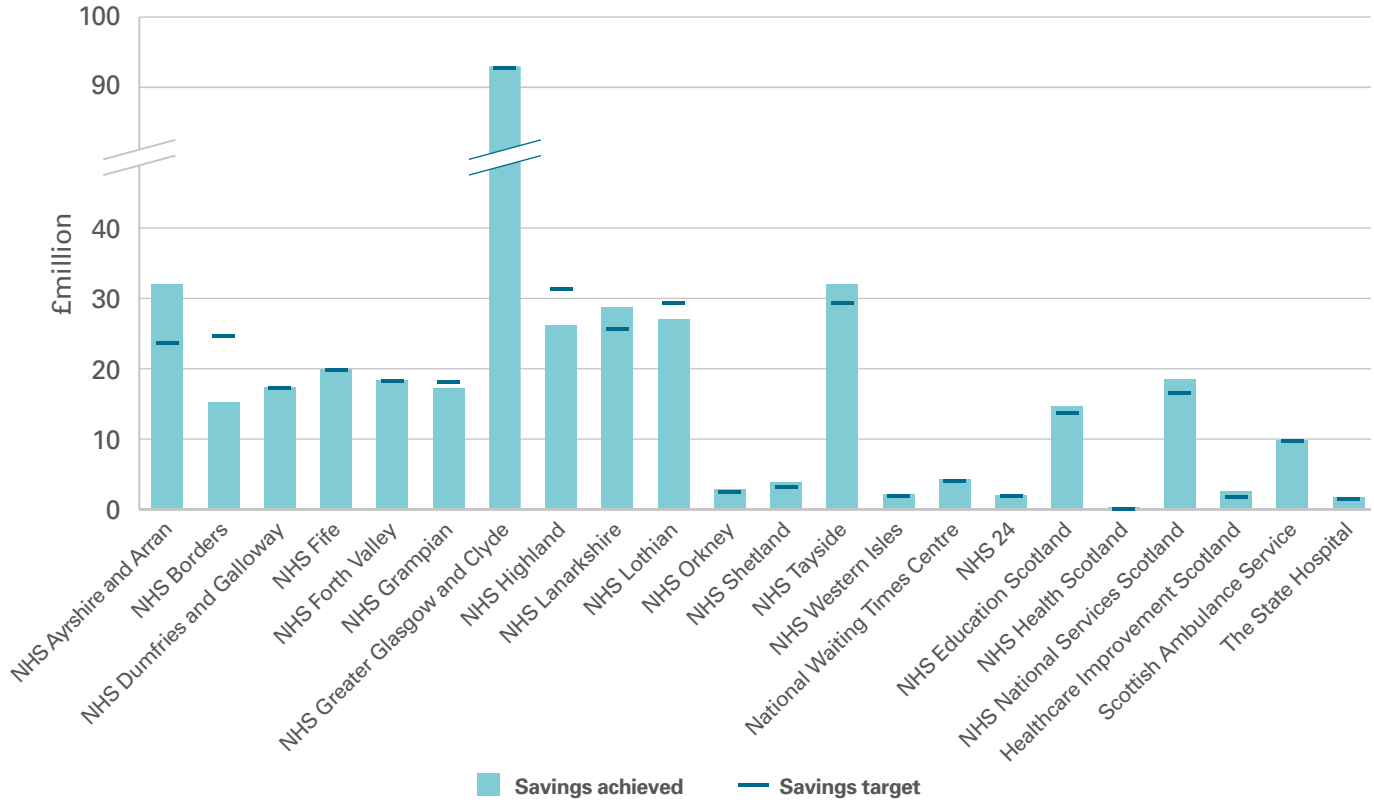
16. The Scottish Government announced that territorial boards would not have to repay any outstanding loans owed at the end of 2018/19. This totalled almost £150 million.[9] It is unclear what the Scottish Government's approach will be if boards require additional financial support in future years.

The NHS almost achieved its savings target for 2018/19, but remains reliant on one-off savings

17. In 2018/19, the NHS achieved £390.4 million in savings. This was 0.3 per cent below its savings target of £391.1 million. This was a significant improvement compared with the previous year, when it achieved savings seven per cent below its target of £480.8 million. Exhibit 3 shows the savings achieved against targets for all NHS boards.

Exhibit 3

Savings achieved against targets in 2018/19



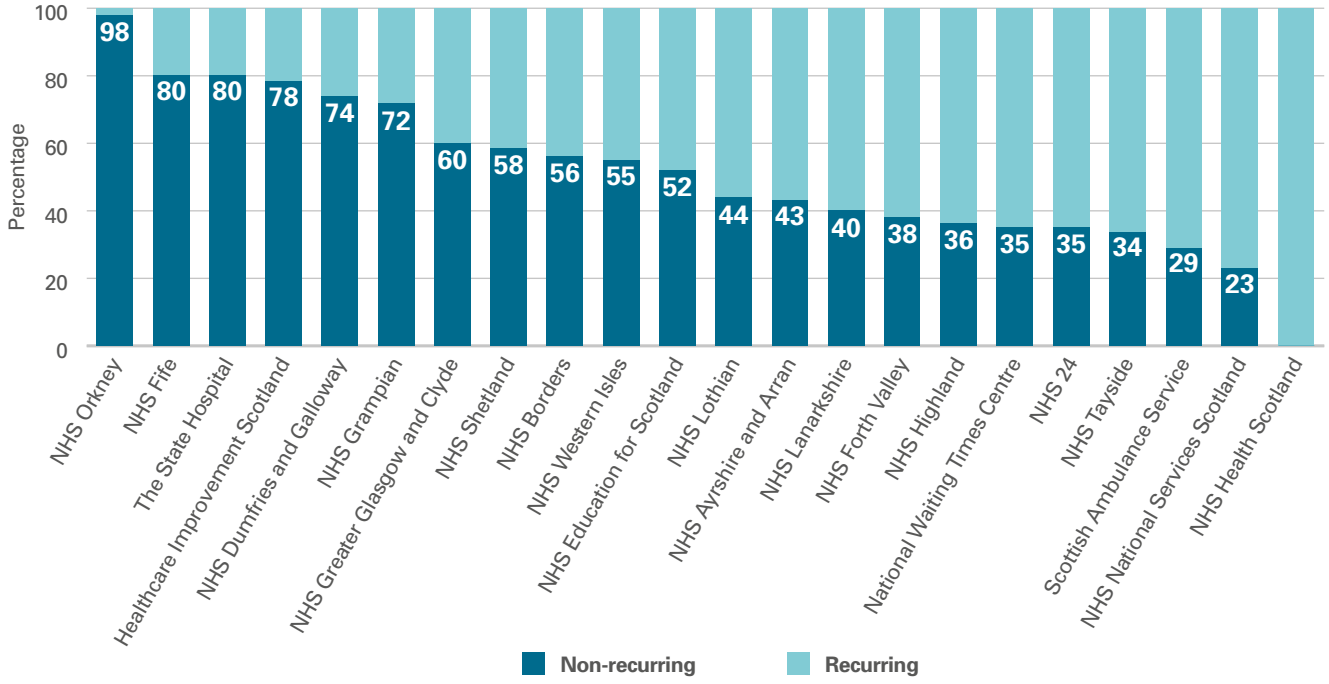
Source: NHS boards' annual audit reports and financial performance reports, 2019

18. In 2018/19, 50 per cent of all savings were non-recurring, up from 35 per cent in 2016/17. Non-recurring savings are not sustainable. They can improve a board's in-year financial position, but they do not reduce the cost of running the organisation and cannot necessarily be repeated in subsequent years. An example of a non-recurring saving is delaying recruitment for a vacant position. Recurring savings can be made in one year and can continue to save money in future years, for example by changing the way a service is delivered, to become more efficient. Boards varied significantly in their reliance on non-recurring savings, with territorial boards being more reliant than national boards (Exhibit 4, page 13).

Exhibit 4

The percentage of savings achieved that were non-recurring in 2018/19

Boards varied significantly in their reliance on non-recurring savings.



Source: Audit Scotland using annual audit reports and month-13 financial performance reports

The level of planned savings that are high risk has increased

19. In their annual plans for 2018/19, NHS boards categorised their planned savings as high, medium or low risk, depending on the likelihood that the savings would be realised. In 2018/19, the NHS in Scotland classified their planned savings as follows:

- 32.0 per cent as high risk
- 28.5 per cent as medium risk
- 39.5 per cent as low risk.

20. The proportion of high-risk savings was significantly higher in 2018/19 than in previous years (13.1 per cent in 2017/18). There was wide variation among boards. For example, NHS Greater Glasgow and Clyde classified all its planned savings as high risk, which had a significant impact on the total proportion of savings classified as high risk.

21. However, NHS boards vary in how they assess savings. For example, only some boards include unidentified savings as high risk. To improve transparency and consistency, NHS boards should ensure that any unidentified savings are classified as high risk.

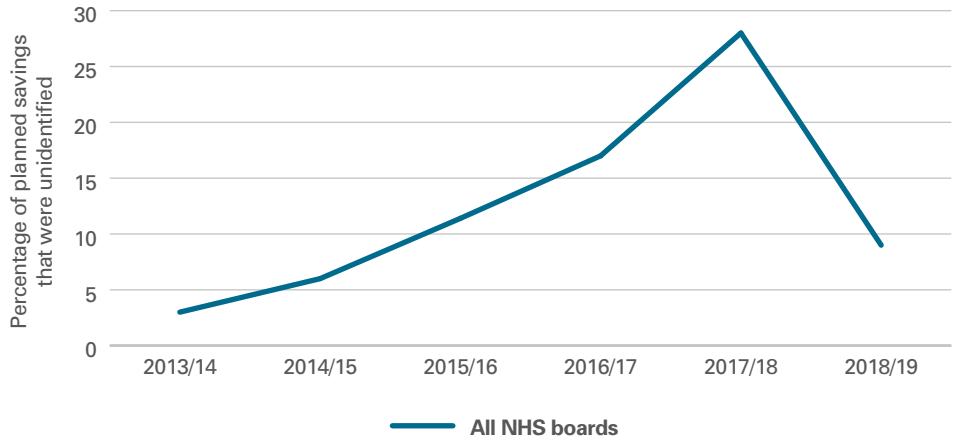
Boards were able to better identify where future savings will come from

22. There was a significant improvement in the proportion of unidentified savings in boards' plans for 2018/19. Last year, boards were unable to identify where 28 per cent of planned savings would come from. This year, nine per cent of required savings were not yet identified in boards' plans, a reduction of 19 percentage points (Exhibit 5, page 14).

Exhibit 5

Trends in unidentified planned savings, 2013/14 to 2018/19

The level of unidentified savings in all boards' plans decreased significantly in 2018/19.



Source: Audit Scotland using NHS boards' local delivery plans/annual operational plans 2013/14 to 2018/19

The Scottish Government has started to put in place the foundations to support financial sustainability

23. In October 2018, the Scottish Government published its MTFF. This was an important step towards supporting improvements to achieve financial sustainability of the NHS in Scotland. It outlines the scale of the financial challenges ahead and acknowledges that reform is necessary if the NHS is to be sustainable.

24. The MTFF sets out the activities required to support the reform needed. It also sets out the intention to invest more in primary, community and social care. The aim is for approximately 50 per cent of savings released from the hospital sector to be redirected to these areas through:

- increases in efficiency savings
- reductions in attendances at A&E, and the numbers of inpatients and outpatients
- regional working and public health prevention strategies.

25. Alongside the publication of the MTFF, the Scottish Government announced that boards will no longer be required to break even at the end of each financial year. Instead, they will be required to break even over a three-year period. This should provide greater flexibility in planning and investing over the medium to longer term.

26. NHS boards were required to produce three-year financial plans for the first time for 2019/20. This is an important step towards the NHS developing more effective longer-term planning. The Scottish Government developed guidance with boards to support the development of these plans, but this was not released until late February 2019. This gave them limited time to develop plans before the start of the financial year in April, and some were not approved until August 2019.

27. The Scottish Government held briefing sessions for boards during September 2019 and intends to release guidance in December 2019, to support them in developing next year's plans. In the first year of this new approach to financial planning, most boards included some information for the next three years, but the level of detail provided varied. Some boards, including NHS Borders and NHS Lanarkshire, did not include full details for all three years.

28. We expect the level of detail in boards' financial plans to improve next year, following the release of further guidance by the Scottish Government. The Scottish Government and NHS boards should work together to make sure that plans are in place and approved in time for the start of each financial year.

Five boards are receiving external support because they are struggling to meet financial and performance targets

29. The Scottish Government has a five-stage escalation process to provide boards with additional support when they are unable to meet financial or performance targets. Most boards are at stage one, which means that they are deemed to be performing steadily and are reporting normally. Stage five means that the Scottish Government deems that a board's organisational structure is unable to deliver effective care. Case study 1 and Case study 2 (page 16) describe the external support being provided to help two boards achieve financial balance. At October 2019, no boards were at stage five, but **five boards were at stage three or four** ⓘ.

Escalation at October 2019:

Stage three:
– NHS Ayrshire and Arran
– NHS Lothian

Stage four:
– NHS Borders
– NHS Highland
– NHS Tayside

Case study 1

NHS Borders receives external support to help it achieve financial balance

In November 2018, NHS Borders moved to escalation stage four in the Scottish Government's performance escalation framework. Boards at stage four face a significant risk to service delivery, quality, financial performance or safety, and senior-level external support is required.

In 2018/19, the board was unable to achieve financial balance and needed £10.1 million in additional financial support from the Scottish Government to break even. This was mainly to alleviate cost pressures at the Borders General Hospital and offset efficiency savings that were not achieved.

The Scottish Government Health and Social Care Directorate Board Recovery Team has been providing support since December 2018. NHS Borders created a new Financial Turnaround Programme to replace its previous transformation programme. The programme aims to achieve a more sustainable improvement in the board's finances. The Financial Turnaround Programme is in its early stage, and its success will depend on the pace of change and the resources made available.

The board has also developed a new project management office (PMO) structure. In the short term, the PMO director will be supported by a turnaround team with experience of successfully delivering similar financial recovery programmes elsewhere.

Source: Audit Scotland, 2019

Case study 2

NHS Ayrshire and Arran is further developing its improvement plan

In October 2018, the Auditor General published a report to draw Parliament's attention to the scale of the challenge that NHS Ayrshire and Arran was facing in meeting its financial targets. The report concluded that some of the cost pressures were not wholly within the control of the board, such as pay increases and the apprenticeship levy. However, the board's operating costs remained too high.

In 2017/18, PwC reviewed NHS Ayrshire and Arran's Transformational Change Improvement Plan (TCIP). It found that the TCIP was not substantial enough to achieve long-term financial sustainability and that greater transformational change would be required. During 2018/19, the PMO strengthened the governance and oversight of the TCIP. The board's internal auditors concluded that this provided only a partial level of assurance for the board and made several recommendations. These focused on improving governance for the implementation of the plan and a better understanding of dependencies between specific projects. Progress is reported regularly to the Corporate Management Team and the Performance Governance Committee.

In 2018/19, the board needed to make savings of £23.8 million. To support this, 143 improvement initiatives were identified. These initiatives achieved recurring savings of £18.4 million. This was £3.7 million more than in 2017/18. The board achieved £32 million of savings in total. Work will continue to implement the recommendations of the internal audit review, to improve the success of the TCIP in achieving recurring savings.

Source: Deloitte, 2019

Capital funding from the Scottish Government has decreased by 63 per cent over the last decade, and there are signs of strain

30. The NHS capital budget, that is, money for new buildings and equipment, can fluctuate as new projects are approved or completed. There has been a trend of reducing funding over the last decade. In 2018/19, capital funding from the Scottish Government was £334 million, a reduction of 63 per cent in real terms since 2009/10 (Exhibit 6, page 17).

31. Demand for capital funding outweighs what is available for the next two years. This will limit boards' ability to invest in their infrastructure. The Scottish Government is prioritising several infrastructure investments over the next two years. These include:

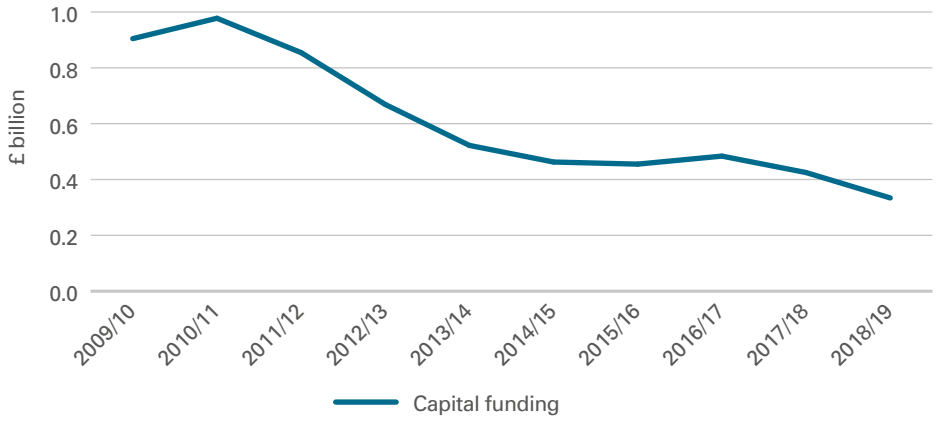
- an elective centres programme to create additional procedural and diagnostic capacity across Scotland[10]
- the new Baird Family Hospital and the Anchor Centre at Foresterhill Campus in Aberdeen
- new community hospitals in Aviemore and Broadford
- the replacement of St Brendan's Hospital, Barra, with a new health and social care hub.

32. NHS boards can use their revenue budget, which is allocated for day-to-day spending, to support additional capital investment. One way of doing this is to enter into contracts where the private sector finances the initial construction costs for the buildings and maintains them for a specific period, usually 25-30 years. NHS boards make annual payments from their revenue budgets for the length of the contract. Investment in these types of projects across the public sector in Scotland will be covered in more detail in our upcoming report on revenue funding of assets.

Exhibit 6

Capital funding from the Scottish Government since 2009/10

Capital funding has decreased in real terms.



Source: Audit Scotland using NHS Consolidated Accounts

33. The condition of the NHS estate has improved, but there is still a significant maintenance backlog (Exhibit 7). Nine per cent of the backlog is classified as high risk, the majority of which (55 per cent) relates to electrical work required at Ninewells hospital in NHS Tayside. The Scottish Government has committed to fund the work required to resolve this. As recommended in *NHS in Scotland 2018*, the Scottish Government has been developing a national capital investment strategy to ensure that capital funding is strategically prioritised. This strategy should be finalised and published as a matter of urgency.

Exhibit 7

The condition of the NHS estate 2016 to 2018

The condition of the NHS estate has improved slightly over the last three years, but the level of backlog maintenance increased.

NHS ESTATE

73%

Estate in good condition increased from 70 to 73 per cent.

£914m

Backlog maintenance across the NHS in Scotland increased from £887 million to £914 million.

9%

High-risk backlog maintenance decreased from 11 per cent to nine per cent.

70%

Estate assessed as suitable for its purpose increased from 69 to 70 per cent.

Source: Scottish Government, 2019

Major capital projects face significant challenges

34. New hospitals have recently been built in Glasgow and Edinburgh. These major new-build projects have come under considerable scrutiny as a result of significant health and safety concerns (Case study 3 and Case study 4, page 18). In September 2019, the Scottish Government committed to carrying out a public inquiry into the issues at the Queen Elizabeth University Hospital in Glasgow and the Royal Hospital for Children and Young People in Edinburgh. The inquiry will look at how the problems with the ventilation systems happened, and what steps can be taken to prevent these problems in future. It is essential that the Scottish Government and NHS boards learn from these projects when planning new healthcare facilities.

35. Delays in opening a new healthcare facility can mean that an older site must be operational for longer than expected. This can result in additional expenditure to make sure that the older site remains fit for purpose for longer. In these circumstances, the relevant NHS board and the Scottish Government should provide assurance that any risks to patient and staff safety have been addressed.

Case study 3

Queen Elizabeth University Hospital, Glasgow

In January 2019, Healthcare Improvement Scotland carried out an unannounced inspection of the Queen Elizabeth University Hospital, including the Institute of Neurosciences and the Royal Hospital for Children. The focus of the inspection was infection control, specifically considering the following standards:

- leadership in the prevention and control of infection
- infection prevention and control policies, procedures and guidance
- decontamination.

The inspection report published in March 2019 included 14 requirements and one recommendation. Nine of these were classed as urgent and had to be implemented within one week. The board developed an improvement plan to address the inspection findings.

The Cabinet Secretary for Health and Sport has also commissioned an independent review of the Queen Elizabeth University Hospital. As well as covering the infection control issues, this review will consider:

- the design of buildings
- the process for commissioning and constructing new healthcare facilities
- the scale of health problems acquired from the healthcare environment
- wider implications for healthcare facilities across Scotland.

The independent review is in its early stages. Two chairs have been appointed, and the terms of reference are under development. There is no timescale for the review to be completed or published.

Source: *Unnanounced Inspection Report – Safety and Cleanliness of Hospitals, Queen Elizabeth University Hospital (including Institute of Neurosciences and Royal Hospital for Children)*, Healthcare Improvement Scotland, 2019; Scottish Government, 2019

Case study 4

Royal Hospital for Children and Young People, Edinburgh

The opening of the new Royal Hospital for Children and Young People (RHCYP) in Edinburgh was delayed after final safety checks of the building found that the ventilation system in the critical care department did not meet national standards.

NHS National Services Scotland (NSS) reviewed all buildings systems in the new hospital that could have health and safety implications for patients and staff. The review assessed the water, ventilation and drainage systems and set out a timeframe for the opening of the hospital. NSS will also assess all current and recently completed new-builds and major refurbishments, to provide assurance that they comply with national standards.

KPMG carried out an independent review of the governance arrangements for the RHCYP. It identified the factors that led to the decision to delay the move to the new hospital, including communication and timescales. It found that a document produced by NHS Lothian during the tender stage of the project in 2012 was inconsistent with guidance, and that opportunities to rectify the error were missed. It also found that there was confusion over the interpretation of technical guidance and standards.

The Scottish Government has asked NHS Lothian to develop a recovery plan with clear milestones and responsibilities. The Cabinet Secretary for Health and Sport also announced that a package of tailored support measures would be made available to the board to support improvements.

Source: Scottish Government, 2019; *Review of: water, ventilation, drainage and plumbing systems*, NHS National Services Scotland, 2019; *Independent assessment of governance arrangements*, NHS National Services Scotland and KPMG, 2019

The NHS in Scotland is facing significant pressures from population changes and increasing demand for services

36. Certain factors, such as demographic changes, rurality and deprivation, can affect demand for services and can make it more costly for boards to deliver services. The Scottish Government uses a formula developed by the NHS Scotland Resource Allocation Committee (NRAC) to assess how much funding each board should be allocated. The NRAC formula considers the demographics of each board area, including population size, deprivation levels and unavoidable geographical variations in the cost of providing services.

37. In 2018/19, all NHS boards received allocations within 0.8 per cent of what the NRAC formula determined they should receive, known as parity.[11] This was an improvement from the previous year, where all boards received allocations within one per cent of parity. This required an additional £30 million investment. To maintain this position for 2019/20, £23 million additional investment was required.[12]

38. NHS Highland was the only board to move slightly further from parity in 2018/19, moving from 0.7 per cent below parity in 2017/18 to 0.8 per cent. NHS Western Isles has historically received an allocation that was significantly above parity; in 2018/19, it was 11.3 per cent above.

39. In 2018/19, demand for hospital care continued to grow with increases in attendances at A&E and the number of people waiting for inpatient and outpatient appointments. At the same time, more people were admitted to hospital for both emergency and planned care, and on average, their stay in hospital was slightly shorter than in 2017/18. The average length of stay in hospital reduced from 6.2 days in 2017/18 to 6.0 days in 2018/19, despite increases in delayed

discharges. Fewer operations were cancelled and there was a small increase in the number of outpatient appointments held, following significant decreases in 2017/18. Exhibit 8 (page 21) shows national trends across selected indicators of demand and activity for acute services in 2018/19. The quality and availability of health and social care data need to improve. This will help boards better understand the reasons for trends in demand and activity and how to make best use of existing capacity.

40. We have consistently reported the lack of data and information available to measure performance and outcomes, especially in primary and community care. It is crucial that this is addressed as a matter of urgency. The establishment of Public Health Scotland is another opportunity to provide boards with more useful data from across the health and social care system. This will allow NHS boards and IAs to make informed decisions when planning and designing services.

41. The Scottish Government has committed to increasing investment in primary care by £500 million by 2021/22. This should provide at least £1.28 billion by 2021/22 to support the new GP contract and primary care reform. This aims to free up capacity in acute hospitals to reduce waiting times and improve access to services. In addition, a whole-system partnership programme to reform adult social care started in June 2019. This work is being carried out in partnership with people with lived experience of social care, unpaid carers and people who deliver the services. The programme aims to create additional capacity in the community to better meet the needs of people, their carers and the workforce.

Boards continue to struggle to achieve key national standards

42. The NHS in Scotland met two of the eight key national waiting times standards in 2018/19 (Exhibit 9, page 22). This is a small improvement from 2017/18, when the NHS met only the drug and alcohol waiting times standard. The standards that were met were:

- patients starting cancer treatment within 31 days (decision to treatment)
- drug and alcohol patients seen within three weeks.

43. National performance declined for six out of the eight standards in 2018/19. Performance improved for outpatients waiting less than 12 weeks following first referral and for patients starting cancer treatment within 31 days of the decision to treat. Appendix 1 (page 42) shows performance against the national standards by NHS board for 2018/19, including the percentage change since the previous year and over the last five years.

44. It is important to acknowledge the impact of rising demand on waiting times. In 2018/19, the number of people seen on time increased for seven of the eight standards. This means that the waiting times targets were met for more people in 2018/19 than in 2017/18. However, demand for services increased at a higher rate, so the percentage of people for whom the targets were met declined.

