PERTH & KINROSS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD

13 MAY 2016

Audit Scotland Reports

Report by Chief Officer

1. PURPOSE OF THE REPORT

1.1 This report considers the implications for Perth and Kinross Integration Joint Board of two Audit Scotland reports, the opinion therein and recommendations.

- Health and Social Care Integration December 2015
- Changing Models of Health and Social Care March 2016

1.2 The report assesses the risks and opportunities laid out in the report, benchmarking the progress made in Perth and Kinross and making recommendations for further action .

2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the content of the Audit Scotland Report on Health and Social Care Integration attached to this report (Appendix 2);

2.2 Notes the key messages and recommendations from Audit Scotland report highlighted at section 4.4 of this report;

2.3 Notes the progress and development of key actions for the IJB to consider in order to mitigate the risks highlighted (Appendix 1).

3.0 FINANCIAL IMPLICATIONS

There are no direct financial implications arising from this report.

4.0 HEALTH AND SOCIAL CARE INTEGRATION - DECEMBER 2015

4.1 In December 2015 Audit Scotland published a report on progress made to date in establishing the new Integration Authorities following the implementation of the Public Bodies (Joint Working) (Scotland) Act 2014. This is the first of three planned audits to be undertaken of the major reform of health and social care services as a result of the changes in legislation. This particular audit provides a progress report during the current transitional year and highlights a number of key risks which need to be addressed as a priority to ensure the reforms succeed. Subsequent audits will look at the progress of Integration Authorities progress after their first year of being established and their longer term impact in shifting resources to preventative services and community based care and in improving outcomes for the people who use these services.

4.2 The report provides background on the need for change in the way in which health

and social care services are provided in order to meet the needs of an ageing population and increasing demands on services. It also describes the "integration journey" through legislative changes aimed at encouraging more joined up approaches to the delivery of health and social care, leading to the current legislation which is the first attempt in the UK to place a statutory duty on the NHS and councils to integrate health and social care services.

4.3 The report goes on to note the progress at the time of the audit (October 2015) of the establishment of Integration Authorities, the scope of services being integrated, the timing of taking on operational responsibility, appointment and scale of board membership, appointment of Chief Officers and subsequent accountability arrangements.

4.4 While the audit found there is wide support across stakeholders for the opportunities offered by health and social care integration, there are concerns about how the arrangements will work in practice. Therefore as a result of the audit, a number of key current issues have been identified and are reflected as follows:

Governance and Accountability

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

- **Sound governance arrangements need to be quickly established** - good governance is vital to ensure that public bodies perform effectively. This can be a particular challenge in partnerships, with board members drawn from a wide range of backgrounds.

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

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

- **Although IJBs will lead the planning of integrated services, they are not independent of councils and NHS boards** - IJBs set out how they will deliver services in their strategic plans, which they develop through strategic planning groups. The legislation allows NHS boards and councils jointly to ask IJBs to change their strategic plans only if they think it hinders their work in achieving the national health and wellbeing outcomes. As such, NHS boards and councils cannot individually veto an IJB decision. However IJBs are not fully independent of NHS boards and councils which can influence them through the membership of IJBs, the approval process to agree future budgets and control of integration schemes (nb resubmission of integration schemes).

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

- **There needs to be a clear understanding of who is accountable for service delivery -** there is a risk that the complex interrelationship between IJBs and councils and NHS boards will get in the way of clear lines of accountability. Their respective roles appear to be clear: IJBs are responsible for planning and commissioning services; councils and NHS boards are responsible for delivering those services; however these could be tested when there is service failure.

- **IAs need to establish effective scrutiny arrangements to help them manage performance -** IAs need to establish effective arrangements for scrutinising performance, monitoring progress towards their strategic objectives, and holding partners to account.

Finance

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

- IAs are establishing financial procedures that look to be sound. While there is a range of approaches to financial monitoring and dealing with overspends and underspends, the processes outlined in the integration schemes are reasonable. There are, however, significant concerns about funding. Councils and NHS boards are having great difficulty in agreeing budgets for the new IAs which is likely to continue until mid 2016.