Exhibit 8

National trends in demand and activity for acute services in 2018/19

Demand	Trend 2014/15 – 2018/19		Change since 2017/18
Number waiting for outpatient appointment	255,061 → 311,503	↑ 22.1% since 2014/15	↑ 2.2%
Number waiting for inpatient appointment	55,973 → 76,832	↑ 37.3% since 2014/15	↑ 6.1%
A&E attendances	1,639,991 → 1,691,952	↑ 3.2% since 2014/15	↑ 2.8%
Activity			
New outpatient attendances	1,494,370 → 1,439,545	↓ 3.7% since 2014/15	↑ 1.1%
Return outpatient attendances	3,035,662 → 2,848,272	↓ 6.2% since 2014/15	↑ 0.9%
Emergency admissions	576,328 → 593,543	↑ 3.0% since 2014/15	→ 0.0%
Daycase admissions	460,571 → 466,817	↑ 1.4% since 2014/15	↑ 2.4%
Elective admissions	186,055 → 146,365	↓ 21.3% since 2014/15	↓ -2.8%
Number of procedures	1,465,847 → 1,440,249	↓ 1.7% since 2014/15	→ 0.0%
	Trend 2016/17 – 2018/19		
Cancelled planned operations	7,288 → 6,788	↓ 6.9% since 2016/17	↓ -16.4%
Bed days occupied by delayed discharges	408,351 → 420,157	↑ 2.9% since 2016/17	↑ 9.0%

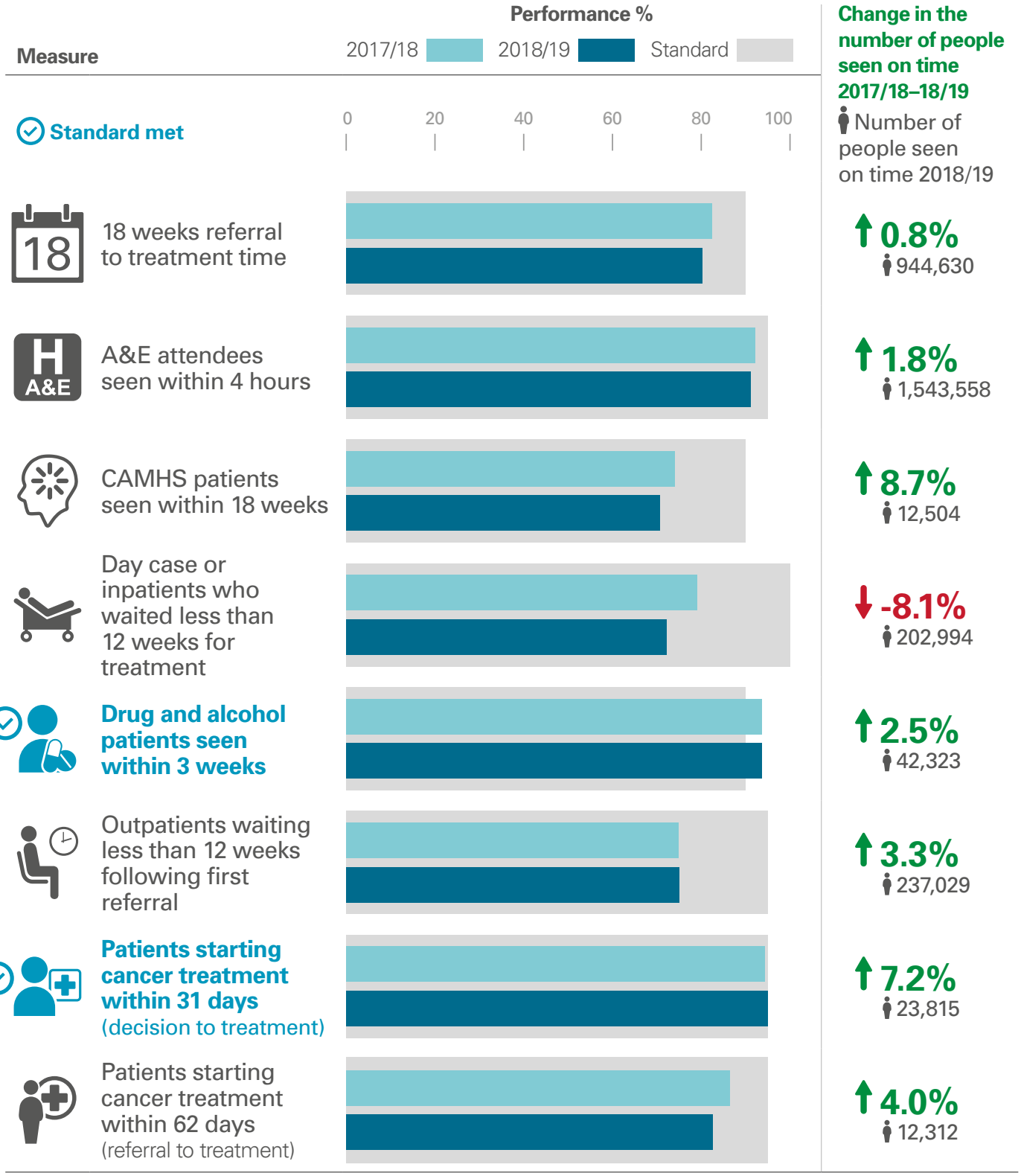
Note: 'Number waiting for outpatient appointment' and 'Number waiting for inpatient appointment' refer to the number of patients on the waiting list at the end of March in each year. 'Cancelled planned operations' refer to operations that have been cancelled for capacity or non-clinical reasons. The definition of bed days occupied by delayed discharges changed in June 2016, so the 2016/17 figure has been adjusted for comparability with subsequent years.

Source: Accident & Emergency Activity and Waiting Times Statistics, ISD Scotland, September 2019; Number on inpatient waiting list, ISD Scotland, August 2019; Number on new outpatient waiting list, ISD Scotland, August 2019; Cancelled planned operations, ISD Scotland, September 2019; Bed days occupied by delayed discharges, ISD Scotland, September 2019; Annual acute hospital activity and hospital beds, ISD Scotland, September 2019

Exhibit 9

NHS Scotland performance against key national waiting times standards, 2017/18 to 2018/19

NHS Scotland met two of the eight waiting times standards in 2018/19.



Note: Figures are annual aggregated performance figures for all standards, apart from 'Outpatients waiting less than 12 weeks following first referral' (census date at 31 March 2018 and 31 March 2019). CAMHS = child and adolescent mental health services.

Source: See Appendix 3 for sources

The Scottish Government and NHS boards have recently introduced initiatives that aim to improve access to care

45. The Scottish Government has been working to improve waiting times and, in October 2018, introduced the WTIP.[13] The Scottish Government is investing more than £850 million over two and a half years. Of this, £535 million will be spent on frontline services and £320 million on capital projects.

46. As part of the WTIP, the Scottish Government introduced new monitoring arrangements for NHS boards that require them to report quarterly on their performance. This enables the Scottish Government to hold boards to account and to provide additional support to those that are not on track to meet their phased improvement goals. So far, £102 million of WTIP funding has been allocated for 2019/20. It is too soon to assess whether this additional funding will help boards to meet the phased improvement goals set out in the WTIP.

47. The Scottish Government has also developed a national independent-sector contract to provide additional capacity and reduce waiting times. This contract is designed to cap private-sector charges for treatment. It is planned to be used as a short-term measure, while elective centres are being set up.

48. The National Theatre Productivity Group is a collaboration between the National Waiting Times Centre (NWTC) and some NHS territorial boards. They are working together to share good practice and introduce new ways of working, to improve efficiency and reduce waiting times. At a recent event, the Golden Jubilee Hospital shared information about an initiative to reduce patient waiting times for cataract surgery. This work focused on improving theatre use by calling patients from a pre-assessment clinic to fill late cancellations. NWTC reported that on average, around 18 per cent of patients who cancelled late were replaced with other patients. There has been very positive feedback from patients. This is a model that has clinical support, has been approved by the General Medical Council and has the potential to be tested in other specialties.

Inpatients' experiences of care and patient safety are improving

49. In 2018, the Scottish Government published its report on a survey of inpatients' experiences of quality of care.[14] It showed that 86 per cent of inpatients had a positive experience of care, an improvement of two percentage points since 2016. There was a consistent picture of positive experience in many areas.

50. Results in relation to arrangements for leaving hospital remained consistent, with 78 per cent of inpatients rating this experience as good or excellent. Only 30 per cent of people reported being delayed on the day of leaving hospital, an improvement of nine percentage points since 2016. The most common reason for such delays continued to be waiting for medications.

Patient safety is improving across a range of measures

51. Despite the financial and demand challenges, staff are working hard across all health and social care settings to provide safe, high-quality care. Recently published data on the NHS Performs website shows improvement across a range of indicators over the past ten years. The Scottish Patient Safety Programme, established in 2008, has successfully improved patient safety.[15] This programme has contributed to the following significant reductions:

- Post-surgical mortality rates have decreased by 36.6 per cent since 2008, following the introduction of the World Health Organization Surgical Safety Checklist.[16] The checklist promotes a culture of teamwork and communication in operating theatres, helping to improve surgical care and safety.

- The number of deaths from sepsis has been reduced by introducing a structured response to, and treatment of, sepsis. Since its launch in 2012, the sepsis programme has contributed to a 21 per cent reduction in mortality rates.[17]

- The Hospital Standardised Mortality Ratio for Scotland has decreased by 14 per cent since 2014 because of improvements in the recognition of, and response to, acutely unwell patients. This means that the number of recorded deaths decreased compared to the number of deaths predicted.

52. In November 2016, the Scottish Ambulance Service (SAS) introduced a new system to prioritise patients. To create the system, over half a million 999 incidents were reviewed to determine what factors had the biggest impact on patient outcomes. This new system better prioritised incidents and matched the timing and type of ambulance response to the needs of the patient. In its first year of operation, there was a 43 per cent improvement in 30-day survival rates for patients in the most urgent category.

53. Minimising healthcare associated infections is a priority for the NHS. It has achieved consistent improvement in two key measures – Clostridium difficile (C. diff) infection rate and meticillin-resistant Staphylococcus aureus (MRSA)-associated bacteraemia rate. Between 2014 and 2018, a decreasing year-on-year trend has been seen in the incidence rate of:

- C. diff, which has decreased by 7.5 per cent in patients 15 years and older

- MRSA, which has decreased by 17.1 per cent between 2014 and 2018.[18]

The amount spent on drugs stabilised in 2017/18

NHS boards and the Scottish Government have implemented a range of initiatives to manage prescription costs

54. The NHS in Scotland spent almost £1.8 billion on drugs in 2017/18, a reduction of 0.2 per cent in real terms since 2016/17 (Exhibit 10, page 25). Good progress continues to be made in the proportion of generic medicines prescribed. This increased from 83.9 per cent in 2017/18 to 84.3 per cent in 2018/19.[19] Generic medicine is usually cheaper, sometimes significantly, compared to branded medicine. Some initiatives that boards have been working on include:

- increasing the use of generic medicines in secondary care

- reducing the amount of drugs dispensed in primary care by more regularly reviewing the medicines that are being prescribed

- switching from high-cost drugs to cheaper alternatives that are chemically similar to the original drugs and close enough to achieve the same results. These are referred to as biosimilars.

Exhibit 10
Expenditure on drugs stabilised in real terms, in 2017/18

£1.8bn

Spent on drugs in 2017/18 by the NHS in Scotland

0.2% less in real terms than 2016/17

Changes in spending varied by board from:

- ↓ 5% decrease for NHS Borders
- ↑ 5.8% increase for NHS Western Isles

16.6%

Net expenditure in the NHS in 2017/18 was on drugs

0.1% less than in 2016/17

£1.3bn

Spent on drugs in community and family health services

0.6% less in real terms than in 2016/17

The amount spent on drugs in hospitals was £438.4 million

- ↑ 0.9% increase since 2016/17

£45m

The Scottish Government, via the New Medicines Fund (NMF), provides additional funding to NHS boards to cover the costs of increasing access to some medicines for very rare conditions and end-of-life care.

£42 million in 2017/18

Source: R600: pharmacy – drugs expenditure, ISD Scotland cost book data, November 2018; Volume and Cost (NHS Scotland), ISD Scotland, July 2019; Scottish Government NHS allocations, March 2019

55. Ten boards have reduced their expenditure on drugs in real terms. An example of a successful approach for reducing drug expenditure is the three-year medicines' efficiency programme launched by NHS Fife in 2016. This has delivered £12 million in savings across health and social care services. The programme included three priorities. These were to restrict the list of medicines available for prescribing, to reduce medicines waste and to review more regularly the medicines that are being prescribed. NHS Grampian also reduced its prescribing budget by £3.5 million compared with last year, mainly through switching to biosimilars.

56. The Scottish Government effective prescribing team supported improvements to reduce costs including by:

- implementing electronic prompts for prescribers, to encourage them to use generic medicines and lower-cost alternatives
- emphasising the importance of carrying out medicines reviews, to safely reduce the number of medications being taken at the same time.

The NHS in Scotland continues to face significant workforce challenges

57. The NHS is reliant on its workforce to deliver healthcare services. However, it is increasingly challenging to recruit enough people with the right skills, particularly in some rural areas. Exhibit 11 (page 26) outlines some important figures relating to the NHS workforce in 2018/19.

Exhibit 11
NHS workforce 2018/19

Headcount
164,114
March 2019
0.6% since last year
3.4% over five years

Full-time equivalent
140,881
March 2019
(excluding some primary care staff)
0.7% since last year
3.9% over five years

Staff costs
£6.9bn
in 2018/19
2.5% in real terms since last year

= 53% of revenue

Vacancy rates

Consultants
7.7%
from 7.5% in 2017/18
Highest: **44.2%** Orkney
Lowest: **1.9%** Lothian

54% Vacancies open for at least 6 months
from 60% in 2017/18

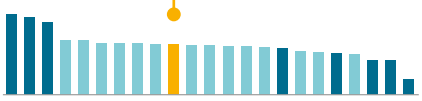
Nursing and midwifery
4.9%
from 4.5% in 2017/18
Highest: **8.4%** Highland
Lowest: **0.7%** Ayrshire and Arran

28.5% Vacancies open for at least 3 months
from 30.3% in 2017/18

Allied health professionals
4.7%
from 4.4% in 2017/18
Highest: **9.1%** Grampian
Lowest: **0.4%** Ayrshire and Arran

32% Vacancies open for at least 3 months
from 29.4% in 2017/18

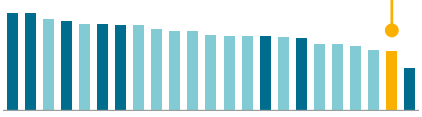
Sickness absence
5.4%
same as 2017/18



Territorial boards
Highest: **5.9%** NHS Forth Valley
Lowest: **4.3%** NHS Shetland

National boards
Highest:
8.6% NHS 24
8.3% State Hospital
7.8% Scottish Ambulance Service

Staff turnover
6.4%
down from 6.6% in 2017/18



Territorial boards
Highest: **9.8%** NHS Shetland
Lowest: **6.5%** NHS Ayrshire and Arran

National boards
Highest: **10.5%** NHS Health Scotland
Lowest: **4.5%** Scottish Ambulance Service

Workforce aged over 55
55+ 22%

Source: Audit Scotland using ISD workforce data and Scottish Government consolidated accounts, 2019

58. The Scottish Government's ambition is for the NHS to provide more care in the community than in acute hospitals. To support this ambition, the way that care and treatment is delivered will change, and therefore the way that NHS staff work will change too. There are examples of where roles have changed to support different ways of working (Case studies 5 and 6).

Case study 5

Pharmacy First has been a success at NHS Forth Valley

NHS Forth Valley has evaluated its Pharmacy First service. This service aims to improve patients access to treatment for certain conditions without the need to see a GP. This service is now available at all community pharmacies, many of which are open at the weekend or evenings, when most GP practices are closed.

Results found that between April 2017 and March 2019, pharmacists were able to provide treatment for 83 per cent of consultations. Pharmacists referred just ten per cent of patients to their GP. The remaining seven per cent of patients were given advice.

Service users were asked for feedback on the service and, of those who responded, 88 per cent said that the pharmacist was able to help them fully, and 100 per cent rated the service excellent or good. Pharmacists in Forth Valley also provided positive feedback on the service and, of the GPs who responded, 53 per cent said that there had been a decrease in the number of patients seeking treatment, as many conditions were covered by the Pharmacy First service.

Source: *Evaluation of the pharmacy first extension service*, NHS Forth Valley, April 2019

Case study 6

The Scottish Ambulance Service is helping to reduce demand for GP appointments

The Scottish Ambulance Service has been testing new ways of working as part of multidisciplinary teams in primary care, to help safely reduce the demand for GP appointments. Paramedics assess patients with urgent symptoms that need to be addressed before the next available GP appointment.

Initial results found that paramedics could safely assess and treat more than 65 per cent of requests for GP home visits, reducing demand for GP appointments. Patient feedback has been very positive. It also found that paramedics involved in this work brought additional expertise back to their 999 calls, with more patients being treated at the scene, which reduced hospital admissions. The Scottish Ambulance Service now plans to further develop this work and roll it out across the country.

Source: Scottish Ambulance Service, 2019

59. In 2018, the Scottish Government published the new General Medical Services Contract, also known as the GP contract. It included plans to expand the role of multidisciplinary teams in primary care, to ease GPs' workload and improve patient access to appropriate care. These teams will be based in GP practices and involve pharmacists, advanced nurse practitioners, physiotherapists and others. It aims to increase the role that GPs have in planning and delivering new health and social care services. It also aims to increase the amount of time that they have available to care for patients, particularly those with complex or difficult to diagnose conditions.

60. Our report *NHS workforce planning - part 2* found that because of a lack of primary care data, it is difficult to assess whether these aims are on track to be achieved. Increasing the primary care workforce as planned will be a significant challenge and any changes are likely to have an impact on other parts of the system.

Temporary staffing costs remain significant, and there is a wide variation between boards

61. As a result of recruitment and retention issues, sickness absence and pressures to meet waiting time targets, NHS boards supplement their workforce by using temporary staff. In 2018/19, NHS boards spent £169.5 million on agency staffing. This was a real-terms increase of 0.3 per cent since 2017/18 (Exhibit 12, page 29).

Boards are working to reduce temporary staffing costs

62. The cost of temporary staffing is significant. Boards have carried out a range of initiatives to reduce temporary staffing costs:

- In 2018/19, NHS Greater Glasgow and Clyde developed a refreshed campaign to recruit graduate nurses. It took a proactive approach to meeting students and promoting the board. It provided graduates with the opportunity to speak to senior nursing staff to learn more about the organisation. The board recruited 458 newly qualified nurses through this recruitment exercise, which filled most of its nursing vacancies. The board saw a real terms reduction of 23.4 per cent in agency spending in 2018/19 compared with 2017/18.[20]

- NHS Grampian has expanded its recruitment to alternative roles. The board has funded a considerable number of additional clinical development fellow, advanced nurse practitioner and physician associate posts. These posts can support areas that are struggling to recruit enough junior doctor posts and can help to reduce the reliance on medical locums. The board also recruited more than 100 nurses from Western Australia and is planning to develop a more formal partnership with Western Australia. It has also been promoting research and development opportunities, to attempt to attract more people to work at NHS Grampian.

Withdrawing from the European Union is likely to exacerbate existing workforce and cost pressures

63. There is considerable uncertainty around the potential impact of the UK's withdrawal from the European Union (EU). The immediate areas of potential impact for NHS boards include reduced access to medicines for certain patient groups and increased costs of medicines and supplies. Higher costs will compound the financial pressure on the NHS. In the longer term, there is uncertainty about future immigration rules and the impact that this may have on being able to attract applicants for vacancies. Professional bodies consider that the number of applicants to the NHS from other EU countries has already declined. This will place further strain on the NHS workforce.

64. The UK and Scottish Governments are leading and coordinating most of the preparations. NHS National Services Scotland has played a central role in contingency arrangements. In line with guidance from National Procurement, NHS boards have not been holding increased stocks of drugs or medical equipment. This is being managed at a UK-wide level.

65. Some boards have acted to strengthen their local arrangements to increase resilience. Several boards, with their partners, have established assurance groups to coordinate preparations, address risks where possible and keep their staff and board members updated. NHS boards should factor any known workforce and cost implications into their financial plans.

Exhibit 12

Temporary staffing costs in 2018/19

In real terms, several boards reduced their spending on temporary staff. Spending on medical agency locums has decreased but spending on agency and bank nurses continues to increase.

Medical locum

2014/15 – £72.8 million
2018/19 – £98.0 million

Peaked in 2016/17 at £114 million and has reduced year-on-year since

Nursing agency

2014/15 – £17.1 million
2018/19 – £26.2 million

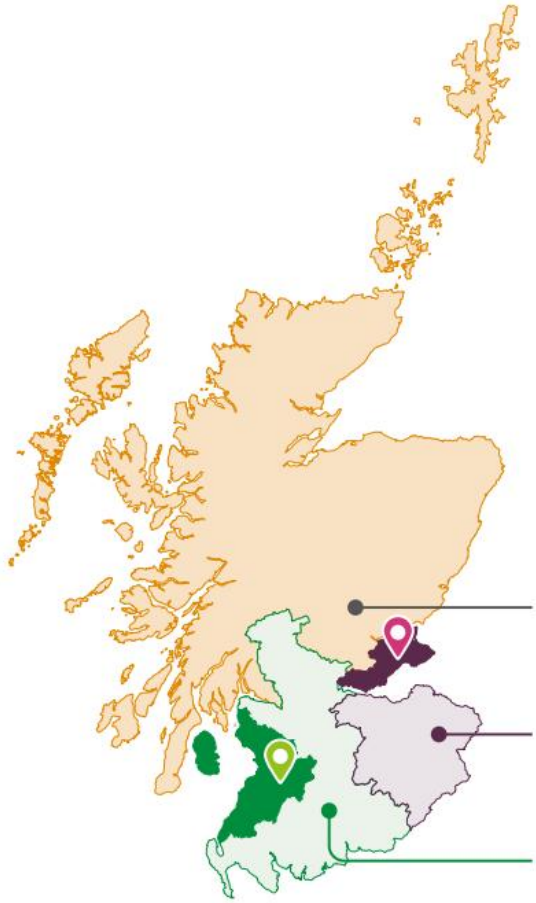
Decreased in 2017/18 but has reached its highest so far in 2018/19

Nursing bank

2014/15 – £138.8 million
2018/19 – £161.9 million

Continuing to rise year-on-year.

This is a more cost effective option for health boards than agency nurses



Compared with 2017/18 costs:

7 **territorial boards** reduced their agency spending in 2018/19, in real terms

NHS Fife saw the largest percentage increase in spending — **20.6%** £1.8 million

NHS Ayrshire and Arran saw the largest percentage decrease in spending — **26.1%** £3.0 million

Spending on agency staffing varied significantly across NHS boards and varied by region:

North region
£43 per 1,000 population

East
£27 per 1,000 population

West
£23 per 1,000 population

Note:
North: Grampian, Highland, Orkney, Shetland, Tayside and Western Isles.
East: Borders, Fife and Lothian
West: Ayrshire and Arran, Dumfries and Galloway, Forth Valley, Greater Glasgow and Clyde and Lanarkshire

Sources: NHS Consolidated Accounts for the financial year 2018/19, Scottish Government, 2019; NHS Scotland workforce, ISD Scotland, June 2019; Mid-year population estimates, National Records of Scotland, April 2019

Part 2

Achieving a sustainable NHS

Key messages

1 The Scottish Government's 2020 Vision is to change the way health and social care services are delivered. The successful integration of health and social care is essential for achieving this, but progress has been slow and the aims of the 2020 Vision will not be achieved on time. NHS boards are working on a significant number of local improvement initiatives, but there is scope to consolidate this activity to achieve larger-scale, system-wide reform. The Scottish Government should identify and prioritise the initiatives that are most likely to achieve the reform needed. It should use this information to develop its new strategy for health and social care for 2020 onwards. Much more work is also required to engage with local communities to inform and co-design changes to services.

2 Reforming health and social care also means that changes to the NHS workforce are required. To support this, the Scottish Government needs a national, integrated, health and social care workforce plan. This is overdue.

3 There has been significant turnover in senior leadership positions across the NHS in Scotland, with 26 new appointments in 2018/19. The Scottish Government has introduced a series of changes to improve its approach to senior leadership recruitment and development. This is a medium- to longer-term solution, and it is too soon to determine the impact of these changes on stabilising senior leadership in the NHS.

4 The NHS needs to improve workplace culture. Following reports of bullying and harassment and an independent review, the Scottish Government has committed to implementing a series of improvements. Boards are now required to provide assurance that they are aware of the culture and behaviours in their organisation and have plans to address any issues identified.

There has been long-term and consistent national policy direction for health and social care integration, but progress has been slow

66. Since 2005 there have been several strategies and frameworks published by the Scottish Government that aim to reform health and social care services across Scotland (Exhibit 13, page 31). To achieve the Scottish Government's vision to change the way services are delivered, successful integration of health and social care is urgently required and is a major priority across the whole system.

Exhibit 13

A timeline of major Scottish Government health and social care policies and publications, 2005–16

2005 The Scottish Government published *Delivering for Health*

This first set out the aim to provide care that is quicker, more personal and closer to home. It aimed to support more integrated working across health and social care, improve patient pathways and develop a culture of teamwork and co-operation.

2009 The Scottish Government and COSLA published *Improving Outcomes by Shifting the Balance of Care Improvement Framework*

It proposed ways that NHS boards and local authority partners could make better use of resources across the health and social care system. It aimed to help them to better manage the impact on acute hospitals of population growth, increase in the number of older people and long-term conditions.

2011 The Scottish Government published its *2020 Vision*

It set out the aim that by 2020 'everyone is able to live longer, healthier lives at home, or in a homely setting'. Ambitions were to shift care from acute to community care, increase integrated working focusing on prevention, anticipate care needs and support self-management of long-term conditions. It aimed to ensure people are discharged from hospital as soon as appropriate with minimal risk of readmission.

2014 Integration legislation passed and introduced the mandate for change with the establishment of Integration Authorities (IAs)

NHS boards need to work in close partnership with IAs and local authorities to plan together how services that were once provided in hospital can be moved to the community. IAs are responsible for planning, designing and commissioning primary care services. They are also responsible for developing primary care improvement plans, in collaboration with NHS boards and local GP subcommittees.

2015 The Scottish Government published the *National Clinical Strategy*

This highlighted areas where improvements would be necessary over the next five to ten years across primary and acute care. Significant changes were required to ensure the NHS could adapt to meet the needs of the population in the future.

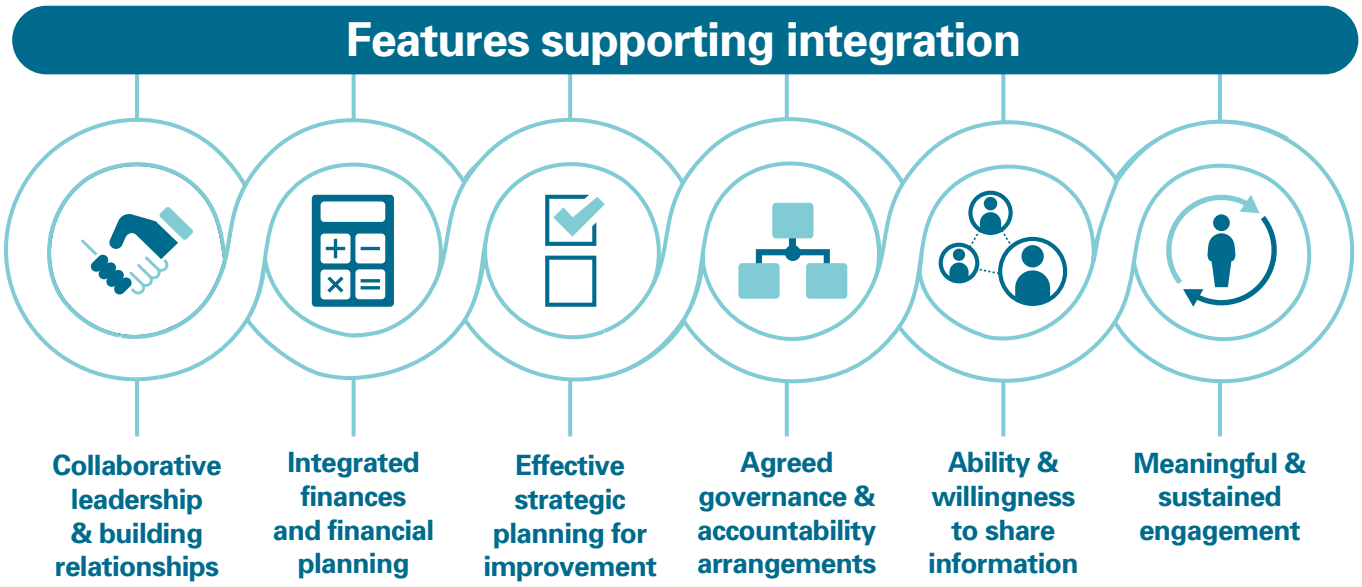
2016 The Health and Social Care Delivery Plan set the direction required to make hospital services more sustainable and available for those who need them in the future

It provided more guidance for health and social care services to change the way services are delivered. It intended to increase the number of people that can be treated and cared for closer to their home, where it is safe and appropriate to do so.

Sources: Delivering for Health, Scottish Executive, 2005; Improving outcomes by shifting the balance of care: improvement framework, Scottish Government and COSLA, 2009; 2020 Vision, Scottish Government, 2011; The Public Bodies (Joint Working) (Scotland) Act 2014, legislative framework for the integration of health and social care services in Scotland; The National Clinical Strategy for Scotland, Scottish Government, 2015; Health and Social Care Delivery Plan, Scottish Government, December 2016

67. Changing how healthcare services are accessed and delivered has been too slow. In September 2018, the Scottish Government, NHS Scotland and COSLA released a joint statement setting out a shared commitment to integration. It clearly stated that the pace of integration needs to be stepped up. In our report, *Health and Social Care Integration: update on progress*, we identified six areas that IAs and their NHS and council partners need to address (Exhibit 14).

Exhibit 14
Features central to the success of integration



Source: *Health and social care integration: update on progress*, Audit Scotland, November 2018

68. In 2018/19, NHS boards' external auditors reported on a range of challenges to the progress of integration. These included the following:

- Several boards reported IA overspends, including NHS Ayrshire and Arran, NHS Fife and NHS Forth Valley.
- There is a variation in the way that NHS boards work with IAs to plan services and budgets. Some reported that agreements are not yet fully implemented or are being renegotiated.
- There are workforce pressures, including the availability of key roles and having the right skills and experience.
- There is difficulty in finding time to support reform and integration while maintaining acute services.

69. As a result of concerns about the pace of health and social care integration, the Cabinet Secretary for Health and Sport commissioned a review of progress. This was conducted in late 2018. The Ministerial Strategic Group for Health and Community Care (MSG) published their findings in February 2019 and set out proposals for ensuring the success of integration.[21] It set out its proposals under the headings identified in Exhibit 14.

70. Following publication of their review, the MSG issued a self-evaluation template to be completed by health boards, councils and IAs. This aimed to evaluate their current position in relation to the findings of the review. This exercise will be repeated to demonstrate any progress made across the country. Work needs to continue to implement the recommendations highlighted in our report and the MSG review. The Scottish Government has appointed a dedicated lead for this work.

There are examples of NHS boards working with partners to successfully change the way that services are delivered

71. There are numerous innovative and successful examples of partnership working across health and social care to change the way that services are delivered. For example, NHS 24 works with Police Scotland and SAS to improve the pathway for people in distress who contact these three organisations. It also engaged with service users and those delivering services, to develop a mental health hub, based on similar models in London and Cambridgeshire. The hub aims to reduce the proportion of people experiencing mental health issues that are referred to emergency services. Early results show that it has been successful, with less than ten per cent of these cases being referred on to emergency services. Case study 7 shows how SAS is working with NHS 24 to reduce the demand on emergency departments.

Case study 7

SAS is collaborating with NHS 24 to improve patient triage

SAS has been working with NHS 24 to improve the way patients are assessed and treated. Many people making 999 calls are experiencing symptoms relating to long-term conditions that may not always require hospital care or admission. SAS and NHS 24 worked with NHS boards and IAs to develop new pathways of care. These pathways are designed to deal with the immediate issue and minimise the risk of future emergencies.

As a result, more patients are being safely managed either within the ambulance control centre or in the community by paramedics, without having to attend A&E. In June 2019, 37 per cent of incidents were managed by paramedics or through the control centre. This compares with 32 per cent of incidents in April 2017.

Good progress is being made, but there is variation across Scotland in the rate of patients being taken to emergency departments. SAS is focusing on reducing this variation. It is working with IAs and GP clusters to develop local solutions with local communities, in line with the principles of realistic medicine.

Source: Scottish Ambulance Service, 2019

The potential of digital technology is not yet being maximised

72. In April 2018, the Scottish Government published a new digital health and care strategy.[22] The strategy sets out national digital priorities for the next decade that aim to support the transformation of health and social care delivery. These include making use of new technologies to:

- share patient information across health and social care boundaries
- improve patient safety and the coordination of care
- support the redesign of services
- build workforce capability.

73. The Scottish Government is developing a new health and social care digital platform. The platform intends to improve access to health records where and when they are needed across acute, primary and community care. New ways of working using new technologies will also be tested, such as virtual clinics and the remote monitoring of chronic illnesses.

74. Work to implement the strategy is at an early stage. It requires collaboration between the Scottish Government, NHS boards and local government, and governance arrangements are being established to monitor progress. We will continue to monitor developments as part of our ongoing work programme.

75. There are examples of good work across Scotland to make the most of the technology that is currently available to improve patient care. The implementation of the electronic frailty index tool is an example of this (Case study 8).

Case study 8

The Living Well in Communities (LWiC) team is improving the identification and management of people with frailty

The LWiC team in Healthcare Improvement Scotland's improvement hub has developed preventative support for people with frailty in the community. It uses an electronic frailty index (eFI) to identify people with frailty before they reach crisis point. The eFI is available to GP practices through a national IT (information technology) system known as the Scottish Primary Care Information Resource (SPIRE). GP practices using SPIRE can now identify their frail population enabling them to better direct and manage their healthcare needs. During the summer of 2019, the LWiC team supported 19 health and social care partnerships across Scotland to implement the eFI. This could lead to more care being provided in the community rather than in acute hospitals and improve the quality of life of people with frailty.

Source: Healthcare Improvement Scotland, 2019

More work needs to be done to engage with local communities when making changes to health and social care services

76. We have previously reported that the NHS in Scotland needs to be more open, by improving public reporting and the way that the community is involved in planning and designing changes to services.

77. In 2019, NHS boards completed the blueprint for good governance self-assessments.[23] These identified that engagement with stakeholders required further development across several boards. It found that boards need to develop more effective communication and engagement strategies. The approach to community engagement was inconsistent, with some boards reporting that they needed more clarity around expectations. Some boards reported that improved guidance was needed to support better dialogue and inclusion of the community in decision-making.

78. The Community Empowerment (Scotland) Act 2015 sets the requirement for all public bodies to work alongside their stakeholders when making decisions about what services are delivered and where.[24] Working in partnership with the community aims to support the co-design of services and improve outcomes. This is particularly important for marginalised community groups. There is still much work to be done to meet the requirements of the Act with many boards still developing engagement strategies.

79. The Place Principle, recently introduced by the Scottish Government and COSLA, aims to support collaboration and co-design of places in the community.[25] It supports inclusiveness and sustainable outcomes. Planning and working together with the community is vital to ensure a positive, shared understanding and agreement on future community developments.

80. In November 2018, the Scottish Government commissioned an independent review of how NHS Lanarkshire had planned for the redevelopment of Monklands Hospital. Concerns had been raised by elected representatives and members of the public about the level of community engagement and consultation. There were also concerns about the quality of the information used in the planning process, particularly around identifying possible new sites for the hospital. The review found that NHS Lanarkshire had carried out their planning and consultation process well, and in line with existing guidance. Nonetheless, to restore public confidence and trust, it recommended that for the redevelopment, they should follow the Place Principle to create a shared vision with the local community.[26]

81. NHS boards should incorporate the Community Empowerment Act principles into their communication and engagement strategies.[27] This will enable a more mature approach to involvement and improve trust and confidence within the community. Providing a range of community groups with a voice will allow a more informed and open conversation about the design and delivery of public services to meet local needs.

The development of a national, integrated health and social care workforce plan is overdue

82. Between June 2017 and April 2018, the Scottish Government published three workforce plans, covering the NHS, social care and primary care.[28,29,30] It also intended to develop, with COSLA, a national integrated health and social care workforce plan. This was due to be published in 2018 but has been delayed until 2019.

83. IAs have been expected to provide health and social care workforce plans since 2017/18. These should include information about the existing workforce across their health and social care partnership, the expected workforce required in the future and an analysis of workforce supply and demand trends. Not all IAs, however, have produced a plan.

84. Health and social care reform incudes changes in the way that care is delivered and by whom. To support planning for a different type of workforce, broader analysis is required. This should identify:

- what roles will be needed and how many
- where they are needed and what skills and training are necessary
- what these changes to the workforce will cost.

85. Acute hospitals and primary and community care services continue to face increasing workforce shortages. It is unclear if commitments to increase the number of GPs and create new multidisciplinary primary care teams can be achieved in the timescales expected. This is in addition to maintaining acute hospital services and establishing new elective centres. The Scottish Government needs to publish the national, integrated health and social care workforce plan and guidance to inform workforce planning.

The Scottish Government should develop a new strategy for health and social care that identifies priorities to support large-scale, system-wide reform

86. The Scottish Government's 2020 Vision is to provide more care closer to home and reduce demand for acute hospital services. This aims to improve patient experience and help achieve the longer-term financial sustainability of the NHS. The successful integration of health and social care is essential for achieving this vision. However, progress has been slow, and the aims of the 2020 Vision are unlikely to be achieved by 2020. NHS boards have been working on a significant number of local improvement projects that may or may not have contributed to these aims.

87. The Scottish Government should identify and prioritise which initiatives are most likely to achieve the level of large-scale reform needed. It should use this information to develop a new strategy for health and social care for 2020 onwards. Spreading successful improvements to support the delivery of a new strategy is not always straight forward. NHS boards need to consider how these initiatives will fit within their local circumstances. This can include the need for additional skills and the development of new relationships. Cultural change may also be required to accept new ways of working.[31] NHS boards should be able to demonstrate how they are meeting the priorities of the new strategy and should report progress regularly to the Scottish Government.

The Scottish Government and boards still have work to do to improve NHS governance

88. Each NHS board is responsible for ensuring that health services are delivered safely, efficiently and effectively. To support this, NHS boards must have good governance arrangements in place that provide sufficient scrutiny and assurance of financial and operational performance. This year, external auditors found that most NHS boards had adequate governance arrangements in place but found recurring areas of concern. These included the capability and capacity of board members, commitment to transparency, and the quality and timing of information provided for board committee meetings. The Scottish Government is carrying out a range of work aimed at strengthening governance arrangements in NHS boards. This includes piloting a standardised review of corporate governance – NHS Scotland's *A Blueprint for Good Governance* – published in February 2019.[32]

89. The blueprint for good governance intends to provide support for NHS board directors to better fulfil their oversight and decision-making role. It aims to create stronger systems and processes for effective scrutiny of performance. The first step in the framework was for NHS boards to conduct a self-assessment to provide a baseline of performance and to identify where improvements were needed. The self-assessment covered five functions of good governance. These are setting the direction, holding to account, assessing risk, engaging stakeholders and influencing culture.

90. Results showed that most boards scored themselves as performing well or exceptionally well across all five functions. Boards have developed action plans to address areas for improvement. NHS boards will provide six-monthly reports to the Scottish Government on progress against their agreed action plans. Themes for improvement include:

- board member induction, skills and ongoing training and development
- strengthening risk management arrangements
- standardising corporate governance documents
- improving the timing and quality of reports that are submitted to the board.

91. The national-level work to support improvement is being managed via three workstreams:

- corporate governance systems
- attraction and recruitment
- retention and development.

92. The blueprint recommends the independent validation of NHS boards in addition to the self-assessments. It is expected that all boards will be independently reviewed over a three-year period. The Scottish Government is currently considering options for the most appropriate way for this to be conducted. The Scottish Government Corporate Governance Steering Group is overseeing activity relating to the framework and workstreams.

The lack of stable leadership in the NHS is impeding reform

93. There has been a significant turnover of senior leadership positions during 2018/19. Exhibit 15 outlines some of these key changes.

Exhibit 15
Changes in senior leadership appointments across the NHS in Scotland 2018/19

26 new appointments
senior leadership positions

22 NHS boards

5 chief executives
NHS Grampian, Highland, Orkney, Tayside, and National Waiting Times Centre

9 board chairs
NHS Borders (interim), Grampian, Highland (interim), Shetland, Tayside (interim), Western Isles, Scottish Ambulance Service, NHS Education for Scotland and National Waiting Times Centre

6 new directors of finance
NHS Forth Valley, Highland (interim), Orkney (interim), Tayside, Western Isles and Scottish Ambulance Service

6 new medical directors
NHS Fife, Lanarkshire, Shetland (interim), Tayside (interim), National Services Scotland and NHS 24

Source: NHS boards' annual audit reports, 2019

94. At October 2019, over half of NHS boards in Scotland have senior leaders holding dual positions. Typically, this involves only one member of each board's senior leadership team, although three members of the NHS Grampian Executive Team held positions at NHS Tayside during 2018/19. At NHS Shetland, auditors were concerned that three members of the leadership team found managing dual roles challenging, as responsibilities continue to increase.

95. NHS boards are finding it difficult to recruit future leaders. It often takes a long time to appoint people to these positions. Vacancies, interim roles and short tenure can lead to short-term decision-making. This can affect the level of reform and the effective working relationships needed across NHS Scotland. The NHS Leadership Academy suggests that chief executives should stay in post for at least five years, to give organisations the stability they need for effective strategic planning. It is also considered that new chief executives can take 15-32 months to transition into their role.[33]

The Scottish Government has improved its approach to senior leadership recruitment and development

96. Greater collaboration and partnership working are needed to support health and social care integration and to improve staff engagement and workplace culture. The Scottish Government recognised that to achieve this, a different style of leadership was required. This was an important factor in the creation of its new leadership development programme called Project Lift.

97. Project Lift has introduced a series of changes that have been progressed over the past two years.[34] Project Lift focuses on building positive relationships, respect and kindness. It intends to help people work together more effectively across health and social care services, communities, local authorities and the third sector to improve outcomes. The changes include the following:

- Values-based recruitment: this is a multi-stage recruitment process that includes a competency-based application form, and psychometric tests that are independently analysed and used to set questions for interview and role play. A one-year evaluation is under way and will include feedback from candidates. This process has been extended from only the recruitment of board chairs to now include board members and executive directors.
- A new approach to appraisal: for chairs and deputy chairs, this aims to include 360-degree appraisal by March 2020. The Scottish Government is planning to extend this to non-executive directors. This process aims to support improvements recommended in *A Blueprint for Good Governance* and the Sturrock review.
- A stronger process for induction and professional development: this has been introduced for new non-executive directors and chairs, and NHS Education for Scotland provides mentoring and coaching opportunities.
- A new talent management process: this has been established to help identify and develop future leaders. Individuals complete an online self-assessment and are invited to participate in a supported process of personal and leadership development. Over 1,500 staff from across Scotland have registered with this programme since its launch in 2018.
- Improved engagement across health and social care and the wider public sector: this has included leadership learning events and support to build relationships and cross system, collaborative working.

98. Project Lift aims to resolve future recruitment challenges. The Scottish Government should continue to monitor the effectiveness of the initiatives and their impact on recruitment and retention of senior healthcare leaders. However, this is a medium- to long-term solution and there is an immediate need to fill existing senior leadership vacancies on a substantive basis.

The NHS needs to improve its workplace culture

99. In 2013, the Scottish Government published its *Everyone Matters: 2020 Workforce Vision*. It set out the commitment to put people at the heart of delivering high-quality care, to value the workforce and to treat people well (i).

100. In September 2018, four senior doctors from NHS Highland publicly reported problems with bullying and harassment. They reported a long-standing culture of fear and intimidation and an environment where concerns could not be raised in an open and transparent way. As a result of this the Cabinet Secretary for Health and Sport commissioned an independent review to further explore the matters raised.

101. John Sturrock QC published his review in April 2019.[35] There was extensive engagement, with input from around 300 NHS Highland staff. Many reported that they had experienced some form of bullying, harassment or inappropriate behaviour that was considered significant and harmful. The review made important immediate and longer-term recommendations that also have wider implications for the NHS in Scotland. We expect all boards and the Scottish Government to respond actively and positively. The recommendations included:

- a requirement for person-centred leadership
- working in partnership and engaging with staff at all levels
- improvements in governance
- improvements in the management of human resources processes.

102. The Scottish Government has committed to supporting improvements across NHS Scotland as a result of the Sturrock review.[36] Several initiatives are being put in place to support a safe, open and honest workplace culture. These include the following:

- The establishment of a ministerial-led short-life working group to ensure that the recommendations from the report are implemented.
- A review of all workplace policies, including bullying and harassment, conduct, and grievance and the development of a single workforce investigation policy.
- The formation of new legislation to establish an Independent National Whistleblowing Officer for NHS Scotland. This will form part of the Scottish Public Services Ombudsman role and will have the authority to investigate the way that whistleblowing complaints are handled and will make recommendations and report to the Scottish Parliament.
- Each NHS board appoints a whistleblowing champion as part of the role of one of their non-executive directors.

NHS Scotland values

– Care and compassion
– Dignity and respect
– Openness, honesty and responsibility
– Quality and teamwork

103. The Scottish Government is seeking assurance that all boards are considering the outcomes and recommendations from the Sturrock review. Given the importance of this issue across NHS Scotland, the Scottish Government should ensure that all NHS boards:

- provide evidence that they actively promote positive workplace behaviours and encourage reporting of bullying and harassment
- have action plans in place to improve culture, address any issues identified and use the findings of the Sturrock review to inform continual cultural improvement.

104. The Scottish Government should consider what it can do to support NHS boards with this and whether a national cultural reform programme is required.

Senior leaders should consider how they can improve engagement with front-line staff

105. The everyone matters: 2020 workforce vision led to the introduction of the iMatter survey in 2015.[37] This staff experience survey was designed to help individuals, teams and health boards understand the extent to which employees feel motivated, supported and cared for at work.

106. The response rate for the 2018 survey was 59 per cent.[38] This was less than the response rate in 2017, at 63 per cent. An employee engagement index (EEI) score is provided when there is a response rate of 60 per cent. Therefore, a national EEI score for health and social care was not published as part of the national report. In 2018, 13 boards, only five of which were territorial, received an organisational EEI score compared with 19 in 2017. The Scottish Government has commissioned an independent academic review to identify reasons for the reduction in response rate and to recommend ways to improve participation.

107. The results of the 2018 national report showed that staff were clear about their work and had confidence in their line manager. Areas that were rated lower included how well staff were involved in decision-making and the visibility of senior leaders. The areas where responses scored lowest align with some of the important leadership and cultural issues discussed in this report.

108. The iMatter survey does not contain questions specifically relating to culture such as bullying and harassment. This is covered in the biennial Dignity at Work Survey, last conducted in 2017.[39] Those results showed an increase in the proportion of staff experiencing bullying. Nine per cent of staff experienced bullying from their manager compared with eight per cent in 2015. Fifteen per cent of staff experienced bullying from a colleague compared with 13 per cent in 2015.

109. The Scottish Government should consider incorporating questions relating to organisational culture and behaviour within a single annual staff survey. This will enable the Scottish Government to monitor staff experience and the status of organisational culture and behaviour across the NHS. This will also avoid the requirement to conduct, analyse and report on two separate surveys. There are examples of public-sector surveys that include a combination of such questions.

Endnotes

1 Audit Scotland using the draft budget for 2019/20, Scottish Government, December 2018; Mid-year population estimates, National Records of Scotland, April 2019.

2 *Draft budget for 2019/20*, Scottish Government, December 2018.

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

4 The 2020 Vision published by the Scottish Government set out the aim that everyone is able to live longer and healthier lives at home or in a homely setting.

5 Audit Scotland using NHS consolidated accounts for financial years 2016/17-2018/19, Scottish Government, 2019.

6 NHS board local delivery plans and annual operational plans 2015/16-2019/20.

7 NHS consolidated accounts for financial year 2018/19, Scottish Government, 2019.

8 *NHS Scotland 2018-19 consolidated financial reporting to 31 March 2019*, Scottish Government, May 2019.

9 Based on data reported in *NHS in Scotland 2018*, Auditor General, October 2018.

10 New facilities will be established in Golden Jubilee National Hospital, NHS Highland, NHS Lothian, NHS Grampian, NHS Tayside and NHS Forth Valley.

11 NRAC parity status, Technical Advisory Group on Resource Allocation, 2019.

12 Scottish Budget 2019-20: Level 4 data, Scottish Parliament Information Centre (SPICe).

13 *Waiting Times Improvement Plan*, Scottish Government, October 2018.

14 *Inpatient Experience Survey*, Scottish Government, January 2019.

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23 *A Blueprint for Good Governance*, NHS Scotland, January 2019.

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25 Place Principle introduction: www.gov.scot/publications/place-principle-introduction/

26 An independent review of the process followed by NHS Lanarkshire Monklands Replacement /Refurbishment Project, Institute of Health and Wellbeing, University of Glasgow, June 2019.

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29 *National health and social care workforce plan: part 2*, Scottish Government, December 2018.

30 *National health and social care workforce plan: part 3*, Scottish Government, April 2018.

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33 *Leadership in today's NHS: delivering the impossible*, The Kings Fund, July 2018.

34 *Putting people at the heart of leadership in health and care in Scotland: Project Lift Progress Report*, Scottish Government, June 2019.

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36 *The Scottish Government response to the Sturrock Review into cultural issues related to allegations of bullying and harassment in NHS Highland*, Scottish Government, May 2019.

37 *Everyone matters: 2020 workforce vision*, Scottish Government, 2013.

38 *Health and social care staff experience report 2018*, Scottish Government, February 2019.

39 *Health and social care staff experience: report 2017*, Scottish Government, March 2018.

Appendix 1

Audit methodology

This is our annual report on how the NHS in Scotland is performing. Our audit assessed how well the NHS managed its finances and performance against targets in 2018/19 and how well the NHS is adapting for the future.

Our findings are based on evidence from sources that include:

- the audited annual accounts and auditors' reports on the 2018/19 audits of the 22 NHS boards
- Audit Scotland's national performance audits
- NHS boards' Annual Operational Plans which set out how boards intend to deliver services to meet performance indicators and targets, and indicative spending plans for the next three years
- activity and performance data published by ISD Scotland, part of NHS National Services Scotland
- publicly available data and information on the NHS in Scotland including results from staff and patient surveys
- interviews with senior officials in the Scottish Government and a sample of NHS boards.

We reviewed service performance information at a national and board level. Our aim was to present the national picture and highlight any significant variances between boards. We focused on a sample of key targets and standards, covering some of the main activities of the NHS. Where we have used trend information, we have selected a time period where information is most comparable. Information about the financial performance of the NHS is included in Appendix 2 (page 43).

Appendix 2

Financial performance 2018/19 by NHS board

Board	Core revenue outturn (£m)	Total savings made – Annual Audit Report (£m)	Non-recurring savings in Annual Audit Report (%)	NRAC: distance from parity (%)
Ayrshire and Arran	796.6	32.0	43	-0.8
Borders	237.7	15.2	56	1.1
Dumfries and Galloway	343.2	17.3	74	2.8
Fife	706.8	20.0	80	-0.8
Forth Valley	568.8	18.4	38	-0.8
Grampian	1,035.1	17.3	72	-0.8
Greater Glasgow and Clyde	2,404.3	93.0	60	1.8
Highland	714.6	26.2	36	-0.8
Lanarkshire	1,271.9	28.8	40	-0.8
Lothian	1,535.1	27.1	44	-0.8
Orkney	58.7	2.9	98	-0.4
Shetland	59.3	3.8	58	-0.4
Tayside	848.7	32.0	34	-0.8
Western Isles	83.8	2.2	55	11.3
National Waiting Times Centre	71.1	4.3	35	
NHS 24	65.0	2.1	35	
NHS Education Scotland	464.4	14.6	52	
NHS Health Scotland	19.5	0.4	0	
NHS National Services Scotland	466.9	18.5	23	
Healthcare Improvement Scotland	29.4	2.6	78	
Scottish Ambulance Service	251.8	9.9	29	
The State Hospital	32.8	1.8	80	

Source: Scottish Government Consolidated accounts, 2019. Annual Audit Reports and Financial Performance Reports, 2019. Information on NRAC parity by board, Technical Advisory Group for Resource Allocation, 2019

Appendix 3

Annual performance against key waiting times standards in 2018/19 by NHS board

Health board	18 weeks referral to treatment time	A&E attendees seen within four hours	CAMHS patients seen within 18 weeks	Patients starting cancer treatment within 31 days of decision
	standard = 90%	standard = 95%	standard = 90%	standard = 95%
Ayrshire and Arran	⊗ 79.0	⊗ 92.2	✓ 92.3	✓ 98.9
Borders	✓ 90.4	⊗ 93.6	⊗ 56.9	✓ 100.0
Dumfries and Galloway	⊗ 89.0	⊗ 92.6	⊗ 85.1	✓ 96.8
Fife	⊗ 79.0	✓ 95.2	⊗ 76.0	✓ 95.6
Forth Valley	⊗ 83.4	⊗ 86.1	⊗ 70.8	✓ 96.8
Grampian	⊗ 65.0	⊗ 94.4	⊗ 44.3	⊗ 91.6
Greater Glasgow and Clyde	⊗ 84.4	⊗ 90.3	⊗ 80.7	⊗ 94.6
Highland	⊗ 80.7	✓ 96.5	⊗ 82.3	⊗ 93.9
Lanarkshire	⊗ 85.7	⊗ 90.8	⊗ 70.9	✓ 98.6
Lothian	⊗ 72.0	⊗ 85.9	⊗ 62.8	⊗ 94.3
Orkney	✓ 93.1	✓ 95.7	✓ 95.0	✓ 96.2
Shetland	⊗ 83.6	✓ 96.3	✓ 95.0	✓ 98.5
Tayside	⊗ 76.3	✓ 97.5	⊗ 43.5	⊗ 92.7
Western Isles	✓ 90.7	✓ 98.9	✓ 95.0	✓ 100.0
Scotland	⊗ **80.2**	⊗ **91.2**	⊗ **70.7**	✓ **95.0**

✓ Standard met ⊗ Standard missed

Health board	Patients starting cancer treatment within 62 days of referral	Outpatients waiting less than 12 weeks following first referral	Day case or inpatients who waited less than 12 weeks for treatment	Drug and alcohol patients seen within three weeks
	standard = 95%	standard = 95%	standard = 100%	standard = 90%
Ayrshire and Arran	⊗ 84.6	⊗ 82.4	⊗ 83.9	✓ 98.6
Borders	⊗ 93.3	✓ 96.8	⊗ 78.4	✓ 95.3
Dumfries and Galloway	⊗ 92.0	✓ 95.9	⊗ 83.7	✓ 94.6
Fife	⊗ 85.4	✓ 98.2	⊗ 70.5	✓ 96.5
Forth Valley	⊗ 81.8	⊗ 88.2	⊗ 60.3	✓ 98.4
Grampian	⊗ 78.9	⊗ 64.9	⊗ 54.7	✓ 91.4
Greater Glasgow and Clyde	⊗ 77.1	⊗ 74.6	⊗ 77.3	✓ 94.8
Highland	⊗ 80.3	⊗ 84.7	⊗ 57.7	⊗ 87.8
Lanarkshire	✓ 95.9	⊗ 89.7	⊗ 63.3	✓ 97.9
Lothian	⊗ 81.0	⊗ 65.1	⊗ 77.2	⊗ 80.5
Orkney	⊗ 89.2	⊗ 78.9	⊗ 83.0	✓ 97.9
Shetland	⊗ 78.2	⊗ 71.2	⊗ 88.1	✓ 96.0
Tayside	⊗ 84.8	⊗ 62.7	⊗ 67.5	✓ 90.6
Western Isles	⊗ 83.3	⊗ 91.6	✓ 100.0	⊗ 89.3
Scotland	⊗ **82.5**	⊗ **75.0**	⊗ **72.2**	✓ **93.6**

✓ Standard met ⊗ Standard missed

Sources: Child and Adolescent Mental Health Services: waiting times, workforce and service demand, ISD Scotland, June 2019; National drug and alcohol treatment waiting times, ISD Scotland, June 2019; 18 weeks referral to treatment: ISD Scotland, May 2019; New outpatient appointment: waiting times for patients waiting at month end, census date at 31 March 2019, ISD Scotland, May 2019; Inpatient or day case admission: waiting times for patients seen, ISD Scotland, May 2019; Accident and emergency: attendances and time in department, ISD Scotland, June 2019; Performance against the 62-day standard from receipt of an urgent referral with suspicion of cancer to first treatment by NHS board, ISD Scotland, June 2019; Performance against the 31-day standard from date decision to treat to first cancer treatment by NHS board, ISD Scotland, June 2019

NHS in Scotland 2019

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Contents

Introduction

Our NHS celebrated its 70th Birthday this year and it is clear that our most cherished of public services has had to evolve, changing to reflect advances in medicine and the changing needs of our people. Our NHS, and the wider health and social care system, will need to continue to adapt, recognising changing demands and that people are living longer, thanks in no small part to the NHS and the care and treatment it has provided.