- NHS boards and councils have faced several years of financial constraints and this is expected to continue in the coming years. There is a risk that, if NHS boards and councils seek to protect services that remain fully under their control, IAs may face a disproportionate reduction in their funding, despite the focus on outcomes that all partners should have.

- Other specific factors in adding to the difficulties in agreeing budgets include problems in agreeing the level of hospital set-aside budgets and different budget setting cycles between local authorities and NHS.

Service Redesign

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

- **Most IAs are still developing their overall strategic plans, but those that are in place tend to be aspirational and lack important detail** - strategic planning is central to the role that IAs will have in commissioning and helping redesign local health and care services however difficulties in reaching agreements around budgets are hindering the development of comprehensive strategic plans leading to concerns around the readiness of IAs to make an immediate impact in reshaping local services. For those plans which are more developed, there tends to be weaknesses in their scope and quality, with broad direction set out without clarity around the resources available to support it or how to match to priorities.

- **Most IAs have still to produce supporting strategies -** IAs need to establish supporting strategies for important areas such as workforce, risk management, data sharing, and how they will work with people who use health and social care services. In many IA's however, it is likely to be up to 12 months after the IA becomes operational before these strategies are due to be agreed and can start to

contribute to progress with integrating services. This leads to questions about the effectiveness of some IAs at least in the first year of operation.

Workforce

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

- **Few IAs have developed a long-term workforce strategy -** Developing a suitably skilled workforce is crucial to the success of integrated health and social care services. This is particularly challenging, given the wide range of people involved and the size of the workforce. IJBs need to work closely with professional and regulatory bodies in developing their workforce plans

- IAs are responsible for coordinating services from this varied mix of staff and carers. There will be implications for the skills and experience that staff will need to deliver more community-based support as services change. Developing and implementing workforce strategies to meet these needs will be challenging. Further difficulties will arise through financial pressures in the NHS and councils, difficulties in recruiting and retaining social care staff and the role of the voluntary and private sectors. In addition, there are concerns about the difficulties in recruiting and retaining GPs and linked to this is concern over time GP's will be able to contribute actively to the success of integrated services.

Performance Management

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

- There is wide support for the Scottish Government's focus on health and wellbeing outcomes, with 23 measures identified to cover a mixture of outcome indicators. In addition, the Scottish Government has provided further support through the Information Services Division of NHS National Services Scotland to provide access to local data and technical support to help partnerships understand and plan for their areas health and social care needs. There are some difficulties in accessing this data as data sharing agreements are not yet in place.

However, the following issues have emerged

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

- **The process of linking measures and outcomes is incomplete and it may be difficult to measure success** - this means that the Scottish Government will be unable to see what progress is being made nationally, or to compare the different approaches adopted by IAs to identify which are most effective

- **It is important that there is a balance between targeted local measures and national reporting on impact -** this has the benefit of providing flexibility so that local partnerships can focus their efforts on priority areas. It is important that local partnerships set ambitious targets.

4.5 Following on from the key findings of the audit, the report sets out a range of recommendations. These are set out in Appendix 1 with an associated action plan to be adopted locally within Perth and Kinross to ensure the risks highlighted in the audit report are mitigated. Consideration was given to the Audit Scotland Report in developing the Strategic Plan and recommendations where appropriate have already been reflected in the Strategic Plan and noted as actions already undertaken in the action plan.

5.0 CHANGING MODELS OF HEALTH AND SOCIAL CARE MARCH 2016

5.1 In March 2016, Audit Scotland produced a second report outlining the Changing Models of Health and Social Care. The report outlines a number of key messages including

5.1.1 Increasing numbers of people with complex health and social care needs, together with continuing tight finances, means current models of care are unsustainable. New models of care could avoid unnecessary admissions to hospital, or quicker discharge when admission is needed to improve quality of care and make better use of resources.

5.1.2 The widespread support for the 2020 Vision, which aims to enable longer, healthier lives at home or in a homely setting and evidence that new approaches to health and care are being developed in parts of Scotland.

5.1.3 The change is not happening fast enough to meet growing need, and new models of care are generally small-scale and not widespread. The Government is challenged to provide stronger leadership and a clear evidence framework to guide local development of what works with measures of success to monitor progress.