Our staff do an outstanding job, day in and day out. The vast majority of people get a fantastic and timely service, demonstrated in high satisfaction levels. For example - 90% of Scottish inpatients say NHS hospital care and treatment was good or excellent.

Planning for the future of our health and social care services requires a clear financial context which outlines the challenges facing the system, but at the same time looks at our approach to addressing these pressures – through a combination of investment and reform.

This Financial Framework aims to consider the whole health and social care system and how this supports the triple aim of better care, better health and better value. It outlines that investment, while necessary, must be matched with reform to drive further improvements in our services - considering the health and social care landscape at a strategic level. It has been developed with input from NHS Boards, COSLA, Local Government and Integration Authorities.

Context

This framework and supporting data will be updated as reform plans evolve, allowing local systems to develop plans within an overall set of financial parameters and alongside workforce and service considerations. Throughout this document, 2016/17 is used as the baseline year for data, reflecting that this is the latest year of published information from the NHS Cost Book and Local Government Local Financial Returns.[1]

Determining the factors which contribute to the wider financial context we will operate within is far from simple, not least as the Scottish Government does not have all the flexibility and levers to manage and plan its finances, as much of this remains reserved to the UK Government.

Additionally, our public finances continue to face the impact of the financial constraints imposed on us by the UK Government's austerity approach – a £2.6 billion real terms reduction in the our discretionary block grant between 2010/11 and 2019/20.

1 For NHS Costs Book see: http://www.isdscotland.org/Health-Topics/Finance/Costs/ and for Local Financial Returns see: https://beta.gov.scot/publications/scottish-local-government-financial-statistics-2016-17/pages/9/

Perhaps the greatest threat to our future finances is the damage caused by Brexit. The economic damage of Brexit could reduce Scotland's GDP by £12.7 billion by 2030 compared with staying in the EU[2] and it is impossible to ignore the risk it creates to some of the planning assumptions in this framework.

The UK Government funding announcement for NHS England in June 2018 included projections through to 2023/24[3] – and indicated associated Barnett resource consequentials for the devolved administrations. The funding assumptions in this document cover the same time period and are predicated on the assumption that the funding the UK Government has promised will be delivered as a true net benefit to the Scottish Government's budget. Clearly any actions by the UK Government which did not deliver this additional funding as a net benefit would have potential consequences on funding for Scotland's public services.

It should also be noted that the funding announced by the UK Government for NHS England in June fell some way short of the resource required to address the fundamental challenges facing the health and social care services in England. It did not, for example, touch on necessary funding for social care and public health services.

Health and Social Care Delivery Plan

The *Health and Social Care Delivery Plan*[4] set out a framework for the delivery of services, bringing together the National Clinical Strategy and our key reform programmes, such as Health and Social Care Integration. Its aim is to ensure that Scotland provides a high quality service, with a focus on prevention, early intervention and supported self-management, and if people need hospital services, they are seen on a day case basis where appropriate, or discharged as soon as possible.

Over the last ten years there has been significant investment in the health service – with the health budget having increased to a record level. Striking progress against key challenges to our nation's health and healthcare has been seen, with steady falls in mortality from the 'Big Three' – cancer, heart disease and stroke.

Bold action has been taken in Scotland in public health improvement, including major and innovative developments such as the ban on smoking in public places, raising the age for purchasing tobacco from 16 to 18 and the introduction of a minimum unit price for alcohol. Those aged 65 and over are entitled to free personal care when they need it, with extension to those under 65 who need it being delivered by April 2019, and there is free nursing care for anyone at any age who requires these services.

The Integration of Health and Social Care aims to ensure that people are supported at home to live independently for as long as possible, ensuring that people's care needs are anticipated and planned appropriately. This is focused on the key areas of reducing the inappropriate use of hospital services and shifting resource to primary and community care.

We recognise that like other health and social care systems around the world, we do face inflationary pressures, which could be exacerbated by the uncertainty that is being created by Brexit. Achieving long-term financial sustainability and making best use of resources is critical to delivering on the Delivery Plan's objectives.

The guiding principle underpinning this framework is simple – that we continue to deliver a service for our patients that is world class and that takes forward our ambition that everyone is able to live longer, healthier lives at home, or in a homely setting.

2 Scottish Government, Scotland's Place in Europe: People, Jobs and Investment

3 UK Government, UK Government's 5-year NHS funding plan

4 Scottish Government, Health and Social Care Delivery Plan, December 2016. http://www.gov.scot/Resource/0051/00511950.pdf

Health and Social Care Expenditure

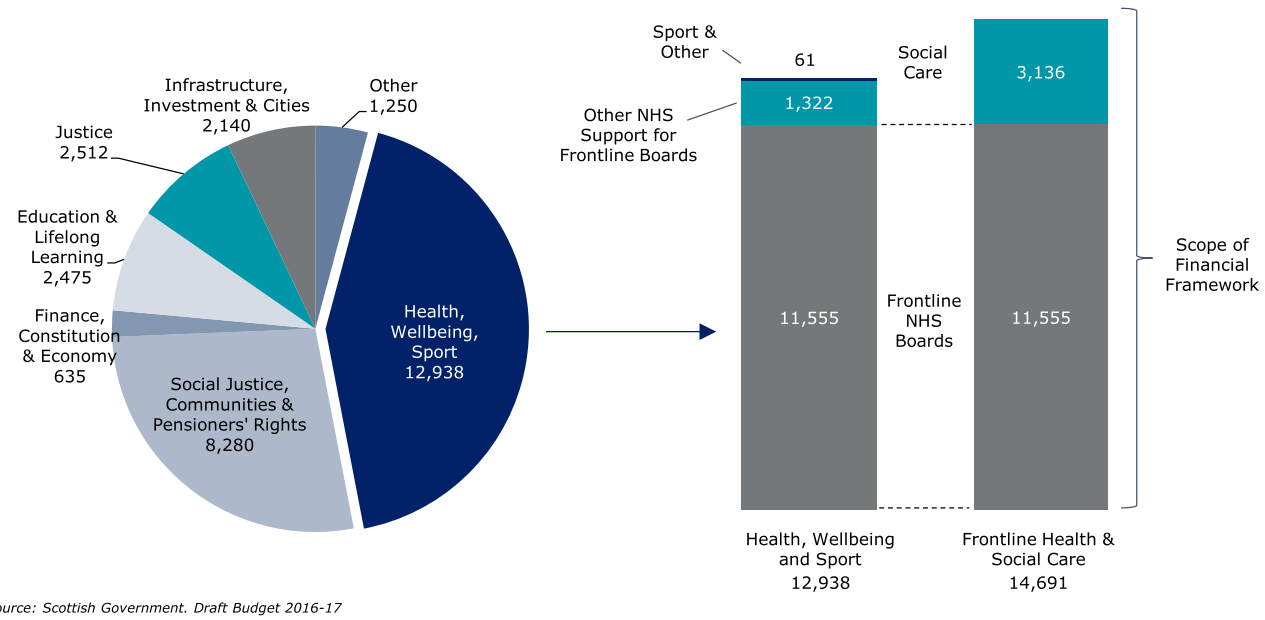
Scottish Government Expenditure

The total Scottish Government budget was £30.2 billion[5] in 2016/17, with funding for the Health and Sport portfolio at record levels of £12.9 billion. Health expenditure is the largest component of the Scottish Government's budget, with spending on the NHS accounting for 43% of total Government expenditure, compared to 37% in 2010/11. Given that there has been a reduction to Scotland's fiscal budget by 8.4% in real terms between 2010/11 and 2019/20, this proportion is expected to increase in future years due to the protection to health spend, with the Scottish Government's commitment to increase the health budget by £2 billion over the lifetime of the current parliament and passing on further Barnett resource consequentials arising from the funding settlement for the NHS in England.

The majority of health expenditure is accounted for by the 18 frontline NHS Boards (£11.6 billion), which comprise the 14 territorial NHS Boards, as well as NHS24, the Golden Jubilee Hospital, the State Hospital and the Scottish Ambulance Service. The analysis within this framework document is focused on frontline NHS Board expenditure plus Local Government net expenditure on Social Care (£3.1 billion in 2016/17). Together, this accounts for £14.7 billion in expenditure in 2016/17 on health and social care. More than £8 billion of this total is now managed by 31 Integration Authorities, which have responsibility for commissioning health and social care services for their local populations. Integration Authorities' budgets are comprised of approximately £5 billion from frontline NHS Boards and £3 billion from Local Authorities.

It should be noted that there is health expenditure delivered through NHS National Services Scotland, Healthcare Improvement Scotland, NHS Education for Scotland and NHS Health Scotland, and also through activity administered centrally within the Scottish Government, including capital expenditure. For the purposes of this document, this expenditure is not included in our analysis.

FIGURE 1. SCOTTISH GOVERNMENT REVENUE BUDGET 2016/17 (£m)

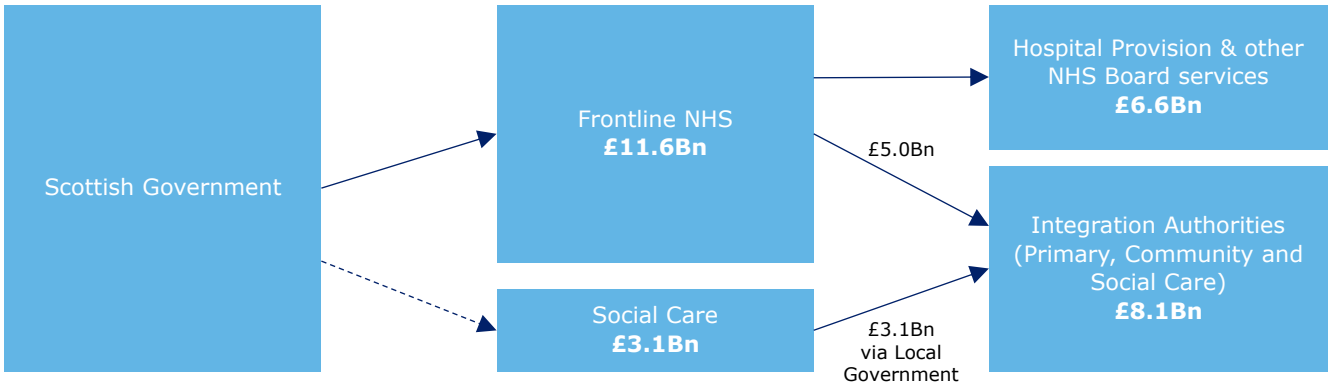


Source: Scottish Government. Draft Budget 2016-17

5 Scottish Government, Total Departmental Expenditure Limit, Draft Budget 2016/17

Figure 2 below illustrates how funding for health and social care is allocated within Scotland following the creation of Integration Authorities.

FIGURE 2. HEALTH AND SOCIAL CARE FUNDING FLOWS IN SCOTLAND

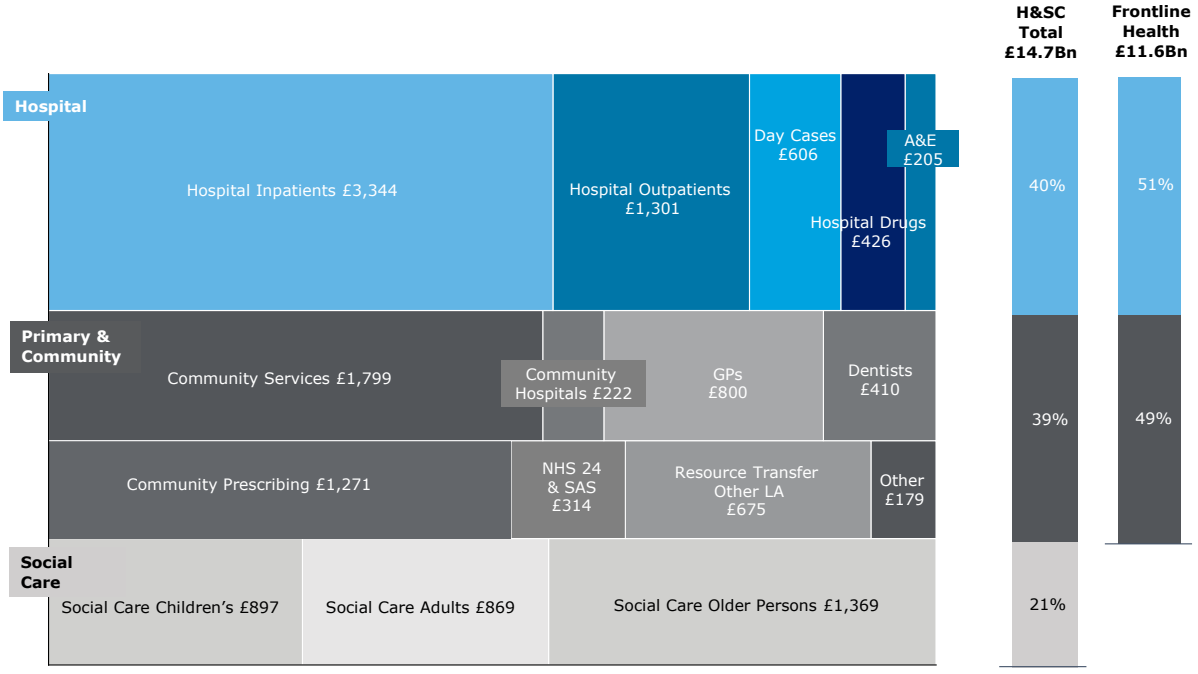


Health and Social Care Expenditure

Figure 3 provides an overview of the composition of health and social care expenditure in Scotland in 2016/17. It illustrates that the majority of NHS expenditure is concentrated on the hospital sector (51%), with the largest area of expenditure on inpatient hospital services (£3.3 billion). Areas of significant expenditure include £2 billion spent on community health services (the provision of district nurses, community hospital services and teams), £1.3 billion on the provision of hospital outpatient appointments, £1.3 billion on GP prescribed drugs and a similar amount on social care support for the elderly.

Overall, the NHS budget accounts for approximately 79% of joint health and social care expenditure. Approximately 60% of frontline health board budgets are delegated to Integration Authorities, covering at least adult primary care and most unscheduled adult hospital care. All of adult social care budgets are also included in Integration Authorities' budgets and some also have responsibility for children's services.

FIGURE 3. HEALTH AND SOCIAL CARE EXPENDITURE 2016/17 (£m)



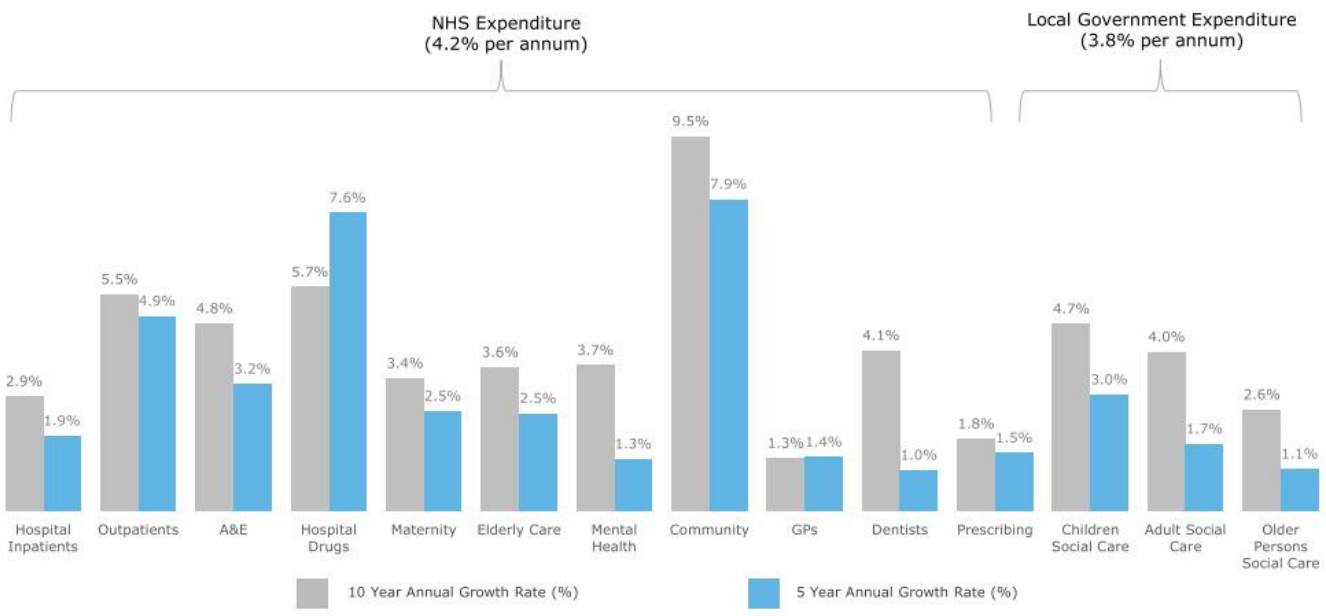
Source: ISD Scotland Cost Book 2016/17, Net Local Authority Expenditure 2016/17

Historical Expenditure Trends

One of the aims of this framework is to provide an estimate of the future resource requirements across health and social care. To provide some context, historical expenditure trends in both health and social care have been examined. NHSScotland and Local Authority expenditure data has been collected in a consistent format for over ten years, and provide some indication of long term trends.[6]

Figure 4 illustrates average annual expenditure growth rates for each major category of health and social care in Scotland from 2006/07 to 2016/17.[7] Overall, NHS expenditure has increased by 4.2%, and social care by 3.8% year on year over the past ten years. However, this rate of growth has slowed in the last five years to 3.2% and 1.8% for the NHS and social care respectively. This largely reflects the real terms reduction in the overall Scottish Government budget as a result of decisions taken by the UK Government, and specifically for Social Care, the use of eligibility criteria to manage resources.

FIGURE 4. HEALTH AND SOCIAL CARE HISTORICAL EXPENDITURE TRENDS (2006/07 – 2016/17)



Historic trends show a significant increase in the level of community health services spend over the past ten years. Specific policy decisions to invest in community services have contributed to expenditure in this area growing on average by 9.5% year on year.[8] Although we have seen growth in spending on community services, this does not yet represent a shift in the overall balance of care: expenditure on hospital services has also been growing significantly, with high rates of growth in outpatient (5.5%), Accident and Emergency (4.8%) and hospital drug expenditure (5.7%). Expenditure on hospital drugs has increased significantly in the last five years, growing at 7.6% year on year, as new and innovative drugs for cancer and other conditions become more widely available.

6 Recognising that historical expenditure trends cannot fully capture the impact of wage increases or future policy changes.

7 Mental health, maternity and elderly care includes elements of both hospital and community service provision.

8 Part of this growth can also be explained by increases in resources which are allocated to Integration Authorities to fund services provided by Local Authorities for services related to care of the elderly, Learning Disabilities and mental health and to facilitate discharge from hospitals. Total NHS Scotland expenditure on these resources was £689 million in 2016/17.

Expenditure on GP prescribing has shown a slower growth profile over the period, primarily due to a reduction in the price of certain drugs, as well as more generic drugs becoming available to the NHS.

Social care expenditure has also increased in all categories, however in the last five years adult social care spend has risen broadly in line with GDP.[9]

Historical Activity Growth and Trends in Productivity

Over the last few years, activity levels across the health and social care sector have generally increased, particularly in relation to hospital outpatient attendances and elderly care at home hours delivered (Box 1 below). The increase in care at home hours is largely as a result of the policy to keep people at home for longer.

BOX 1. ACTIVITY LEVELS ACROSS HEALTH AND SOCIAL CARE

2.1m (+10%) additional elderly care at home hours delivered from 21.6m in 2010/11 to 23.7m today

1.8m (+21%) additional hospital outpatient attendances from 8.5m per year to 10.3m

140,000 (+17%) additional hospital inpatient cases from 830,000 per year to 970,000

98,000 (+6%) additional A&E attendances from 1.6m per year to 1.7m

67,000 (+16%) additional hospital day cases from 420,000 per year to 490,000

No change in elderly residential care home places since 2010/11 remaining at 30,000 places

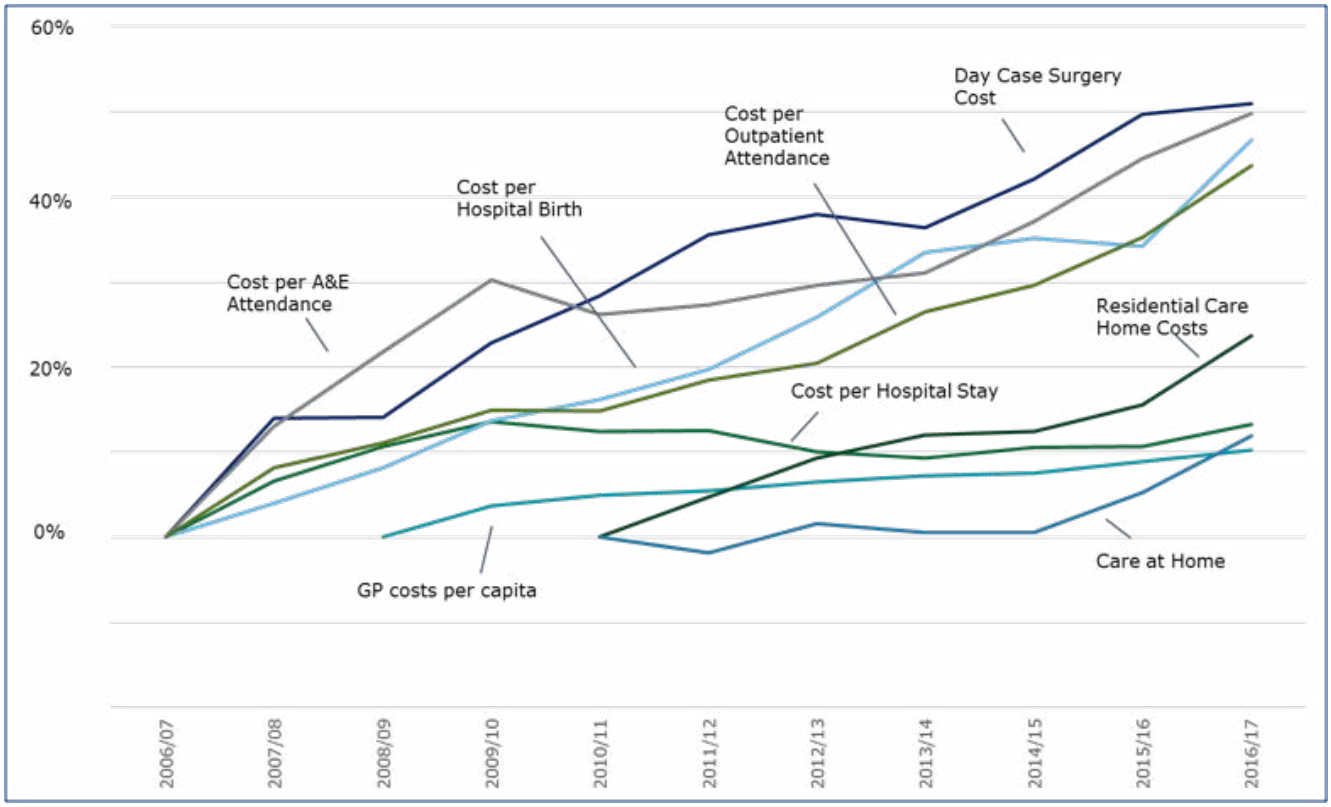
5,000 (-5%) fewer inpatient births in Scottish Hospitals from 102,000 to 97,000 episodes per year

There are now 1.8 million more outpatient attendances in Scotland compared to ten years ago whilst most other hospital activity metrics have also increased.

It is also important to consider whether health and social care services are more productive than they were ten years ago. Gains in productivity would mean that health and social care services are delivering more with the money they receive, and increasing productivity will be critical to ensuring the future sustainability of the system. Figure 5 provides an indication of how unit costs have changed over the past ten years based on a selection of available metrics for some of the largest areas of spend.

9 It should be noted that unmet need has not been quantified in any of the categories in the Figure 4 graph.

FIGURE 5 UNIT COST GROWTH (%)[10]



This illustrates that unit costs have increased by around 50% over the past ten years for certain hospital services. For example, the cost of an A&E attendance was £82 in 2006/07 and is now £123; likewise an outpatient attendance has increased from £81 to £116 over the same period. The increase in outpatient costs is partly due to the fact that more complex activity is now being done on an outpatient basis than was the case 10 years ago. The increase in A&E attendance costs is partly due to investment in emergency services to support delivery of the four hour target, with the Scottish Government providing specific investment over the last few years to improve capacity and resilience in this area. Inpatient hospital costs have not followed a similar pattern with costs per case only 13% higher over the period, as shorter lengths of stay have enabled hospitals to reduce the number of beds they have needed whilst still seeing more patients. Historically, there is less robust primary and social care data, however, work is underway to provide more of this data. Analysis illustrates that GP costs per capita and care at home unit costs have grown less significantly over the period.

Productivity is complex to assess, particularly within a health and social care context, as activity statistics on their own can often hide other benefits, such as the quality of care. The incline from 2016 in residential care and care at home partly reflects policies relating to the Living Wage.

10 Care at home costs is for people aged 65+.

Summary

Expenditure and activity are at record levels and growth trends across the developed world indicate that the level of funding will only need to increase. However, with greater pressures on the system, this will also require change in the way services are delivered. Many of these initiatives are described in the Health and Social Care Delivery Plan and are being driven forward through the integration of health and social care. Delivering improvements in productivity will also be key, ensuring that high quality services are delivered to the population of Scotland whilst managing within the available resources.

Future Demand for Health and Social Care

Drivers of Demand Growth

There are numerous studies which consider the factors driving expenditure on health and social care. Many of these studies have attempted to quantify future demand based on forward projections of need, including analysis carried out by the Health Foundation, the Fraser of Allander Institute, as well as the International Monetary Fund (IMF) and Organisation for Economic Co-operation and Development (OECD). Most of these studies conclude that the demand for health and social care will increase faster than the rate of growth of the wider economy and that over time, the share of GDP spent on these services will gradually increase. The factors for this growth can be broadly classified into three areas:

Price Effects: the general price inflation within health and social services;

Demographic Change: this includes the effect of population growth on the demand for health and social care services as well as the impact of a population living longer; and

Non Demographic Growth: this relates to demand-led growth, generated by increased public expectations and advances in new technology or service developments, for example, expenditure on new drugs.

In May 2018, the Institute for Fiscal Studies and the Health Foundation reported that UK spending on healthcare would require to increase in real terms by an average of 3.3% per year over the next 15 years in order to maintain NHS provision at current levels, and that social care funding would require to increase by 3.9% per year to meet the needs of a population living longer and an increasing number of younger adults living with disabilities.

Our analysis and assumptions are in line with these assessments and take into account the Scottish Government's twin approach of investment and reform, recognising the increasing demand and expectations placed upon our frontline services and being clear that the status quo is not an option.

Future demand forecasts therefore assume the following rates of growth and reform for health services in Scotland:

- price effects will move in line with UK Government GDP deflator projections and will reflect the impact of the NHS pay deal[11] (combined impact of 2.2-2.4% each year over the next five years);
- demographic factors will on average increase the demand for healthcare by 1% year on year;
- non-demographic growth will contribute 2-2.5% growth year on year within the healthcare sector; and
- benefits realised from savings and reform will amount to 1.3% each year and will be retained locally.

Based on these assumptions and their interaction with variable and fixed costs, future demand projections for health have been based on an annual growth rate of 3.5%

11 In terms of the GDP deflator, it is recognised that short term price pressures will also be influenced by changes in pay policy, most notably the recent lifting of the public sector pay cap.

Taking into consideration the various estimates of social care growth, pressures in the social care sector are likely to be slightly higher than in healthcare for various reasons, including pay a strong focus on the very elderly, where demographic pressures are at their greatest. For the purposes of modelling, a rate of 4.0% has been used.

Summary

National and international studies point to the fact that health and social care demand will continue to grow in Scotland, as is the case throughout the developed world. While recognising the significant additional investment planned in health and social care, if the system does not adapt or change, then there will be a net increase of £1.8 billion over the period - driven by growth in the population, public demand and price pressures. In the following sections, the policies and measures in place to address this challenge are set out, including how they will influence the future shape of health and social care expenditure.

Future Shape of Health and Social Care Expenditure

Government Spending Policy Commitments

The Scottish Government has made a number of policy commitments to be delivered in this parliament in relation to health and social care expenditure, that will influence the future shape of the budget, as well as drive reform across the system. Over the medium to long term this will influence the setting in which care is delivered, as well as redirect resources to priority areas for expenditure. The financial implications of these commitments are important to understand and plan for over the next 5-7 years and beyond.

The focus of the financial framework is on the main health and social care expenditure commitments, as set out below:

- over the course of this parliament, baseline allocations to frontline Health Boards will be maintained in real terms, with additional funding over and above inflation being allocated to support the shift in the balance of care. This means that health expenditure will be protected from the impact of rising prices and will continue to grow in excess of GDP deflator projections;
- over the course of the next five years, hospital expenditure will account for less than 50% of frontline NHS expenditure. This relates to the policy commitment to '*shift the balance of care*', with a greater proportion of care provided in a setting close to a person's home rather than in a hospital;
- funding for primary care will increase to 11% of the frontline NHS budget by 2021/22.[12] This will amount to increased spending of £500 million, and about half of this growth will be invested directly into GP services. The remainder will be invested in primary care services provided in the community; and
- the share of the frontline NHS budget dedicated to mental health, and to primary, community, and social care will increase in every year of the parliament. For adults, and in some cases for children, these services, along with unscheduled hospital care, are now managed by Integration Authorities.

The analysis below considers how these commitments will influence the future shape of health expenditure through to 2021/22 and the associated implications for future funding growth.

Future Shape of the Frontline Health Budget

Modelling was undertaken to assess what existing baseline spending for frontline Boards may look like in 2021/22, taking into account the commitments outlined above. Figure 6 illustrates the results, comparing the current position with that projected in five years' time. It illustrates that at present 50.9% of frontline health expenditure is allocated to the hospital sector, with 34.0% spent on community services, 8.1% on mental health[13] and 6.9% on GP services (funded directly by the General Medical Services contract).

In the future, it is estimated that the baseline budget for frontline Boards will be at least £1.5 billion higher at £13.1 billion. This reflects the impact of increased spending in line with inflation, supporting the shift in the balance of care, and providing additional support to improve waiting times. Within this overall position, the share of expenditure on hospital services will comprise less than half of frontline spending, with a corresponding increase in funding for community health services. In addition, there is

12 Letter to Health and Sport Committee - February 2017

13 Mental health expenditure is incorporated in both the hospital and community service expenditure lines, but is presented separately in the charts on the next page for clarity of presentation.

expected to be further funding flowing from the commitment to pass on Barnett resource consequentials in full, and this will also be prioritised towards supporting the shift in the balance of care.

FIGURE 6. FUTURE SHAPE OF FRONTLINE HEALTH EXPENDITURE

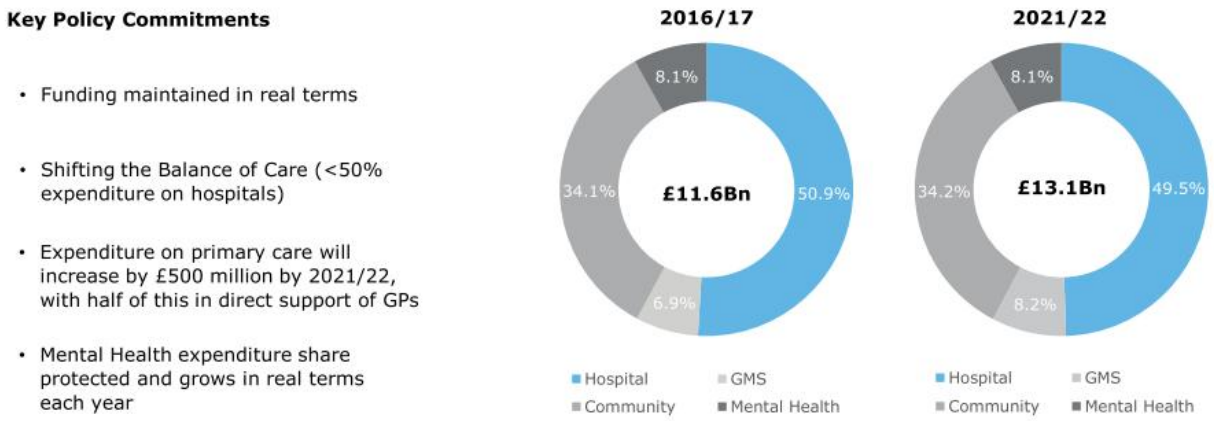
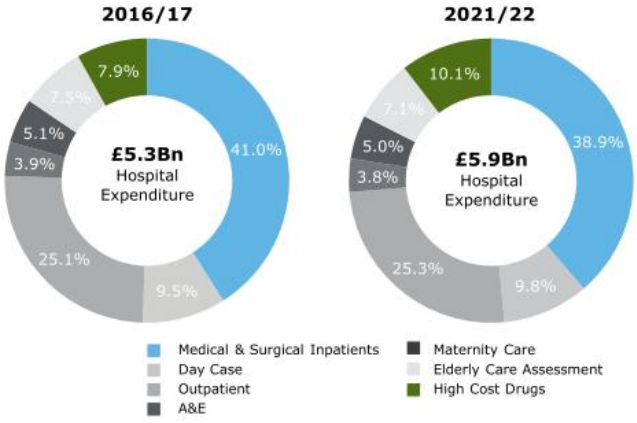


Figure 7 illustrates the main components of current hospital expenditure, with medical and surgical inpatient services accounting for the majority of expenditure (41%), followed by outpatient services (25%) and day case surgery (9.5%). In five years' time the hospital budget would be larger, standing at £5.9 billion, but the composition of spend will likely be different.

FIGURE 7. FUTURE SHAPE OF HOSPITAL EXPENDITURE



Summary

The analysis illustrates how we plan to reshape expenditure patterns across the health and social care sector, with a gradual rebalancing of expenditure towards care delivery outwith a hospital setting. There is evidence that health and social care is being reformed and that there will be significant investment to support this over the next five years. We know ultimately that the outcomes in many circumstances are better, with fewer interventions, when care is delivered in a community setting. Health and Social Care Integration focuses on delivering care in the right place, at the right time, ensuring both the quality and sustainability of care.

Early evidence from Integration Authorities suggests that achieving this shift to primary and community care can be delivered, given the opportunities to deliver care in different settings and in different ways, however it will require appropriate investment in reform and a change in the way services are delivered across Scotland.

Through the Ministerial Strategic Group for Health and Community Care, partnerships have shared projections for their performance on the Delivery Plan objectives over the period to the end of 2018/19 and these show improvements in a number of areas. For example, for unplanned bed days, there is already an overall 7% reduction projected against the 2016/17 baseline, which is consistent with the Delivery Plan objective for a 10% reduction by end 2020. This includes a 16% reduction in days lost to delay.

Reforming Health and Social Care

Introduction

The actions required to address the challenges facing the health and social care system in Scotland are set out in the Health and Social Care Delivery Plan. The Delivery Plan brings together earlier reform programmes – such as the National Clinical Strategy, and other reform initiatives – into a framework that is designed to provide focus and acceleration for reform. Its actions are designed to set us on the right course to address the financial pressures facing the health and social care sector by reforming the way care is delivered, as well as reshaping the future balance of expenditure across care settings.

This framework has been developed to support plans at a local, regional and national level in identifying the financial impact of various policy initiatives and how they will contribute to system sustainability. The analysis provides a high level indication of the scale and type of factors that will help reform the health and social care system. Further work will be carried out at a local and regional level to develop these into more detailed delivery plans.

Reform Activities

Five specific areas of activity have been modelled as contributing to the reform of health and social care delivery across Scotland and these are summarised below:

Shifting the Balance of Care

This is one of the key policy commitments of the Health and Social Care Delivery plan and underpins our longer-standing commitment to integrating health and social care. Many activities currently undertaken in hospital could be delivered in primary, community and social care settings so a patient is seen closer to home. There is also evidence which highlights the variance in care levels across Scotland, for example, with hospital admission rates and A&E attendance rates varying widely across geographical areas.

The Financial Framework assumes potential productive opportunities through reduced variation across A&E attendance rates, outpatient follow up rates and hospital inpatient lengths of stay. These estimates are based on the health and social care system improving performance to the national average and provide a high level view of the potential scale of savings that this can deliver. Local systems will then use these high level assumptions to reflect local circumstances building on evidence about variation.

While it will be challenging given existing pressures in the system, shifting care out of a hospital setting requires investment in primary, community and social care service provision, and it is assumed that approximately 50% of savings released from the hospital sector would be redirected accordingly under the direction of Integration Authorities through their strategic commissioning plans.

Regional Working

This activity relates to better collaboration to improve services, including greater regional approaches to the planning and delivery of services. This will help drive change in how clinical networks are formed and help to reduce duplication in services and functions. The National Clinical Strategy[14] also envisages a range of reforms so that healthcare across the country can become more coherent, comprehensive and sustainable. It sets out, for example, a framework for how certain specialist acute services should be provided on a wider regional footprint.

Based on evidence from other healthcare systems it is assumed that productivity savings of just over 1% could be delivered through effective regional working.

Public Health and Prevention

Scotland, in common with many developed societies face challenges associated with lifestyle behaviours, and wider cultural factors that can prevent positive health choices being made. Addressing these requires a concerted, sustained and comprehensive approach and a number of health improvement actions have been set out in relation to smoking, exercise, diet and alcohol. These initiatives, alongside the promotion of self-care, and helping to stop people entering the health system through prevention and shared decision making (i.e. Realistic Medicine) are important themes within the Health and Social Care Delivery Plan. For example, in the East of Scotland, work is being undertaken to deliver a prevention programme to reduce the incidence or reversal of type-2 diabetes in the region dramatically. The region is taking forward a comprehensive approach to health-based interventions such as weight-loss support and advising on self-management of the condition, and more widely, the promotion of active travel and targeted interventions for children and young people. The work links into the Scottish Government's Diet and Healthy Weight Strategy.

It is not yet possible to fully quantify how these policies will ultimately impact upon the health and social care sector but it is important to capture the potential. As a result, a 1% reduction in demand is included in the financial framework from the implementation of these initiatives, starting towards the end of the five year period.

Once for Scotland

The Health and Social Care Delivery Plan also sets out how taking a 'Once for Scotland' approach can continue to deliver more effective and consistent delivery of services, building on the principles of the National Clinical Strategy. For the purposes of the financial framework a 0.25% reduction in cost is assumed, to reflect potential savings in this area. These savings estimates could increase further in the future through advances in technology.

14 A National Clinical Strategy for Scotland. 2016.

Annual Savings Plans

These relate to the operational delivery of productivity and efficiency savings that all health and social care organisations manage on an annual basis. They typically consist of a number of improvement initiatives, from reducing the reliance on bank and agency staff, to making savings on medical or surgical consumable purchases, right through to changing how services are delivered.

The financial framework has included a target of 1% year on year against these plans, although there is potential for further savings to be delivered in this way. For example, a study by NHS England estimated that historical savings in the NHS were around 0.8% year on year, but that it was considered feasible for providers to deliver efficiency savings as high as 1.5-3% year on year.[15]

15 Five Year Forward View. Health Select Committee Briefing on technical modelling and scenarios. May 2016.

Bridging the Financial Challenge

The Financial Framework provides an indication of the potential approach and type of initiatives that would create a financially balanced and sustainable health and social care system. This presents a macro level view across Scotland and within this framework, local systems will put in place local level delivery plans and developments. These plans and developments will vary in each part of the country, depending on the requirements and arrangements put in place.

Figure 8 illustrates how all of the assumptions on these reform initiatives and ongoing efficiency savings would combine to address the financial challenge over the coming years. Taking account of assumed Barnett resource consequentials through to 2023/24, total funding will be £4.1 billion higher than in 2016/17 and this is presented in figure 8. This is split between an inflationary growth in funding, and additional investment for reform. Based on this modeling there would remain a residual balance of £159 million across the health and social care system in 2023/24.[16] We would anticipate further updates to the assumptions on the reform activities mentioned above in order to address the residual balance over the period.

FIGURE 8. SYSTEM REFORM BRIDGING ANALYSIS

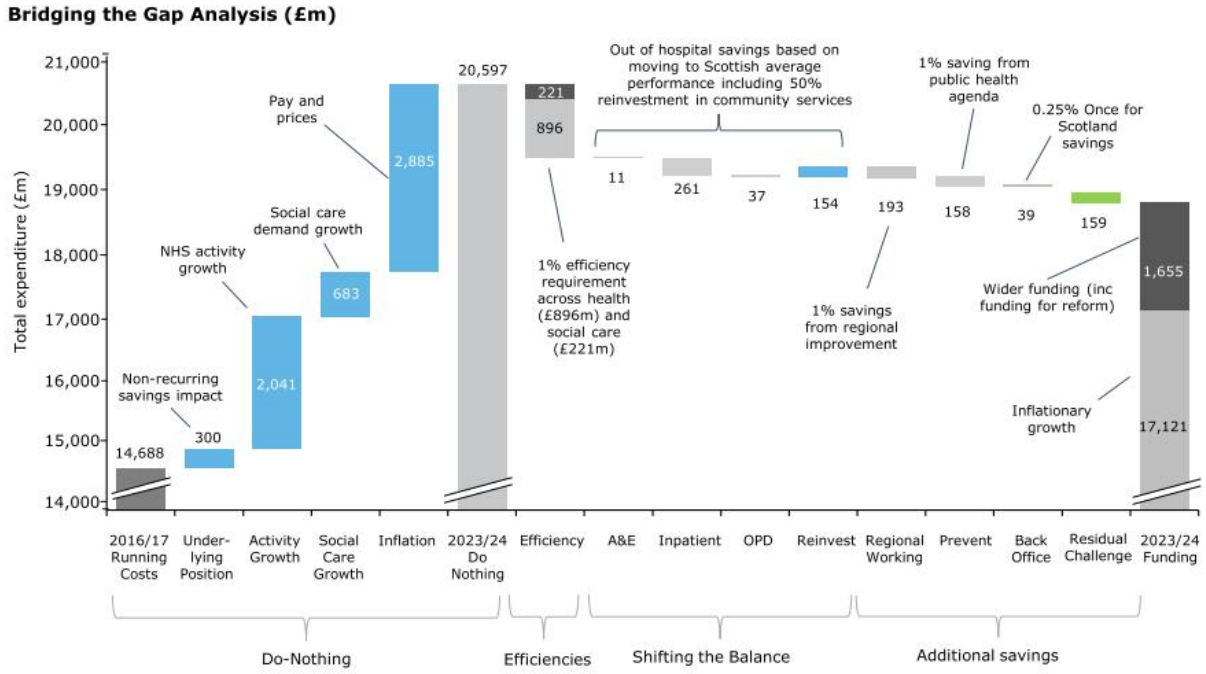


Figure 8 illustrates that from a starting point in 2016/17, with running costs of £14.7 billion, the health and social care system would require expenditure of £20.6 billion in 2023/24 if the system did nothing to change. Reform programmes have however already begun, particularly the integration of health and social care, which will help to address this 'do nothing' challenge. More progress is nonetheless needed to drive forward reform and address the residual savings balance. This will require further work across the health and care system to identify new ways to provide services to the population of Scotland.

Future iterations of the Financial Framework will include assessments of local and regional delivery plans in achieving these ambitions.

16 Presumed real terms (GDP) uplift to health and social care funding.

Summary

The Health and Social Care Delivery Plan brings together a number of policy initiatives that have been designed to reform how care is delivered to the people of Scotland. These will not only support the delivery of high quality care, but will help the system to manage the predicted growth in demand for health and social care over the next five years. There are challenges associated with this, for example, savings assumed through preventative plans may not deliver as anticipated, while the challenges are different across localities due to varying pressures.

In addition, although initial plans are in place, delivering on this agenda will require further change beyond the scope of this framework. Building on progress already underway through integration, there will need to be proportionately less care delivered in hospitals and there is an expectation that new digital technology will change care delivery models.

The System Bridging Reform Analysis does however provide a clear framework from which, regions, NHS Boards and Integration Authorities can build plans. It draws out the significant additional investment through to 2023/24, but highlights that this investment must be used to support the reform that is required across the health and social care system to ensure ongoing sustainability.

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Health and Sport Committee
Comataidh Slàinte is Spòrs

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Contents

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To consider and report on matters falling within the responsibility of the Cabinet Secretary for Health and Sport.

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healthandsport@parliament.scot

0131 348 5524

Committee Membership

Convener
Lewis Macdonald
Scottish Labour

Deputy Convener
Emma Harper
Scottish National Party

George Adam
Scottish National Party

Miles Briggs
Scottish Conservative and Unionist Party

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Sandra White
Scottish National Party

Brian Whittle
Scottish Conservative and Unionist Party

Introduction

1. At the start of the Parliamentary Session, the Committee agreed to adopt a full year budgeting approach, building an element of budget scrutiny into all aspects of its work, as detailed in its 2nd report, 2016 (Session 5) Health and Social Care Integration Budgets .

2. In 2018, the Committee undertook pre-budget scrutiny in May/June and published a report in October 2018 aimed to feed into the budget process, rather than responding to the Budget when published. The Scottish Government provided a detailed response shortly after the Budget was published, in December 2018. As such, the Budget Process Review Group recommendations were reflected in the Committee's approach.

3. In recent years, the focus of the Committee's budget scrutiny has been on Integration Authorities (IAs). The Public Bodies (Joint Working) (Scotland) Act 2014 required local authorities and NHS boards to form partnerships called integration authorities by 1 April 2016. The aim of the policy was -

> To improve the quality and consistency of services for patients, carers, service users and their families; to provide seamless, joined up quality health and social care services in order to care for people in their homes or a homely setting where it is safe to do so; and to ensure resources are used effectively and efficiently to deliver services that meet the increasing number of people with longer term and often complex needs, many of whom are older. [1]

4. IA budgets totalled £8.9 billion in 2018-19, of which £6.3 billion was delegated from the NHS budget. IAs therefore direct almost half of the total health and sport budget. The Committee agreed a continued focus on IA budgets in the pre-budget scrutiny for 2020-21, particularly in light of the ongoing concerns raised by the Committee in respect of the progress of integration.

5. The 2018 Audit Scotland report identified that Integration Authorities (IAs) are "operating in an extremely challenging environment and there is much more to be done". It made a number of recommendations in six areas -

- **Commitment to collaborative leadership and building relationships;**
- **Effective strategic planning for improvement;**
- **Integrated finances and financial planning;**
- **Agreed governance and accountability arrangements;**
- **Ability and willingness to share information; and**
- **Meaningful and sustained engagement.** [2]

The Ministerial Strategic Group for Health and Community Care (MSG), Review of Progress with Integration of Health and Social Care - Final Report, agreed with the Audit Scotland recommendations and comments that the recommendations should be acted upon in full by the statutory health and social care partners in Scotland. It

also acknowledges that "the pace and effectiveness of integration need to increase." [3]

6. To inform our work, we held informal sessions, in private, with Scottish Government officials and Audit Scotland. We also invited selected Integration Authority chief officers to give evidence to the Committee on 21 May and 4 June 2019. These meetings focussed on budget setting challenges, reporting against outcomes, operation of the set aside budget, performance data specifically in respect of delayed discharge and unscheduled care hospital admissions.

7. The timing of this report, in advance of the publication of the Scottish Government's budget, is to provide the Scottish Government with time to consider the implementation of our recommendations in its forthcoming budget 2020-21.

Budget setting process

8. Integration authorities direct health board and local authority funding. IA budgets consist of two elements, which may vary in size and scope depending on the functions delegated to the integration authority[i] -

   - Health care (including primary and community health, as well as relevant hospital services); and
   - Social care.

9. To set IA budgets, the integration authority, NHS and local authority partners work together to determine how much is required to deliver the delegated services and how much each partner will contribute to these identified costs. This budget is then directed to the integration authority. [4]

10. An issue the Committee has pursued vigorously over recent years is access to comprehensive and timely information on IA budgets. In response to Committee recommendations, the Scottish Government is now providing quarterly financial updates. While this is welcome, there is a time lag in reporting. This means that in May/June 2019, when the Committee was undertaking pre-budget scrutiny, no information was available on the budgets agreed for 2019/20. Through the normal reporting timescales, this information would not be available until September – six months into the financial year to which they relate. Therefore, whilst some progress has been made and welcomed, there remains a considerable delay in accessing information on budgets agreed at the start of the financial year.

11. We have previously been informed the reason for the delay in IAs agreeing budgets was due to the difference in financial planning timeframes in local authorities and health boards which has impacted on the agreement of budgets in advance of the start of the financial year. In response to this the MSG report recommended budgets be agreed by the end of March 2019 and, in response to a question in the Chamber, the Cabinet Secretary indicated she expected this timetable to be met. [5] It is understood that budgets are now being agreed more timeously. However, it remains challenging to access this information on a consistent and comparable basis until well into the financial year.

12. At our evidence session on 4 June 2019, we asked witnesses if there was a particular reason why timely financial information can not be provided to the Parliament. We received an overwhelmingly positive response from chief officers. Stephen Fitzpatrick, assistant chief officer for Glasgow Integration Joint Board (IJB) stated, “we set our budget at our March meeting, just over two months ago. It would be straightforward to find a mechanism to share that information with the Parliament. I’m sure that would not be problematic.” [6] This position was reiterated by Aberdeen City IJB and West Lothian IJB at the meeting.

13. **Scottish Government Response**

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i The Scottish Parliament Information Centre briefing, 'Health and social care integration: spending and performance update', page 16

The Scottish Government has indicated the challenge in reporting agreed budgets for IAs relates to the timing of IA board meetings, at which the release of financial information needs to be agreed by all partners. Although this is currently an obstacle to the provision of budget information, the positive reaction of those giving evidence to the Committee suggests it would be feasible to agree earlier release of budget information. This would ensure more timely access to budget information to inform partners, recipients and crucially to permit more informed parliamentary scrutiny.

14. We recommend the Scottish Government works with IAs to deliver more timely release of information on agreed budgets.

Link between budgets and outcomes

15. Integrated Authorities have a statutory duty to report against nine national health and wellbeing outcomes . In our budget report of 2016, we first raised concerns over the IAs' awareness of these reporting requirements and the apparent lack of progress towards publishing budget information of this nature. [7] Our 2018 report highlighted continued challenges with IAs adopting this approach. We concluded –

> The Scottish Government must, in advance of the publication of the budget, provide reassurance that developing budget information against outcomes is a top priority, advise when this information will be available and provide further information on the work that is being undertaken with the deadlines set for delivery. [8]

16. **Scottish Government View**

In response to the recommendation in our 2018 report, the Cabinet Secretary stated -

> We recognise the importance of linking expenditure to outcomes, and that it will enable us to establish the value of expenditure on services in terms of people's experience of care. Integration Authorities are making progress using the data provided via the Source system (managed by NHS National Services Scotland) and analytical support for strategic commissioning provided via the LIST (Local Intelligence Support Team) provided by NHS National Services Scotland. The processes for planning and reporting under integration – strategic commissioning plans that span three years, annual financial plans, and annual performance reports and financial statements – all provide important mechanisms to set out local expectations and experience of the relationship between spending and outcomes. [9]

17. It is our understanding that the Scottish Government is working with the Integration Authority Chief Finance Officer Network to provide guidance on linking budgets to outcomes. Reflecting on our 2016 and 2018 reports, we were keen to hear from witnesses what progress had been made.

18. However, when asked on 4 June 2019 what support the Scottish Government provides for developing budgeting relating to outcomes, limited information was given. The question was repeated again in written correspondence and we received the following responses –

> Aberdeen City have not received any support from the Scottish Government in this regard. (Aberdeen City IJB) [10]
>
> There has been limited support to date provided by the Scottish Government on outcome based budgeting. (West Lothian IJB) [11]
>
> The Scottish Government has been in discussion with the Chief Finance Officers in relation to this subject. (Glasgow IJB) [12]

19. Whilst Stephen Fitzpatrick, assistant chief officer for Glasgow IJB recognised,"there can be clear advantages from developing an outcome based budgeting model," [13] he also highlighted the challenges encountered from implementation. He argued it is "resource intensive and extremely complicated to develop a modelling tool which will accurately reflect which budgets contribute to the delivery of which outcomes". [14]

20. Edinburgh IJB also confirmed that "whilst the idea of linking money to outcomes is valid, it is not straightforward. There is not a one to one relationship between investing money in a service and getting the outcome that you want, because outcomes are delivered through a variety of services." [15]

21. In written evidence, South Lanarkshire IJB acknowledges the "complexity and level of ongoing change involved with integration makes it ***impossible*** to directly link cause and effect". [16] They are therefore using a tool called 'contribution analysis'. It is a method for linking inputs (such as time, money, expertise, resources) to outcomes (such as good quality of life, reduced inequalities) and is very useful when the inputs and outputs are complicated. The aim of the methodology is to identify the contribution a development intervention – such as a project or programme – has made to a change or set of changes. Aberdeen IJB confirmed they will be visiting South Lanarkshire to review this new approach.

22. East Ayrshire IJB highlighted that the Scottish Government is providing "rich data" [17] which helps to ask questions about the changes required in the community and identify the priorities.

23. It would appear that through their own initiatives, IAs are taking an innovative approach and sharing good practice in order to meet their statutory duty in this area.

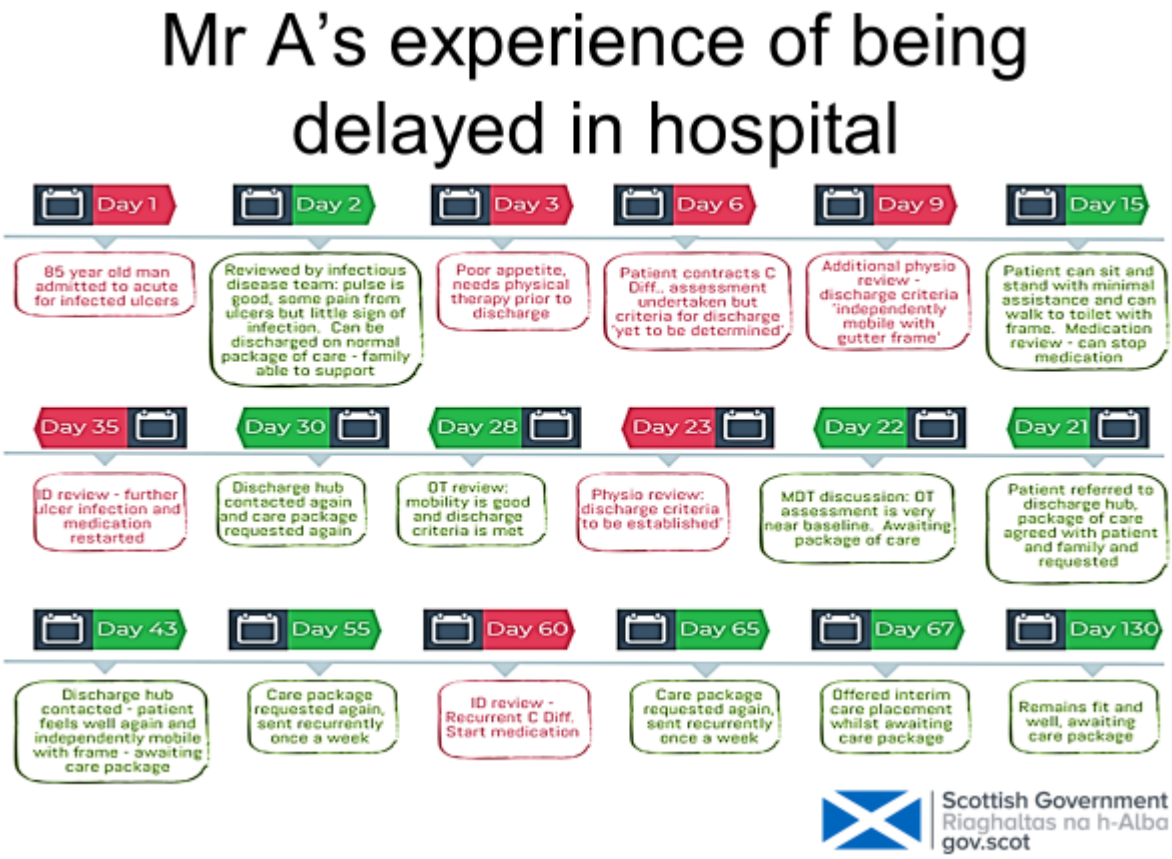
24. We expect this statutory duty to be met by all IAs and welcome an update from the Scottish Government as to when this will happen and how details of it will be reported. We would also welcome details of the support currently being provided by the Scottish Government in this area.

Delayed discharge

25. The Information Services Division (ISD) Scotland advise, “for most patients, following completion of health and social care assessments, the necessary care, support and accommodation arrangements are put in place in the community without any delay and the patient is appropriately discharged from hospital. A delayed discharge occurs when a patient, clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available, for example to purchase a care home place". [18]

26. Understanding the reasons for varying levels of delayed discharge in particular, was a key aspect of our Committee pre-budget scrutiny. If this aspect of the health service is not managed effectively, it has serious implications for the overall budget.

27. Prior to our oral evidence sessions for this inquiry, the Scottish Government provided the following information on delayed discharge. The diagram below represents a pathway for one delayed patient, Mr A. Mr A was an 85 year old man admitted to hospital with infected ulcers. He was still delayed after 130 days in hospital. This was his experience of care –



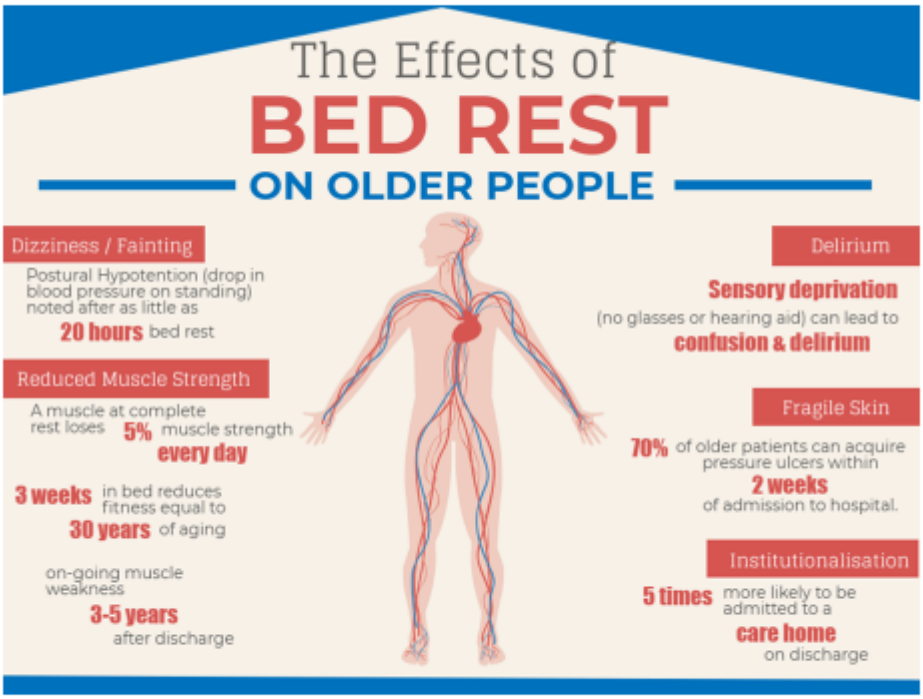
Source: The Scottish Government

28. Day 2 in Mr A’s journey through the care system was the window of opportunity to help him achieve a good outcome. Mr A had some pain but little sign of infection at this stage and his family were able to support him. An opportunity missed at Day 2

for Mr A led to a series of complications until Day 130 when he was finally ready to await a care package.

29. The Scottish Government also highlighted the detrimental effects of staying in hospital for too long and the physical impact this can have on the body, particularly for older people –

- Muscle wastage (3 weeks in bed = 30 years of ageing)
- Pressure sores, loss of independence, delirium – 5 times more likely to be admitted to a care home.
- Nearly 1 in 5 older people moving independently before admission will need assistance to walk after discharge.



Source: The Scottish Government

30. It could therefore be argued that that whilst sending patients home too early may pose a risk, keeping patients in hospital, when ready for discharge, is equally damaging to their health. Reviewing a patient's case and discharging them from hospital at the earliest opportunity is crucial (for example day 2 for Mr A). Once home, the patient's needs can be assessed and a care package finalised. Being assessed in their own home, with their family present is also likely to increase the patient's confidence.

31. We know that the Scottish Government is committed to significantly reducing the number of patients waiting to move to their next destination and the most recent Audit Scotland report found that there had been a reduction in delayed discharge between 2016-17 and 2017-18. However, this progress is not consistent across the

country as shown in the table below and in evidence from the chief officers on 4 June 2019. Also, in some cases positive progress in 2017-18 has been reversed in 2018-19.

4. Delayed discharge bed days; all reasons

Partnership of residence	2017-18	2018-19	Change (number)	Change (%)
Aberdeen City	**19,202**	**13,172**	**-6,030**	**-31%**
Aberdeenshire	16,334	17,221	887	5%
Angus	7,042	5,318	-1,724	-24%
Argyll & Bute	8,414	9,530	1,116	13%
City of Edinburgh	**76,933**	**81,071**	**4,138**	**5%**
Clackmannanshire	2,227	4,025	1,798	81%
Dumfries & Galloway	12,228	15,593	3,365	28%
Dundee City	10,893	9,376	-1,517	-14%
East Ayrshire	**4,730**	**5,038**	**308**	**7%**
East Dunbartonshire	3,557	5,031	1,474	41%
East Lothian	10,668	7,839	-2,829	-27%
East Renfrewshire	1,860	2,284	424	23%
Falkirk	16,726	19,644	2,918	17%
Fife	29,173	33,811	4,638	16%
Glasgow City	**29,897**	**38,656**	**8,759**	**29%**
Highland	36,302	37,824	1,522	4%
Inverclyde	1,609	835	-774	-48%
Midlothian	12,295	12,934	639	5%
Moray	11,487	12,727	1,240	11%
Na h-Eileanan Siar	5,854	7,876	2,022	35%
North Ayrshire	16,854	19,373	2,519	15%
North Lanarkshire	36,834	34,760	-2,074	-6%
Orkney Islands	1,411	452	-959	-68%
Perth & Kinross	16,785	14,203	-2,582	-15%
Renfrewshire	4,680	6,085	1,405	30%
Scottish Borders	14,246	12,750	-1,496	-11%
Shetland Islands	1,499	1,395	-104	-7%
South Ayrshire	14,152	21,536	7,384	52%
South Lanarkshire	**41,187**	**38,473**	**-2,714**	**-7%**
Stirling	5,827	6,991	1,164	20%
West Dunbartonshire	3,439	3,512	73	2%
West Lothian	**19,269**	**21,880**	**2,611**	**14%**
Stirling and Clackmannanshire	8,054	11,016	2,962	37%
Scotland	493,614	521,215	27,601	6%

Source: Information Services Division (ISD)

32. The table above illustrates the number of days where beds are occupied by patients ready to be discharged, for each IA over the past two years. The overall figure for Scotland has increased from **493,614** (2017/18) to **521,215** (2018/19), an increase of **6%** overall.

33. Theresa Fyffe, Director of Royal College of Nursing Scotland, commented on the ISD report and 6% increase -

> It is unacceptable for people to be kept in hospital unnecessarily and is completely at odds with the Scottish Government's vision of safe, high quality care at home or in a homely setting. More must be done to improve the resources in our communities.
>
> Scotland's care homes are struggling to recruit the nursing staff required to ensure they can meet the needs of those who are well enough to be discharged from hospital but continue to require clinical care.
>
> The Scottish Government must do more to address these workforce challenges and ensure Integration Authorities and NHS boards have the resources they need. [19]

34. Of the six IJBs who gave evidence to our Committee, Aberdeen City has seen the most substantial reduction at -31%. In written evidence, they also stated, "comparing the total number of bed days lost to delayed discharges in year 2015/16 to the bed days lost in the most recent full year, 2018/19, there has been a 70% decrease recorded. Through a programme of dedicated work focussing on delays (alongside wider prevention workstreams), year on year decreases have been achieved". [20]

35. New figures obtained through Freedom of Information legislation on 12 September 2019, revealed that "86 people died in Lothian hospitals in 2018/19 while waiting to be discharged, the highest number in Scotland". [21]

36. Age Scotland, also published research earlier this year which highlighted the average waiting time for people to access social care after being assessed as having "critical" or "substantial needs" was five weeks in Edinburgh and more than six weeks in West Lothian. The longest wait was more than 35 weeks. [22]

37. Brian Sloan, chief executive of Age Scotland, described the situation as "tragic". He said -

38. > These are people who were well enough to be discharged, but most were delayed because the social care they needed was not available.
>
> Despite the Scottish Government's repeated promises to tackle delayed discharges, these figures show that the problem is spiralling out of control. It's unacceptable that people in Edinburgh and the Lothians face waits of up to 35 weeks to get the care they need. We urgently need more investment in our social care system, so that every older person can access the care they are entitled to. [23]

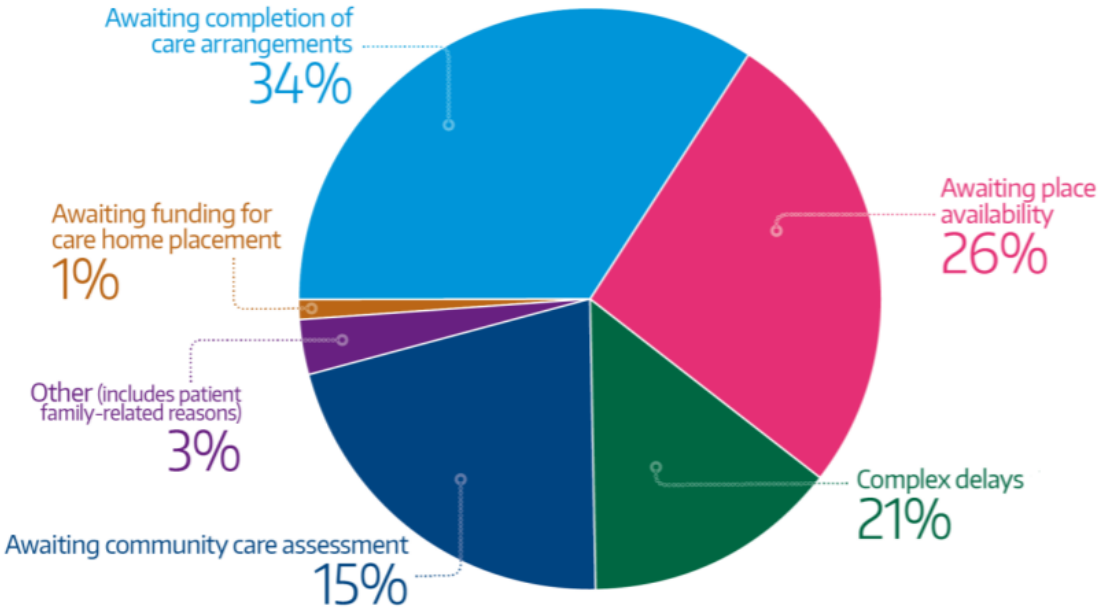
39. West Lothian IJB has experienced an increase of 2,611 (14%) over the past two years. Chief officer, Jim Forrest, addressed the concerns on delayed discharge at our Committee meeting. He admitted their "performance on delayed discharges deteriorated quite significantly about 18 months to two years ago". [24] He argued that the cause of this delay is due to care home beds being at full capacity, the standard of care homes decreasing which affects new admissions, a change in demographics and significant operational issues. [25]

40. Glasgow City IJB has also experienced an increase of 8,759 (29%). However, Stephen Fitzpatrick, assistant chief officer for Glasgow IJB, highlighted progress made on delayed discharge over the past few years, stating, "our performance in managing delays has improved progressively since 2011 to December 2017, when our performance experienced its first sustained reversal in almost 7 years. Performance has since consolidated at a higher level compared to November 2017". [26] He did also readily admit that the IJB has “already realised most of the opportunity that exists to improve the overall impact of delays on the system”. [27] Stephen Fitzpatrick made a key point that hospitals can only make limited progress on delayed discharge moving forward. The strategic focus needs to “move away from the back door, to the front door". [28]

Reasons for delayed discharge

41. The ISD report published on 11 September 2018, highlighted the key reasons for delayed discharge in Scotland. In 2017/18, awaiting completion of care arrangements was the most frequent reason with an average number of 459 delays (34%). In addition, an average of 347 (26%) delays were due to people waiting for care home availability and 285 (21%) delays were due to complex delay reasons, which includes delays under adults with incapacity legislation. Awaiting community care assessment accounted for 15% of delay reasons, other reasons (including patient and family related delays) accounted for 3% and delays awaiting funding for care home placements accounted for 1% of delay reasons. [29] The information is illustrated in the figure below.

42. **Figure 8: Proportion of delayed discharges by reason; Scotland; Apr 2017 - Mar 2018**



Source: Information Services Division (ISD)

Cost of delayed discharge

43. The ISD report also estimated the cost of delayed discharges in 2016/17 in Scotland was £125 million, with an estimated average daily cost of £234 per patient, per day. In comparison, the estimated cost of delayed discharges in 2015/16 was £132 million and an estimated average daily cost of £233 per patient, per day. [30]

44. It is recognised a focus on the most effective pathway for patients commencing at pre-admission and admission will reduce delays in discharge and help to alleviate costs and pressures on acute care.

Intermediate care

45. To reduce delayed discharge in hospitals, intermediate care is used in some areas of Scotland to varying degrees. In follow up evidence to the Committee, Stephen Fitzpatrick, assistant chief officer at Glasgow City IJB, advised that "the aim is to ensure that patients discharged from hospital, where possible, return to their own home. However, for some individuals, a return home is not possible due to the level of support required at that time of discharge, the housing circumstances which may not support discharge, or a requirement to undertake further assessment in order to ensure effective decision making about the longer term needs of the individual". [31] He also advised, there are "90 beds commissioned within 6 x 15 bed units across Glasgow City which act as a step down facility for residents of Glasgow City from hospital". [32]

46. We also heard from Kenny O'Brien, service manager at Aberdeen City IJB. He stated, there are "20 beds in a care home that deliver intermediate care with wraparound physiotherapy and OT [Occupational Therapy] but we also have 19 flats that are designed to mimic a person's own front door and their home." [33] Patients can regain their independence whilst they are being assessed. Often, the amount of care, support and social care a patient requires initially, is reduced as a result of the intermediate care model.

47. Although progress has been made by way of intermediate care, it was suggested that a reduction in delayed discharge figures does not "directly mean that people are getting their social care packages quicker". [34] Intermediate care is not a final destination for the patient, it merely moves them out of the acute setting and alleviates pressure on the ward whilst the patient is assessed at another location. Returning patients to the most appropriate destination is still being delayed regardless of the terminology used. In Glasgow, we heard that patients can often wait four weeks until a package at home or appropriate social care setting is provided. [35]

48. We also received written evidence to confirm that "West Lothian does not operate a bed based model of intermediate care as an alternative to a care at home approach". [36] Therefore, as the intermediate care provision does not operate in all areas of the country, it is difficult to gauge its sustainability and success.

49. Some reductions in delayed discharge have been made by utilising intermediate care. However, we heard evidence that not all IJBs use this model of care and it has varying degrees of success across Scotland.

50. We ask the Scottish Government to advise if intermediate care is an appropriate approach to caring for vulnerable people and if so should it be implemented across the country. We also request the Scottish Government to advise what data on intermediate care is available and their intention to collect and publish this data.

Unplanned acute bed days

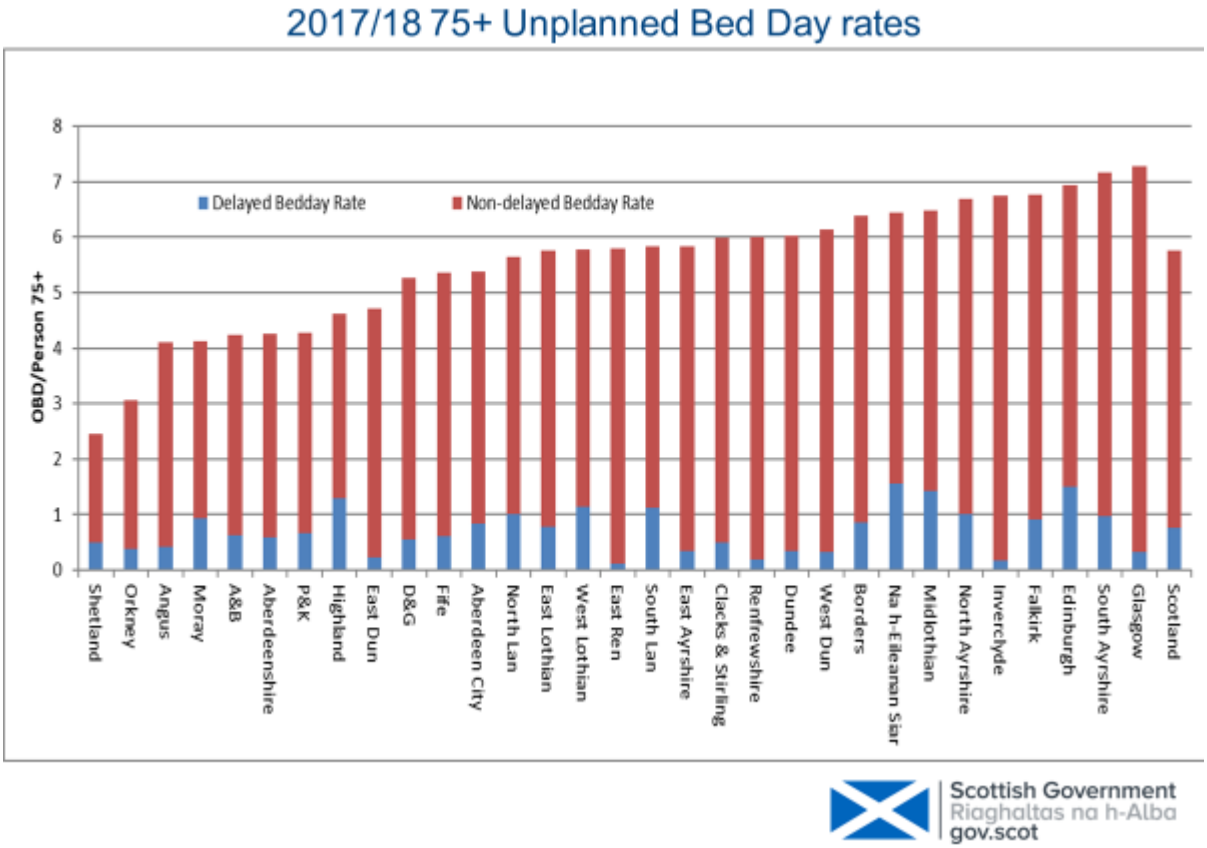
51. In addition to delayed discharge and intermediate care, chief officers discussed acute unplanned bed days with us, which is also an indicator monitored by the MSG. It is intended that more effective integration of services will help reduce the number of unplanned acute bed days. As outlined earlier in our report, attention also needs to focus on preventing hospital admissions.

52. Glasgow's IJB board paper in May describes how the IJB is tackling unscheduled hospital admissions. It highlights a decrease in unscheduled acute bed days in each year since 2016-17. However, the trajectory suggests an increase in 2019-20. Glasgow's written evidence to the Committee states that,"progress has been made in relation to unscheduled hospital admissions, and bed days lost due to delays" but it has been challenging.

53. Eddie Fraser, chief officer for East Ayrshire IJB, commented on the lack of any reduced pressure in acute services in response to reductions in unscheduled bed nights –

> MSG indicators on unscheduled care bed nights show that many partnerships across Scotland—probably the majority—have reduced the number of unscheduled care bed nights that they commission from the acute sector, but sometimes the acute hospitals are just as busy. In board areas such as NHS Ayrshire and Arran, where more than one IJB uses a hospital, all the partners need to reduce the pressure on the hospital before there is any release" of unscheduled care beds. [37]

54. The Scottish Government provided us with data which illustrates the number of unplanned bed days per person aged 75+ by partnership. On average, delays make up 13% of overall bed days, but this varies from 2.5% in Inverclyde to 28% in Highland.



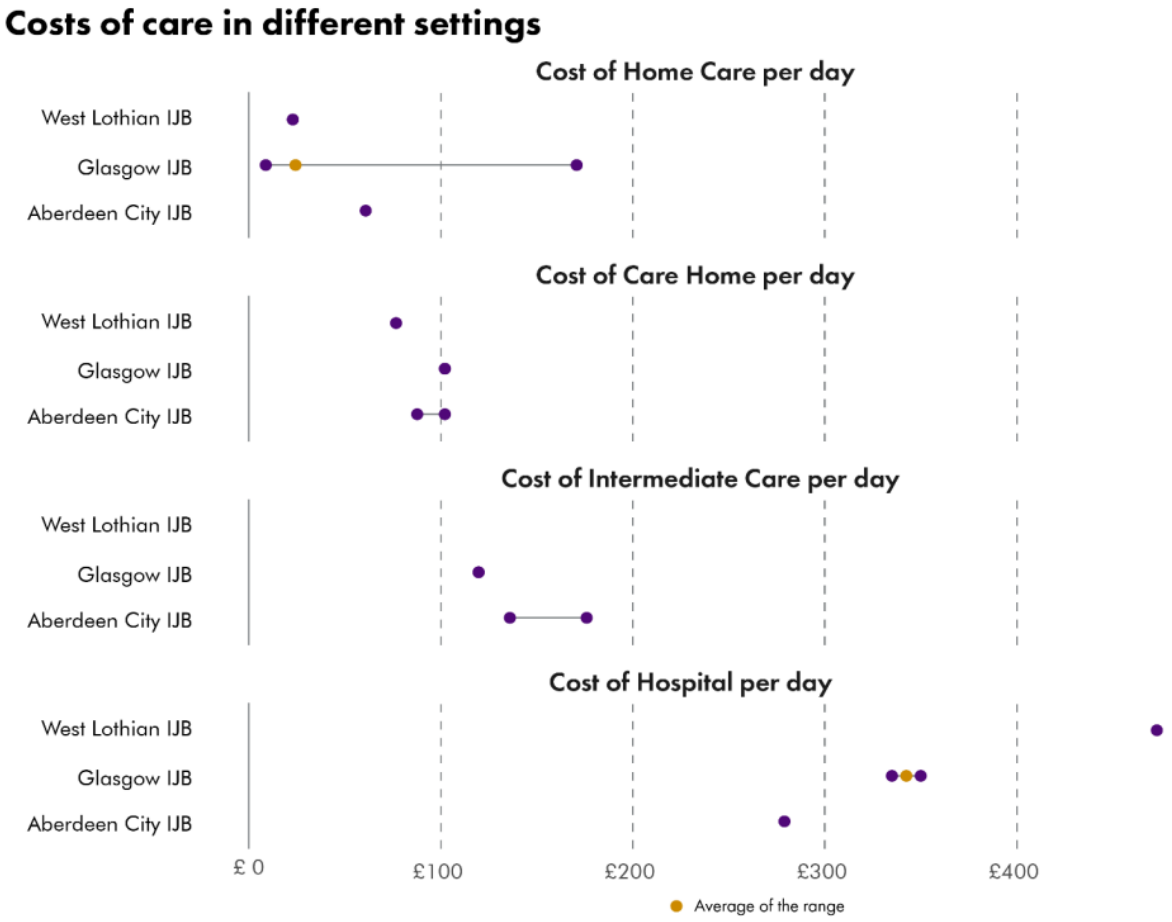
Source: The Scottish Government

55. Sandra Ross, chief officer for Aberdeen IJB, also highlighted the way in which the city has addressed hospital admissions. They have “tested and implemented acute care at home, which started off being geriatrician led, and through which people have either been coming out of hospital or have been turned around at the front door”. [38] Often, patients with dementia are re-admitted to hospital and Aberdeen are considering a dementia village to alleviate this concern. Sandra Ross also confirmed the IJB "work closely with GPs and care homes in order to maintain clinical oversight of patients" [39] and reduce hospital admissions if they can be prevented.

56. On a similar theme, Jim Forrest, chief officer for West Lothian IJB, outlined the ways in which they are tackling dementia in the area without hospital admissions. He stated, “we seconded a GP to work with a nurse practitioner to go round all our care homes to look at how we set anticipatory care planning for patients”. [40] In addition, West Lothian have also created a mental health team led by psychology colleagues. The team work with care home staff to provide support for patients. [41]

57. The Committee requested further information on the range of daily costs for each care environment. The information below was provided by Glasgow, Aberdeen City and West Lothian IJBs. It is clear that the average cost of hospital per day in each of the three IJBs is greater than all other care settings provided.

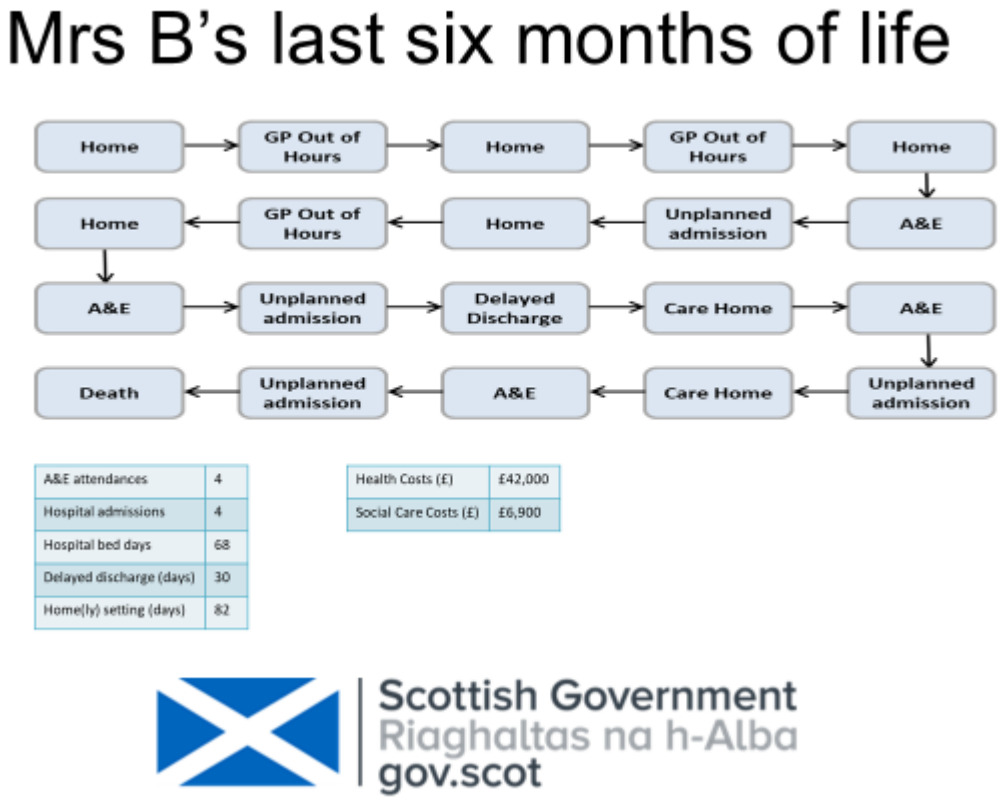
58.



Source: The Scottish Parliament

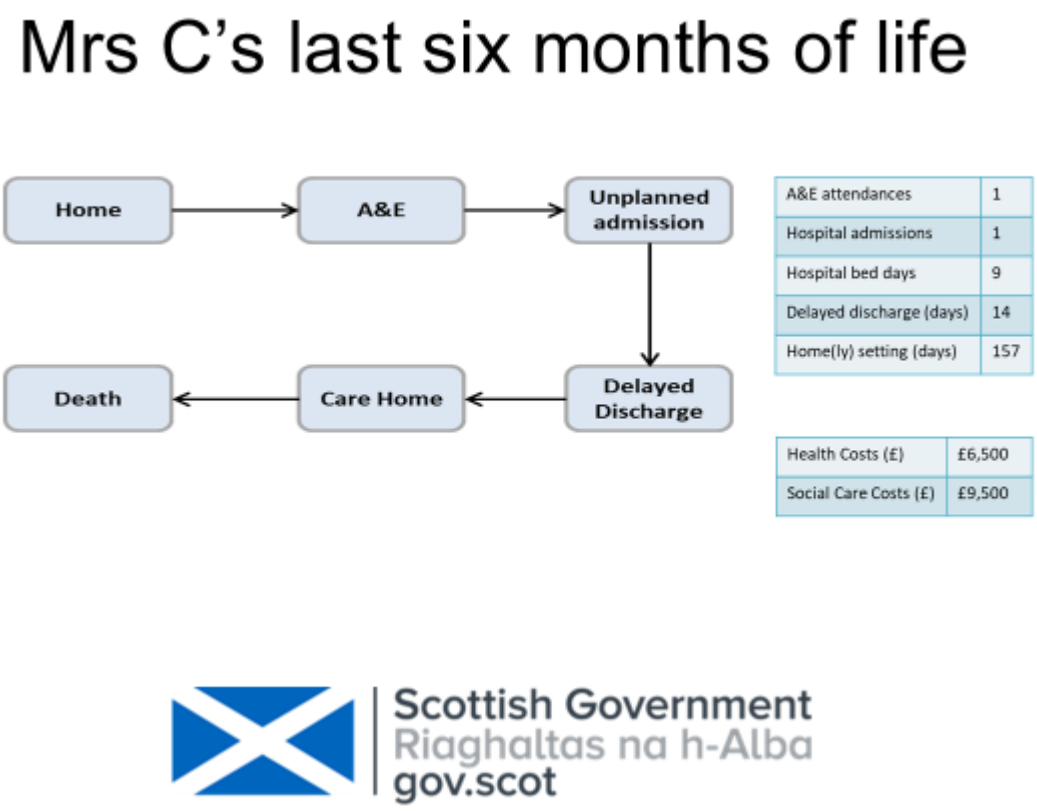
59. The Scottish Government also provided us with a case study to illustrate the costs involved for the last six months of a patient's life and their journey through the health care system.

60. The diagram below illustrates Mrs B's experience of care at age 80. Mrs B had five long term conditions (Arthritis, Cancer, Chronic Obstructive Pulmonary Disease (COPD), Dementia and Diabetes) and lived in a relatively deprived area. Mrs B was living at home at the start this period. Mrs B spent 55% of her last six months in hospital; 30% in a care home; and 15% at home. The cost of her care was **£49,000.**



Source: The Scottish Government

61. By contrast to the care of Mrs B, the diagram below illustrates a different example from the same partnership. Mrs C was another 80 year old woman, she had four long term conditions (cardiovascular disease, chronic heart disease, chronic obstructive pulmonary disease (COPD) and dementia) and lived in a relatively affluent area. In total, Mrs C spent 46% of her last six months at home and 41% in a care home, the rest (14%) being in hospital. The cost of her care was **£16,000.**



Source: The Scottish Government

62. Reviewing the above information from the Scottish Government and written submissions, it is clear that the daily cost of intermediate care, home care or a care home are all significantly less than residing in hospital. It is clear that whilst delayed discharge is a key issue across Scotland, it is not the sole reason for delays and there are opportunities which exist and could be utilised, for example, preventative medicine.

63. Reducing the number of patients entering hospital by meeting their needs in the community, will have a positive impact on occupancy, staffing levels and waiting times overall. This will also improve outcomes for patients and reduce costs.

64. The Integration Authorities are vital to making progress in this area. Yvonne Lawton, head of strategic planning at West Lothian IJB, advised, "we should be looking at it from the other angle. If we presume that home is the first place that we want to be, how can we design our systems around maintaining someone at home for as long as possible?". [42]

65. In agreement, Sandra Ross, chief officer at Aberdeen City IJB advised, "we need to start looking at the whole system and thinking about how to shape the prevention agenda. How do we make sure we that we will have fitter adults? We need to focus on our children, then we will have less ill population in the future. That prevention agenda will help shift that balance. Given the demographics, it will be extremely difficult to maintain things if we continue with what we have at the moment." [43]

Housing adaptations

66. Another area fundamentally linked to delays in discharge and the transformation of delivery of services from acute care into the community are housing adaptations. When patients are in hospital and due to return to the community, often discharge is delayed as their house requires an adaptation or they are waiting on suitable accommodation to meet their needs. We heard that “adaptations are a good, robust example of work that we do to sustain people in their homes". [44]

67. The issue of housing adaptations was also addressed by the Local Government and Communities Committee in their 2019-2020 pre-budget scrutiny . In a letter to that Committee, the Cabinet Secretary for Communities said –

> We are grateful to the Committee for its continued interest in our work on housing adaptations. This work has a practical focus, identifying barriers and potential areas for development within existing regulations, guidance and practice relating to adaptations. Officials will work actively with stakeholders to support Integration Joint Boards and their partners to improve arrangements at local level in the planning and delivery of the adaptations and ensure the person centred, tenure neutral approach to housing adaptations that both Ministers and the Committee want to see right across the country. We expect this work to continue to progress over the course of the calendar year and complete by the end of 2019. [45]

68. We asked chief officers if they felt there remained barriers to the timely provision of housing adaptations and any particular aspects that needed addressed. Kenny O’Brien, service manager for Aberdeen City IJB admitted there has “certainly been pressure on budgets and increasing demand” [46] but they have done relatively well in Aberdeen on this issue. He observed, there will always be a “lag of time from the identification of the need to completion”. [47] However, the IJB is working hard with social work employees and discharge hubs. "If someone has surgery for an amputation and we know that they live in a tenement three floors up, rather than wait until they are referred, we will get housing issues sorted earlier". [48]

69. The IJB has also obtained tenancies of two disabled-access and wheelchair accessible flats in the city. They have been adapted significantly to “work with a wide spectrum of individuals with different occupational therapy and adaptational needs”. [49] This initiative, allows patients to leave hospital sooner and retain their skills and independence, whist they are waiting to be rehoused or for their own home to be adapted.

70. Stephen Fitzpatrick, assistant chief officer for Glasgow IJB, confirmed that housing adaptations is a live issue in Glasgow too. They had saught to “prioritise and protect the budget when income for social care has been reducing”. [50] Whilst noting the importance of adaptions, he also highlighted that the issue is a “marginal factor in delayed discharge in Glasgow and a marginal cause of unscheduled admissions to acute care”. [51] The balance of care within the community is key.

71. South Lanarkshire stated, "supporting people and households to live independently in their own home or a homely setting within the community is a core cross-cutting theme." [52] They also advised that "over the three year period since 2016, a total of £15.587m has been spent by Housing Services on equipment, adaptations and the care of gardens to support people to remain at home." [53]

72. The Local Government and Communities Committee have completed work on housing adaptations during their pre-budget scrutiny for the past two years. We endorse their conclusion that "people should have access to a safe and secure home which meets their needs. A properly funded, streamlined and effective adaptations programme is an important part of enabling people to remain in their homes for longer as well as enabling people to more quickly return home from hospital thus reducing delayed discharge". [54] We also note a key recommendation of the Report of the Adaptations Working Group stating there should be a strategy for housing adaptations, which is 'tenure neutral' with a single funding source.

73. Further information can be found in their Report on the Scottish Government's Draft Budget 2018-19 and Report on the Scottish Government's Draft Budget 2017-18

74. It is clear that sustained focus on the timely provision of housing adaptations is a necessity to enable older people to live at home for longer. All IJBs we contacted, acknowledged the significance of housing adaptions and the need for funding requirements but accepted it is only one aspect of transferring care from acute services to the community.

Changing perceptions

75. We have highlighted the daily cost of residing in hospital compared to home care, intermediate care or a care home and shown that shifting the balance of care from acute services to the community using preventative care and housing adaptations is a positive, necessary and cost effective move. Public engagement on changing models of care was another theme we explored in our inquiry.

76. Eddie Fraser, chief officer for East Ayrshire IJB, illustrated his concern on this topic when he said, “our clinicians are only willing to transfer care if they see safe alternative models of care: if a practitioner is not going to refer someone to hospital, there must be an alternative that they feel is safe”. [55]

77. Val de Souza, chief officer for South Lanarkshire IJB, agreed, highlighting the challenges for integration authorities in the future. She said, “we work in an environment in which demand and complexity are increasing as people live longer and with more conditions”. [56] Transformation of services is required and we “need bigger national messages to bring the public with us in relation to what is required to take the next steps”. [57] Val de Souza also acknowledges that many people in society do not like change, but it is the responsibility of chief officers to lead on this transition, demonstrate that change is good and promote confidence in the system.

78. Val de Souza, also saw a need to change perceptions around hospital and community care –

> We need a scattergun approach to communicate the need for change and the fact that being in hospital is a bad thing. The general public still believe that a hospital is a good and safe place in which to be, but—with no disrespect to my acute colleagues—it is not a place in which to languish or stay. [58]

Transformation of services

79. It was suggested the term 'transformation of services' requires further clarity and to be clearly communicated to members of the public. It is estimated that a saving of £300 million must be made across the 31 integrated authorities this year and every year for the next three years. [59] To achieve this £900 million, difficult decisions will have to be taken, resulting in a change to the way services are delivered throughout each community. Eddie Fraser, chief officer for East Ayrshire IJB, is of the view that it is still possible to make savings and invest in the community. He argued that individuals need to feel valued and included, stating, "our public health colleagues tell us that the impact of someone being excluded and of social isolation is the same as if they smoked 15 cigarettes a day". [60]

80. **Scottish Government view**

In a response to our report in 2018, "Looking ahead to the Scottish Government - Health Budget 2019-20: Is the budget delivering the desired outcomes for health and social care in Scotland?", the Cabinet Secretary for Health and Sport committed that, "by the end of this Parliament, more than half of frontline NHS spending will be in community health services". [61] In order to accelerate the pace of change required in behaviour and practice, we asked the Scottish Government to consider re-evaluating this aim and whether a more ambitious target could be provided.

Latest figures show a shift towards community health services in 2017-18. The level currently stands at 49.6% and this is set out in the diagram below.

81.

Shifting Balance of Care to Community Health Services

	2017-18			2016-17		
NHS Board	Hospital £000	Community £000	Total £000	Hospital £000	Community £000	Total £000
Total Spend	5,996,859	5,895,041	11,891,900	5,882,803	5,669,166	11,551,969
Balance of Care Split	50.4%	49.6%		50.9%	49.1%	

Source: The Scottish Government

82. The Scottish Government's Ministerial Strategic Group (MSG) for Health and Community Care focuses on six indicators that are regularly monitored. These are -

- Acute unplanned bed days;
- Emergency admissions;
- A&E performance (including four-hour A&E waiting time and A&E attendances);
- Delayed discharge bed days;

- End of life spent at home or in the community; and
- Proportion of over-75s who are living in a community setting. [62]

83. Audit Scotland reviewed performance data for each of the above indicators and found that performance had improved against four of the indicators. Performance had weakened in respect of emergency admissions and A&E performance.

84. Audit Scotland also found significant local variation in performance between IAs. The MSG report also made reference to the variation in performance and highlighted that future savings within the health and social care budget depend on reducing this variation –

> The Scottish Government Medium Term Financial Framework includes an assumption of efficiencies from reduced variation in hospital care coupled with 50% reinvestment in the community to sustain improvement. [63]

85. Nationally, there is a mixed picture of success of integration for the six Ministerial Strategic Group indicators (Table 1).

86. **Table 1. Indicators of Scottish integration over time**

n/a indicates unavailable or, in the case of delayed discharge, changes in definitions that make earlier data incomparable to recent data

Scotland totals	2014/15	2015/16	2016/17	2017/18	2018/19	Positive or negative change?
Number of emergency admissions	n/a	581,195	583,277	588,250	n/a	Negative
Number of unscheduled hospital bed days	n/a	4,061,338	4,055,254	4,009,233	n/a	Positive
Number of A&E attendances	n/a	1,447,636	1,468,893	1,496,553	1,540,654	Negative
Number of delayed discharge bed days	n/a	n/a	n/a	493,614	521,215	Negative
Percentage of last six months of life spent in the community	86.2	86.7	87.0	87.9	n/a	Positive
Percentage of population residing in non-hospital settings for all people aged 65+	98.8	98.8	98.9	98.9	n/a	Positive

Data from Scottish Government, personal communication

Source: The Scottish Government

87. A report highlighting progress of the MSG indicators will be considered in November 2019. We request that the Committee is kept informed.

88. We acknowledge the steps taken to streamline the patient journey from hospital to the community with regards to intermediate care and the financial commitment from the Scottish Government for at least 50% of frontline NHS spending to take place in the Community Health Service by 2021. However, delayed discharge continues to be a key issue and progress remains inconsistent across Scotland. It is clear that the daily cost of intermediate care, home care or care homes are all significantly less than residing in hospital and further improvements would both

be of benefit to patients and also deliver budget savings. We are also concerned for the physical and mental well-being of the patient if the risk of residing in hospital is greater than the risk of being discharged.

89. We recommend an increased focus is given on the 'front door' of hospitals reducing unscheduled care and admissions and ensuring the needs of patients are met and addressed in other areas of the NHS. A proactive approach with emphasis on preventative medicine, GPs working with care homes and district nurses in the community will reduce heavy reliance on acute services.

90. We recommend a review of communication strategies around alternatives to GP referrals. GPs must have the confidence to offer alternative aspects of the health care system to the patient. Hospital is not always the best and most suitable option.

91. We also recommend an increase in the provision of health education and awareness, particularly in relation to ensuring patients are fully informed of all options to obtain appropriate advice and care. This will reduce unnecessary calls to the GP, out of hours service and A&E. In turn, this will assist in alleviating costs and pressures on the acute service.

92. Where there is more than one IJB using the same acute care service, it is essential they work together to reduce the number of unscheduled care admissions.

93. Priority also needs to be given to housing adaptations - reviewing and speeding up ways in which the move from hospital to person-centred accommodation is provided. IJBs must improve arrangements at a local level in the planning and delivery of adaptations across the country. This needs work to be monitored and reported on and its delivery from the next calendar year onwards. We look forward to receiving an update on progress towards implementing the recommendations in the Adaptations Working Group report.

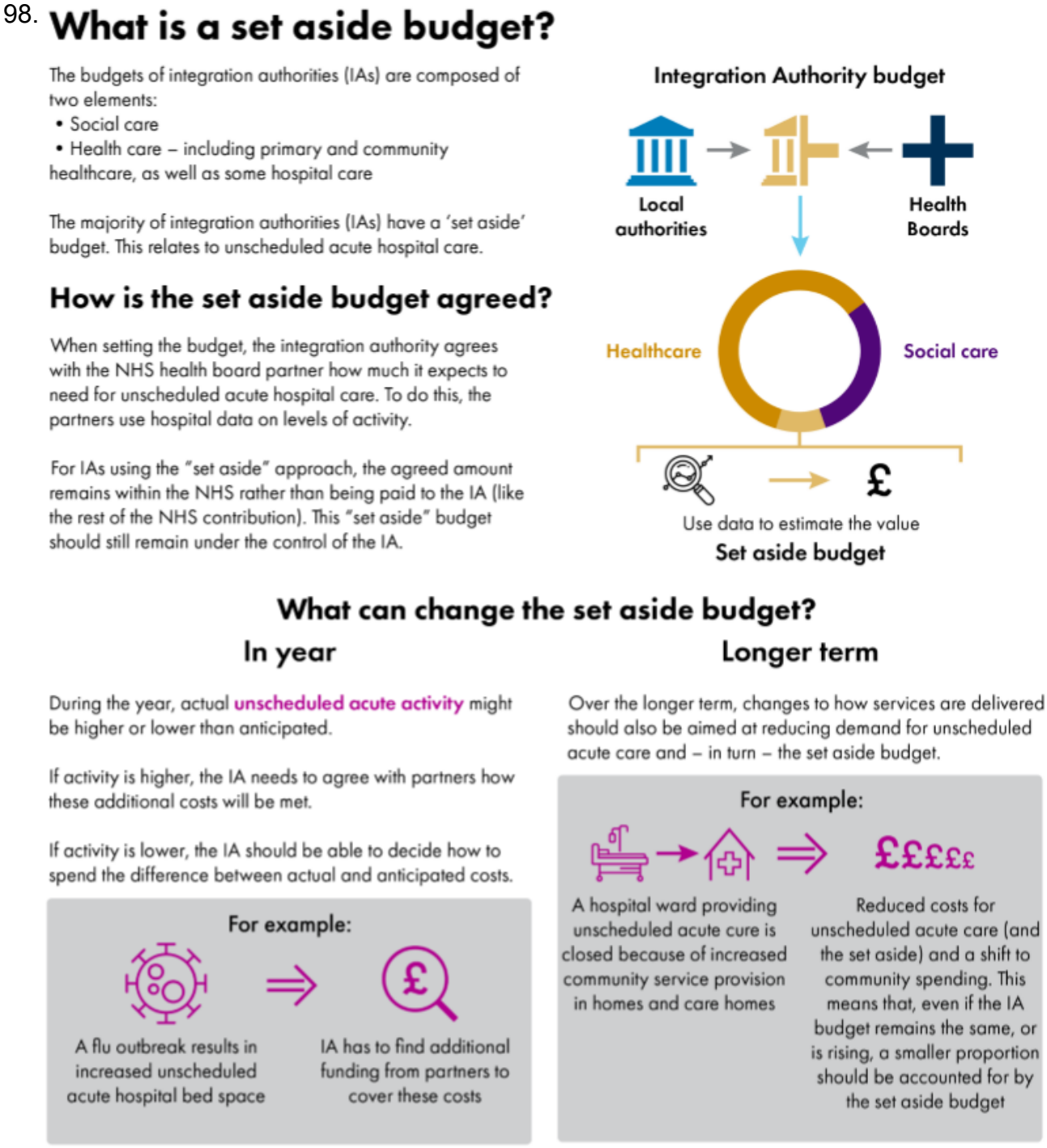
94. It is clear there is a responsibility on the chief officers to lead and fully engage with the local authority, health board, Scottish Government and wider community in order to move forward with the transition in the way services are delivered. A shift in public perception and expectation is required. All public bodies must work towards this outcome and it is imperative there is transparency, confidence and openness in the health care system.

Set aside budget

95. Closely linked to unplanned acute bed days/unscheduled care is the set aside budget. The set aside budget represents the Integrated Authorities share of the budget for delegated acute services provided by large hospitals on behalf of the IA.

96. An IA identifies how much it expects will be required for unscheduled care in its area. A decision is then made as to whether this amount is included or excluded in the sum allocated to the IA by the NHS Board. When not directly included, it is "set aside" and retained by the NHS Board to be drawn down by the IA as needed.

97. Some NHS boards manage set aside differently and do not use this terminology but the principle we are referring to is described in this section of the report and illustrated in the diagram below -

98. 

Source: The Scottish Parliament

99. If expenditure on delegated acute services is more than the amount anticipated in the budget, the IA will be required to fund this additional expenditure from elsewhere in the budget. Alternatively, if expenditure is lower than anticipated (for example a reduction in A&E or unplanned admissions) then the IA should – in theory – have access to the funds released and be able to direct that additional funding to other parts of its operation.

100. Set aside was a topic we followed closely in our 2018 report, "Looking ahead to the Scottish Government - Health Budget 2019-20: Is the budget delivering the desired outcomes for health and social care in Scotland?". We concluded that "there remains a disconnect between how the set aside budget should operate in principle compared to how it is operating in practice". [64] It was apparent that IJBs were not

effectively controlling set aside and funds were remaining under the control of the health board.

101. We also concluded that "The Scottish Government described the set aside budget as a mechanism for shifting the balance of care, however this mechanism is not being utilised effectively across all IAs. Some IAs describe the budget as a "notional" budget rather than an actual budget that they can use to affect change." [65]

102. **Scottish Government view**

In response to our conclusions in the 2018 report, the Cabinet Secretary confirmed-

> We need to step up the pace of integrating health and social care. Truly integrated services, focused on the needs of citizens – individuals, carers and families, and on the health and wellbeing of local communities – require leadership and personal commitment. We need to act together to accelerate progress. We expect each health board, in partnership with the Local Authority and Integration Authority, to fully implement the set aside requirements of the legislation in line with the statutory guidance published in June 2015. [66]

103. Following our report, the Ministerial Strategic Group report agreed the set aside budget is not operating as intended -

> Each Health Board, in partnership with the Local Authority and IJB, must fully implement the delegated hospital budget and set aside budget requirements of the legislation, in line with the statutory guidance published in June 2015. These arrangements must be in place in time for Integration Authorities to plan their use of their budgets in 2019/20. The Scottish Government Medium Term Financial Framework includes an assumption of efficiencies from reduced variation in hospital care coupled with 50% reinvestment in the community to sustain improvement. The set aside arrangements are key to delivering this commitment. [67]

104. Reflecting on the outcome of our 2018 report, we were intrigued to hear further evidence on this aspect of the budget. Stephen Fitzpatrick, assistant chief officer of Glasgow City IJB, outlined the difficulty when an acute service is operating at 90% capacity. He stated there is reluctance to release some of the resource to invest in community alternatives. He accepted that the "system can not be sustained" [68] unless funding can be reviewed and there is a more efficient way to fund services. A whole system approach is required.

105. We also heard the set aside budget is clearly not working as originally intended in South Lanarkshire. Chief finance officer, Marie Moy suggested, "Over the next eight years up to 2027, the older population in Lanarkshire will increase by almost 30%. To accommodate that increase, [we] would need to make available more beds and social care home services by shifting the balance of care. The underlying assumption that we could release resources from the acute services to fund [a shift to community care] is unrealistic and flawed". [69]

106. On a more positive stance, Edinburgh IJB were able to provide the Committee with examples of where they have "planned and delivered services differently with

funding from acute services being used or earmarked to deliver more community based or community facing, services –

- Services for people transferred from the Acute Mental Health Royal Edinburgh Hospital to deliver support to people in their own tenancy in the community;
- Closure of the Corstorphine Hospital and support to men and women with learning disabilities in the community in their own homes; and
- Plans for the closure of the Liberton Hospital and for resources there to deliver community models of support, re-enablement and early intervention under a Home First model." [70]

107. South Lanarkshire IJB were able to provide a concrete example of when the set aside budget has been used effectively although recognising there was "no pathway or guidance when [they] started to work on it." [71] Their example of Udston Hospital was also used as a case study in the 2018 Audit Scotland Report "Health and social care integration: Update on progress".

108. The case study reported on the closure of a care of the elderly ward at Udston hospital, after it was identified that patients could be better served in a community setting. "Prior to the ward closure, it was estimated over £1 million would be available to be used for other aspects of the health care system. Of this, it was eventually agreed that £0.70 million should be redirected to improve or provide community-based services. The remaining £0.37 million was retained by the hospital sector, to meet cost pressures on the set aside budget (such as inflation) and for reinvestment in acute hospital services, as demand was expected to change as a result of the ward closure. The plans for the £0.70 million for community reinvestment (alongside £0.06 million from elsewhere in their budget) are illustrated in the diagram below". [72]

109. **South Lanarkshire reinvestment to community services**

Service	Spend (£000s)
Homecare	376
Community nursing	243
Support Workers	60
Physiotherapy	40
Pharmacy	42

South Lanarkshire IJB, 2019[36]

Source: The Scottish Parliament

110. The aim of this transition was to address the need for services that respond to crisis care, prevent hospital re-admission and reduce the need to reside in hospital.

111. Particular issues identified during the process were -

1. Consultation and engagement - the integration joint board undertook public engagement to develop their Strategic Commissioning Plan allowing for the ward closure and change to community care (and existing governance arrangements as they related to engagement with NHS staff).

2. Ownership of the money and savings, as well as how these were spent – it was complicated to determine and agree where identified savings belonged in relation to the integration authority, health board, or local council. [73]

112. Set Aside budgets continue to be problematic in many ways including initial identification and release of “savings”. This is an unacceptable position four years after integration and we expect all issues to be resolved by the end of this financial year and clear identification of released sums reported quarterly.

Leadership and cultural change

113. Leadership and the importance of relationships has been a theme throughout our work this session, during our pre-budget scrutiny and an issue we investigated in our 2018 report, "Looking ahead to the Scottish Government - Health Budget 2019-20: Is the budget delivering the desired outcomes for health and social care in Scotland?". In the 2018 budget report, we concluded that "a number of integration authorities do not appear to be exerting [a] challenge function and ultimately their authority and control over the budget is being dictated by individual partners". [74]

114. That report further states, "We do not believe at this stage we are seeing evidence that IA leadership across all 31 IAs is equipped to deliver [the required] change in relationships and ultimately deliver the transformational change in health and social care that is required". [75]

115. Audit Scotland found that "a lack of collaborative leadership and cultural differences are affecting the pace of change" and highlighted the high level of turnover at senior level, the dual roles often held by chief officers/chief financial officers and the lack of support services.

116. The Ministerial Strategic Group report also committed the Scottish Government and COSLA to identify and address leadership development needs and stated that "relationships and collaborative working between partners must improve".

117. **Scottish Government View**

The Cabinet Secretary for Health and Sport provided the following response to this aspect of the Committee report on 21 December 2018 –

> The Scottish Government agrees that strong, effective leadership centred on partnership working across health and social care is central to the success of integration. It is important to be clear that responsibility for making good progress in reasonable timescales is shared across the system and does not sit solely with individual organisations or individuals, no matter how senior. Trust between partners varies around the country. We are committed to ensuring both the correct expectations and conditions for integration are in place locally and nationally, and our work to review progress with integration is focussing especially on leadership challenges. [76]

118. We have been interested throughout the year to examine leadership and ascertain what if any, improvements can be identified since we reported.

Scrutiny of NHS boards

119. This session, our Committee has undertaken one-off evidence sessions with all territorial health boards. As organisations that receive public funds, they fall to be held accountable by the Health and Sport Committee in relation to their performance, value for money and meeting of objectives.

120. Common themes identified throughout this process was the issue of brokerage and lack of leadership at the most senior level. We heard from a number of health

boards which sought brokerage over consecutive years. Last year, the Scottish Government provided one health board with £18 million to balance the financial overspend on areas such as "medical staffing—particularly locum medical staffing—drugs and social care". [77] At least two Boards have also been have been escalated to 'Stage 4', the second highest level of concern and risk identified by the Scottish Government, which is defined as there being '*significant risks to delivery, equality and financial performance or safety; senior level external support required*'. [78]

121. We would welcome confirmation from the Scottish Government as to whether brokerage provided in this financial year will require to be repaid.

122. In our 2018 report, The Governance of the NHS in Scotland - ensuring delivery of the best healthcare for Scotland, we considered Corporate Governance. We highlighted that "the main purpose of boards is to provide effective leadership, direction, support and guidance to organisations and ensure that the policies and priorities of Scottish ministers (and the Scottish Government) are implemented". [79]

123. We looked at how NHS leadership was providing the vision and the strategic direction to deliver the transformational change required in health and social care. As well as considering the functions boards should perform, we also considered whether the approach and behaviours adopted at the senior levels of the NHS were fostering a culture of openness and improvement.

124. The Scottish Government 'On Board' guidance details that two of the main functions of a board are to ensure strategic leadership and financial stewardship. The guidance details this should include developing and agreeing the organisation's strategy and ensuring financial information is accurate and financial controls and systems of risk management are robust and defensible.

125. The Cabinet Secretary for Health and Sport told us, "Our NHS boards are responsible for providing the vision and the strategic direction through which they deliver high-quality, safe and effective care to our communities." [80]

126. However, our evidence suggested that boards faced challenges in delivering this strategic leadership. There was a perception from some board members that NHS boards were powerless to set strategy and affect the change they want. They attributed this largely to the delegation of board functions to IJBs, the greater regional planning of services, and their assertion that much of the strategic direction is set centrally by the Scottish Government. [81]

127. Our Corporate Governance report in 2018, our 2018 budget report, our ongoing scrutiny of NHS health boards as well as this report, all provide evidence to highlight the challenges at senior leadership level. We remain clear that only through strong leadership can the transformational change required across health and social care be delivered.

128. The Public Audit and Post-legislative Scrutiny Committee's recent report also highlighted leadership and workforce challenges as a key theme for audits in the public sector.

129. Their report concluded there is an urgent need to address the leadership challenges the public sector is facing and "effective leadership is critical to the delivery of high quality public services which meet the needs of users of such services and also provide good value-for-money". [82] They also consider the "style and quality of leadership within organisations affects service users, staff, and the partners with whom public bodies need to work". [83]

130. The Committee further recognised that "making decisions requires leaders to take risks to pursue certain services and to stop providing others and, as such, leaders will need to possess the necessary skills and experience in order to do so". [84] It recommended that the Scottish Government take action across its directorates, and in collaboration with other public bodies, to address this issue.

131. In written evidence to our Committee this year, Glasgow City IJB made a number of comments that suggested relationships were not supporting integration and there is still considerable work to be done–

> The chief officer and chief finance officer experienced very limited engagement with NHS Greater Glasgow and Clyde during 2018/19 in the lead up to the budget offer issued. [85]

132. They also said–

> Integration requires all three parties [Local Authority, Health Board and IJB] to work together to assess what is required to deliver integration in the local area, which includes the budget. The IA is required to operate in this way, however to date Partner bodies and budget process continue to operate in isolation which results in budget decisions being taken by one partner which can have implications for the wider health and social care system and therefore the other Partner body and IA. [86]

133. This topic was investigated further with Stephen Fitzpatrick, assistant chief officer for Glasgow IJB. We also requested further written evidence with regards to whether money has lost its ‘social care’ or ‘health’ identity in the IJB in order for integration to exist. Stephen Fitzpatrick advised there has been a “conscious effort made by the IJB to lose the identity of funding within the elements of the system that the partnership controls”. [87] However, there is a structural issue still to be resolved of how the money flows in and out. This continues to place constraints on the IJB.

> Both sets of Partners remain vested in the budget allocation which they delegate to the IJB and expect this to be used to fund services within their respective services. As an example, Glasgow City Council’s budget report stated, ‘It is anticipated that the contribution from the IJB to the Council will be in line with the Council’s approved budget.’ This is contrary to the spirit of integration and the IA’s statutory responsibility to determine how funding is directed. [88]

134. When reviewing the cultural change required for the Local Authority and Health Board, he stated it is “not realistic to expect cultural change to take place on the

same timescales" [89] Glasgow IJB have "concerns that the conditions do not yet exist to give full effect to the policy intentions of the legislation". [90]

135. Jim Forrest, chief officer for West Lothian IJB, agreed more can be done and a shift in culture and attitude is at the heart of the issue. He highlighted that "good governance structures and oversight" [91] are needed to allow a change to happen. Adding, this is still an ongoing development.

136. In written evidence to the Committee, Jim Forrest also advised that "good progress is being made in developing integrated approaches to planning but more work needs to be done in this area." [92] He also provided a few examples of where pooled funding is being used to deliver the best outcomes for people -

- The Learning Disability Transformation Programme has facilitated the redesign of local services for people with learning disabilities. The programme has involved a whole system approach and is delivering a shift in the balance of care enabling people to live as far as possible in a homely setting;
- Pooled funding has been used to establish an integrated discharge hub within St John's Hospital which has seen health and social work staff co-located alongside the local carers' support organisation. The purpose of the hub is to deliver more seamless and timely discharges from hospital where ongoing care and support are required; and
- Pooled funding has been used to develop a discharge to assess model to support early discharge from hospital through a reablement approach. This has seen resources from health and social care being invested to enhance social care provision. [93]

137. Progress has also been made in Aberdeen City. Chief officer, Sandra Ross confirmed the "IJB has full control over their budget and there is no or little reference to where the budget ultimately came from in the budget monitoring or budget setting processes. It's difficult to provide a specific example, as there is no ownership over funding and the budget is managed and operated as one". [94]

138. Kenny O'Brien, service manager for Aberdeen City IJB, also confirmed "he has a shared budget now, it is not a council budget. It does not matter what is on the ledger. Consequently, I was very able to talk with our primary care colleagues and agree the appropriate contracts and service level agreements to support the medical cover and nursing cover to allow the seamless flow and turnover of people into those kind of settings". [95]

Sharing good practice

139. In a response to our 2018 budget report, the Scottish Government also provided information on how integration authorities are working together to share good practice. The Cabinet Secretary said -

> "chief officers of Integration Authorities across Scotland launched a collaborative leadership network called "Health and Social Care Scotland" at their inaugural annual conference on 7 December 2018. The First Minister opened the event, which provided an opportunity for partnerships to share learning and practice with one another". [96]

140. However, evidence received in our Committee meeting on 4 June, highlighted limited success in this area. When asked if enough is being done to share good practice across all integration authorities, Kenny O'Brien, confirmed, "it is not 100 NHS boards consistent across all the elements that we are working on". [97] Stephen Fitzpatrick, concurred, stating there is always room for improvement. He said, "there is a lot of innovation out there and sometimes you happen upon it by accident. Glasgow tries to "look externally and to avoid the temptation to be too insular". [98] Stephen Fitzpatrick added–

> ...it is important for all agencies to have a proactive approach to sharing information, reviewing what is working well across other partnerships and investigating how that can be achieved in your own area.

141. Strong leadership is fundamental to the integration of health and social care in order to deliver transformational change in services. Whilst we have heard concrete examples of where integration is working, there are still too many areas where this is not happening. Four years into the integration process there is evidence that funding for integration authorities is still failing to 'lose its identity' and all become partnership funding as legislation intended. It is clear that improvements require to be made.

142. We are unclear why this is taking so long and given the preponderance of reports highlighting this issue, sceptical about the attention and urgency being diverted in this area.

143. Leadership is critical and we observe the six indicators which are the focus of regular monitoring of the MSG [99] do not directly measure this. We recommend the Scottish Government identify a set of leadership indicators requiring boards to demonstrate their achievements and progress.

Conclusions

144. We heard Hospital is not a "place in which to languish or stay". Prolonged stay can have a detrimental effect on the health and well being of the patient, particularly the elderly. There is clear evidence hospital is for many not a cost effective or healthy setting.

145. In order to transfer care from the acute to community setting, an increased focus on the ‘front door’ of hospitals is required. There is a need to reduce unscheduled care and admissions and ensure the needs of patients are met and addressed in other, more appropriate areas of the NHS.

146. Leadership and financial management of the IJB budget remain paramount and require closer attention and monitoring.

147. The level of engagement required with members of the public must become a key focus in order to truly transform services.

Annexe A

Extracts from the Minutes of the Health and Sport Committee Meetings

12th Meeting, 2019 (Session 5) Tuesday 30 April 2019

1. Pre-Budget Scrutiny 2020-21 (in private): The Committee considered its approach to Pre-Budget Scrutiny 2020-21.

14th Meeting, 2019 (Session 5) Tuesday 21 May 2019

2. Pre-Budget Scrutiny 2020-21: The Committee took evidence as part of its Pre-Budget Scrutiny from—

- Judith Proctor, chief officer, and Moira Pringle, Chief Finance Officer, Edinburgh Integration Joint Board;
- Val de Souza, chief officer, and Marie Moy, Chief Financial Officer, South Lanarkshire Integration Joint Board;
- Eddie Fraser, chief officer, and Craig McArthur, Chief Financial Officer, East Ayrshire Integration Joint Board.

3. Pre-Budget Scrutiny 2020-21 (in private): The Committee considered the evidence heard earlier in the meeting.

16th Meeting, 2019 (Session 5) Tuesday 4 June 2019

1. Pre-Budget Scrutiny 2020-21: The Committee took evidence as part of its Pre-Budget Scrutiny from—

- Stephen Fitzpatrick, assistant chief officer, Older People's Services and South Operations, and Alan Gilmour, planning manager, Older People and South Locality, Glasgow City Integration Joint Board;
- Sandra Ross, chief officer, and Kenny O'Brien, service manager, Aberdeen City Integration Joint Board;
- Jim Forrest, chief officer, and Yvonne Lawton, Head of Strategic Planning, West Lothian Integration Joint Board.

3. Pre-Budget Scrutiny 2020-21 (in private): The Committee considered the evidence heard earlier in the meeting.

22nd Meeting, 2019 (Session 5) Tuesday 1 October 2019

1. Pre-Budget Scrutiny 2020-21 (in private): The Committee considered a revised draft report on its Pre-Budget Scrutiny 2020-21. Various changes were agreed to, and the report was agreed for publication.

Annexe B

Written evidence

- Edinburgh Integrated Joint Board written evidence
- South Lanarkshire Integrated Joint Board written evidence
- East Ayrshire Integrated Joint Board written evidence
- Glasgow City Integrated Joint Board written evidence
- Aberdeen City Integrated Joint Board written evidence
- West Lothian Integrated Joint Board written evidence

Supplementary written evidence

- Letter from Lewis Macdonald MSP, Convener of the Health and Sport Committee to Jeane Freeman MSP, Cabinet Secretary for Health and Sport – 14 May 2019
- Letter to Lewis Macdonald MSP, Convener of the Health and Sport Committee from Jeane Freeman MSP, Cabinet Secretary for Health and Sport – 20 May 2019
- Letter to Lewis Macdonald MSP, Convener of the Health and Sport Committee from Jeane Freeman MSP, Cabinet Secretary for Health and Sport – 5 June 2019
- Letter to Judith Proctor, chief officer, Edinburgh Integrated Joint Board from Lewis Macdonald MSP, Convener of the Health and Sport Committee – 6 June 2019
- Letter to Val de Souza, chief officer, South Lanarkshire Integrated Joint Board from Lewis Macdonald MSP, Convener of the Health and Sport Committee – 6 June 2019
- Letter to Eddie Fraser, chief officer, East Ayrshire Integrated Joint Board from Lewis Macdonald MSP, Convener of the Health and Sport Committee – 6 June 2019
- Letter from Eddie Fraser, chief officer, East Ayrshire Integrated Joint Board to Lewis Macdonald MSP, Convener of the Health and Sport Committee – 25 June 2019
- Letter from Judith Proctor, chief officer, Edinburgh Integrated Joint Board to Lewis Macdonald MSP, Convener of the Health and Sport Committee – 27 June 2019
- Letter from Val de Souza, chief officer, South Lanarkshire Integrated Joint Board to Lewis Macdonald MSP, Convener of the Health and Sport Committee – 8 July 2019
- Letter to Stephen Fitzpatrick, assistant chief officer, Older People's Services and South Operations, Glasgow City Integrated Joint Board from Lewis Macdonald MSP, Convener of the Health and Sport Committee – 24 June 2019

- Letter to Sandra Ross, chief officer, Aberdeen City Integrated Joint Board from Lewis Macdonald MSP, Convener of the Health and Sport Committee – 24 June 2019
- Letter to Jim Forrest, chief officer, West Lothian Integrated Joint Board from Lewis Macdonald MSP, Convener of the Health and Sport Committee – 24 June 2019
- Letter from Stephen Fitzpatrick, assistant chief officer, Older People's Services and South Operations, Glasgow City Integrated Joint Board to Lewis Macdonald MSP, Convener of the Health and Sport Committee – 8 July 2019
- Letter from Sandra Ross, chief officer, Aberdeen City Integrated Joint Board to Lewis Macdonald MSP, Convener of the Health and Sport Committee – 19 July 2019
- Letter from Jim Forrest, chief officer, West Lothian Integrated Joint Board to Lewis Macdonald MSP, Convener of the Health and Sport Committee – 22 July 2019

Official Reports of meetings of the Health and Sport Committee

Tuesday 21 May 2019 - evidence from Integrated Joint Boards

Tuesday 4 June 2019 - evidence from Integrated Joint Boards

1 The Scottish Parliament Information Centre briefing, 'Health and social care integration: spending and performance update', p6

2 Audit Scotland, 'Health and social care integration report, update on progress' , page 5

3 Scottish Government publication, Health and social care integration: progress review.

4 The Scottish Parliament Information Centre briefing, 'Health and social care integration: spending and performance update', page 16

5 The Scottish Parliament Information Centre, Committee briefing, 21 May 2019

6 Health and Sport Committee, Official Report, 4 June 2019, Col 2

7 Health and Sport Committee, 2016 (Session 5): Health and Social Care Integration Budgets (SP Paper 44).

8 Health and Sport Committee Report, 'Looking ahead to the Scottish Government Health budget 2019-2020 - Is the budget delivering the desired outcomes for health and social care in Scotland?, page 27

9 The Scottish Government response to the Health and Sport Committee 2018 budget report, 21 December 2018

10 Letter from Sandra Ross, chief officer, Aberdeen City Integrated Joint Board, 19 July 2019

11 Letter from Jim Forrest, chief officer, West Lothian Integrated Joint Board, 22July 2019

12 Letter from Stephen Fitzpatrick, assistant chief officer, Glasgow City Integrated Joint Board, 8 July 2019

13 Letter from Stephen Fitzpatrick, assistant chief officer, Glasgow City Integrated Joint Board, 8 July 2019

14 Letter from Stephen Fitzpatrick, assistant chief officer, Glasgow City Integrated Joint Board, 8 July 2019

15 Health and Sport Committee, Official Report, 21 May 2019, Col 25

16 Letter from Val de Souza, chief officer, South Lanarkshire Integrated Joint Board, 8 July 2019

17 Health and Sport Committee, Official Report, 21 May 2019, Col 26

18 Information Scotland Division (ISD) website

19 Comment provided from the Royal College of Nursing Scotland to the Health and Sport Committee, 17 September 2019

20 Written submission from Aberdeen City Integrated Joint Board

21 Edinburgh Evening News article, 12 September 2019

22 Edinburgh Evening News article, 12 September 2019

23 Edinburgh Evening News article, 12 September 2019

24 Health and Sport Committee, Official Report, 4 June 2019, Col 7

25 Health and Sport Committee, Official Report, 4 June 2019, Col 7

26 Written submission from Glasgow City Integrated Joint Board

27 Health and Sport Committee, Official Report, 4 June 2019, Col 9

28 Health and Sport Committee, Official Report, 4 June 2019, Col 10

29 Information Services Division Report 'Delayed discharges in NHSScotland' 11 September 2018, p12

30 Information Services Division Report 'Delayed discharges in NHSScotland' 11 September 2018, p15

31 Letter from Stephen Fitzpatrick, assistant chief officer, Glasgow City Integrated Joint Board, 8 July 2019

32 Letter from Stephen Fitzpatrick, assistant chief officer, Glasgow City Integrated Joint Board, 8 July 2019

33 Health and Sport Committee, Official Report, 4 June 2019, Col 14

34 Health and Sport Committee, Official Report, 4 June 2019, Col 12

35 Health and Sport Committee, Official Report, 4 June 2019, Col 12

36 Letter from Jim Forrest, chief officer, West Lothian Integrated Joint Board, 22 July 2019

37 Health and Sport Committee, Official Report, 21 May 2019, Col 37

38 Health and Sport Committee, Official Report, 4 June 2019, Col 20

39 Health and Sport Committee, Official Report, 4 June 2019, Col 21

40 Health and Sport Committee, Official Report, 4 June 2019, Col 22

41 Health and Sport Committee, Official Report, 4 June 2019, Col 22

42 Health and Sport Committee, Official Report, 4 June 2019, Col 25

43 Health and Sport Committee, Official Report, 4 June 2019, Col 26

44 Health and Sport Committee, Official Report, 4 June 2019, Col 35

45 The Scottish Government response to the Local Government and Communities Committee 2019-2020 pre-budget scrutiny report, 19 December 2018

46 Health and Sport Committee, Official Report, 4 June 2019, Col 36

47 Health and Sport Committee, Official Report, 4 June 2019, Col 36

48 Health and Sport Committee, Official Report, 4 June 2019, Col 36

49 Health and Sport Committee, Official Report, 4 June 2019, Col 37

50 Health and Sport Committee, Official Report, 4 June 2019, Col 37

51 Health and Sport Committee, Official Report, 4 June 2019, Col 37

52 Letter from Val de Souza, chief officer for South Lanarkshire Integrated Joint Board, 8 July 2019

53 Letter from Val de Souza, chief officer for South Lanarkshire Integrated Joint Board, 8 July 2019

54 Local Government and Communities Committee: Report on Scottish Government's draft budget 2019-2019, 22 January 2018

55 Health and Sport Committee, Official Report, 21 May 2019, Col 7

56 Health and Sport Committee, Official Report, 21 May 2019, Col 6

57 Health and Sport Committee, Official Report, 21 May 2019, Col 6

58 Health and Sport Committee, Official Report, 21 May 2019, Col 13

59 Health and Sport Committee, Official Report, 21 May 2019, Col 13

60 Health and Sport Committee, Official Report, 21 May 2019, Col 12

61 The Scottish Government response to our pre-budget scrutiny report 'Looking ahead to the Scottish Government - Health Budget 2019-20: Is the budget delivering the desired outcomes for health and social care in Scotland?, 21 December 2018

62 Ministerial Group for Health and Community Care, MSG data review, page 6

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82 Public Audit and Post-legislative Scrutiny Committee Report: Key Themes, page 8

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86 Written submission from Glasgow City Integrated Joint Board

87 Health and Sport Committee, Official Report, 4 June 2019, Col 33

88 Letter from Stephen Fitzpatrick, assistant chief officer, Glasgow City Integrated Joint Board, 8 July 2019

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93 Written submission from West Lothian Integrated Joint Board

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95 Health and Sport Committee, Official Report, 4 June 2019, Col 34

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North Ayrshire HSCP Transformation Plans

NORTH AYRSHIRE
Health and Social Care Partnership

thinking different
doing better

Tacking Inequalities

Engaging Communities

Bringing Services Together

Prevention and Early Intervention

Improving Mental Health and Wellbeing

multi-disciplinary teams

older people's day services

reablement in care at home

promote self-directed support

trindlemoss development

reduce reliance on overnight care

bring looked after children back to North Ayrshire

reduce acute elderly mental health wards

charge service users appropriately

invest in primary care and mental health services

charge appropriately for services

manage transitions of care

review of island services

develop national secure adolescent inpatient service

deliver additional support needs residential and respite facility

develop housing alternatives

locality approach to children's services

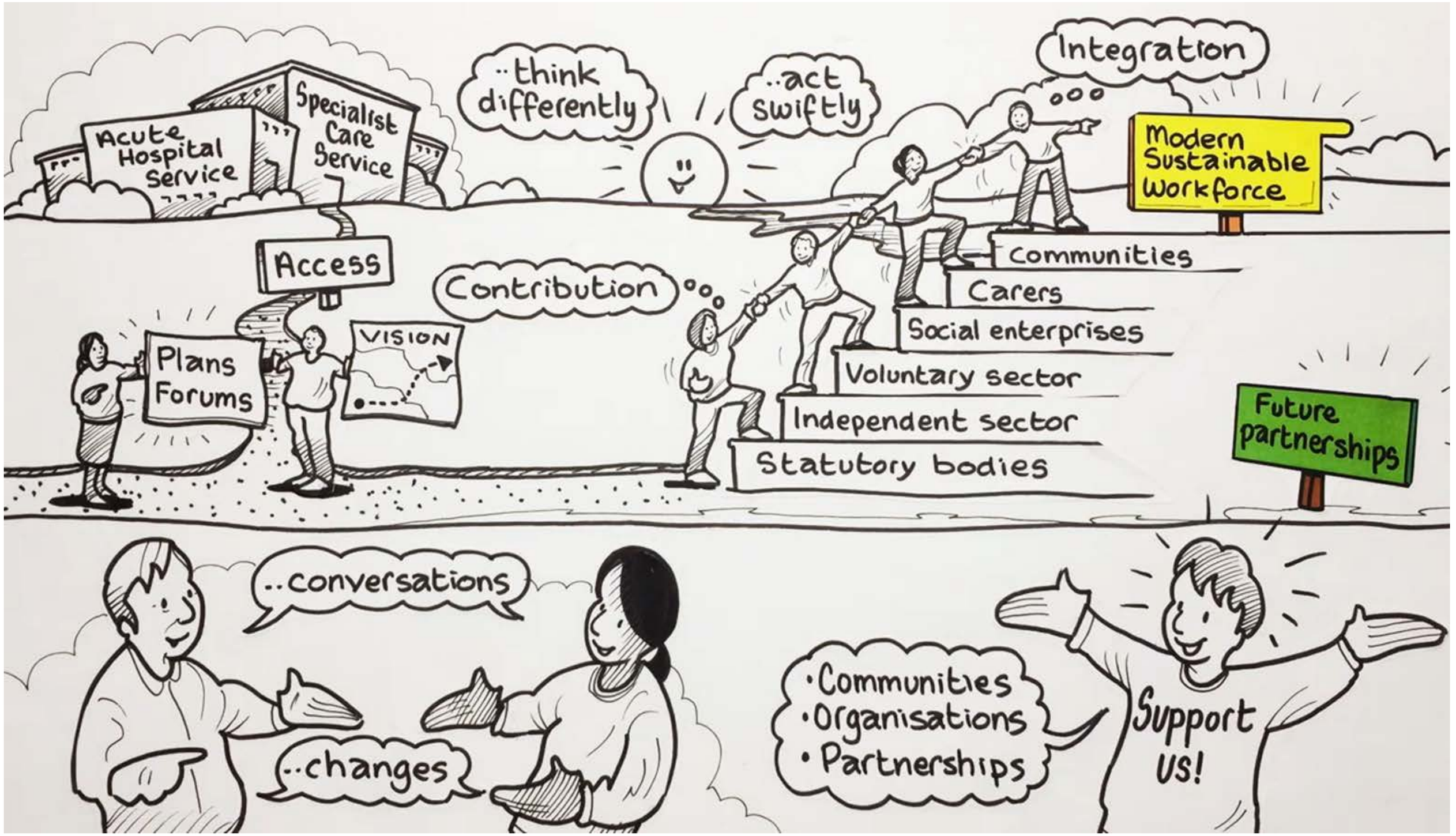
deliver value for money from purchased services

reduce demand for hospital and care home beds


Change
Meets the needs
HEALTH AND SOCIAL CARE SCOTLAND
Collaboration
Response · System
Working together!
Communities
Partnership
Health
Social Care
Support
Voices!
Champion
..help deliver
Sustainable services
Collaborate
Policy · Practice Legislation
Work together
..Capable
..Confident
System leader
Support


Health
Social Care
..Focus..
..feel..
Statement of intent
Integrated
Collective ambition
Transformation of our Care systems
Sustainable, compassionate and caring Scotland
High Quality Care in Communities
HEALTH AND SOCIAL CARE SCOTLAND
New Social Movement
Breakthroughs
the system
Strategic change
..Culture..
Innovation!


Mental health
..proactive & responsive
..life changes -action
Whole System Change
Conditions & diseases not beyond control
Care for themselves & each other
Good health
Tackling risk factors
·Health
·Wellbeing
·Independence
Life course
Care infrastructure
Communities
·Teams
Digital infrastructure
·Care
·Assessment
·Care & treatment
Stronger community care systems & primary care services


Acute Hospital Service
Specialist Care Service
..think differently
..act swiftly
Integration
Modern Sustainable Workforce
Access
Contribution
VISION
Plans Forums
Communities
Carers
Social enterprises
Voluntary sector
Independent sector
Statutory bodies
Future partnerships
..conversations
..changes
•Communities
•Organisations
•Partnerships
Support us!

North Ayrshire Health and Social Care Challenges

NORTH AYRSHIRE
Health and Social Care

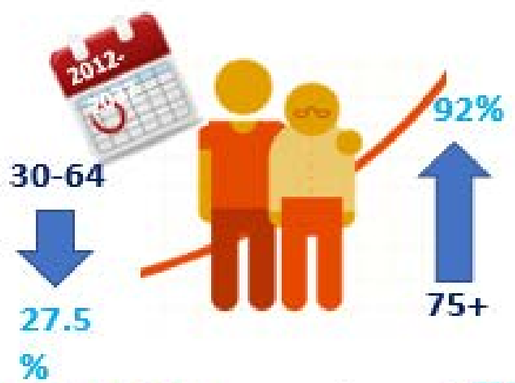
Dependency Ratio

This measures the number of dependents aged zero to 14 and over the age of 65, compared with the total population aged 15 to 64. It is used to measure the pressure on the productive population.

North Ayrshire is the **5th most deprived** local authority area in **Scotland**

Population Changes

The population of North Ayrshire is expected to fall. There will be fewer people aged under 65, meaning less working age adults. The number of people aged 65+ will increase.



92% increase in people aged **75+**

29% of children

live in **Poverty**

Unemployment

24.4%

Households that are **Workless**

5.8%

The Scottish average is 4.2%

39% of residents are amongst the most **deprived** in Scotland

This equates to **53,000** people – that's 1100 more than the capacity of **Hampden Park**

Hospital Admissions

In North Ayrshire we have significant increases in hospital admissions for asthma, COPD, alcohol and drugs than the rest of Scotland

Cost of Care (per week)

91% of Adults can look after their health very well or quite well

84% of adults supported at home agree they are supported well

16.8% of mums breastfeeding

83% of people with a positive experience with their GP

98.2% uptake pre-school immunisation

4,912 people with a community alarm

£31.1m annual cost of prescriptions

21 prescriptions per patient in NA

13 emergency admissions per 1,000 population

45% increase in community link worker referrals

6,907 care at home hours lost due to delayed discharge from hospital

19,373 hospital delayed discharge bed days

88.2% of looked after children supported in the community

£137 Kinship Place

£165 Day Service

£216 Care at Home

£400 Foster Place

£690 Care Home

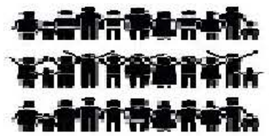
£894 Adult Community Package

£2,832 24 Hour Care in Community

£2,842 Hospital Bed

£4,210 Children's Residential Placement

£6,287 Children's Secure Care



EARLY INTERVENTION AND SUPPORT

CRISIS SERVICES

Spend less

Shift the balance of care

Large population

Spend more

Small population