5.1.4 Government is challenged to model the investment required in new services and new ways of working, and to assess if this can be achieved within existing and planned resources.

5.1.5 NHS boards and councils, are challenged to work with integration authorities, to facilitate change including having a better understanding of the needs of their local populations, evaluating new models and sharing learning; specifically by focusing funding on community-based models and workforce planning to support new models.

5.2 **The Report recommends that the Scottish Government should:**

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

5.2.2 estimate the investment required to implement the 2020 Vision and the National Clinical Strategy

5.2.3 ensure that long-term planning identifies and addresses the risks to implementing the 2020 Vision and the National Clinical Strategy, including:

- barriers to shifting resources into the community recognising reducing health and social care budgets and difficulties councils and NHS boards are experiencing in agreeing integrated budgets
- new integration authorities making the transition from focusing on structures and governance to what needs to be done on the ground to make the necessary changes to services.
- building pressures in general practice, including problems with recruiting and retaining. The role of GPs in moving towards the 2020 Vision should be a major focus of new GP contract terms for 2017

5.2.4 ensure learning from new care models is shared effectively to increase the pace of change. This should include:

- timescales, costs and resources required to implement new models, including staff training and development
- evaluation of impact and outcomes
- how funding was secured
- key success factors, including how models are scaled up and made sustainable

5.2.5 Work to reduce barriers that prevent implementing longer-term plans, including:

- identifying longer-term funding to develop new sustainable care models
- identifying a mechanism for shifting money and staff, from hospital to community settings
- defining in practice the appropriate balance of care between acute and community-based care to support local areas to implement the 2020 Vision
- raising public awareness about why services need to change
- addressing the gap in cost information and evidence of impact for new models.

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

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

5.4 **Information Services Division (ISD) should:**

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

Robert Packham **Jane Smith**
Chief Officer Chief Finance Officer
DATE: 17th April 2016

Appendix 1			
Recommendation	**Perth and Kinross IJB Position**	**Action Proposed**	**Timescale**
The Scottish Government should:			
• Work with IAs to help them develop performance monitoring to ensure that they can clearly demonstrate the impact they make as they develop integrated services. As part of this work: o work with IAs to resolve tensions between the need for national and local reporting on outcomes so that it is clear what impact the new integration arrangements are having on outcomes and on the wider health and social care system	Scottish Government guidance has been issued (National Health and Wellbeing Outcomes: A framework for the planning and delivery of integrated health and social care services) to assist IJBs in developing their performance management systems	The IJB's Strategic Commissioning Plan 2016/7-2018/19 reflects the 9 national outcomes for health and well being and the key actions are structured around these and 5 local strategic priorities. In addition, the partnership is finalising a performance framework which reflects the national outcomes and local strategic priorities and which will be used as part of the IJB's annual report on the delivery of the strategic plan.	
• Monitor and publicly report on national progress on the impact of integration. This includes: o measuring progress in moving care from institutional to community settings, reducing local variation in costs and using anticipatory care plans o reporting on how resources are being used to improve outcomes and how this has changed over time o reporting on expected costs and savings resulting from integration	The strategic plan emphasises the need for services and support to intervene early to prevent later, longer term issues arising, and enabling people to manage their own care and support by taking control and being empowered to manage their situation. Where this is not possible, resources should be targeted where they are needed most, reducing ill health and deterioration and ultimately reducing health inequalities. The strategic plan also makes it clear that the financial challenges facing the partnership are significant, reflecting those of Perth and Kinross Council and NHS Tayside. In this environment achieving financial balance will require a focus	Although the plan describes the IJB's strategic priorities, it needs work to identify and agree future commissioning arrangements to meet its vision and aspirations. Resources will have to be shifted to support the commitment to prevention and early intervention, to prevent later, costly interventions. Some key things need to be addressed, including: • What the partnership budget will be spent on in future – what will be commissioned and decommissioned to meet the	

Appendix 1			
Recommendation	**Perth and Kinross IJB Position**	**Action Proposed**	**Timescale**
	on service redesign within the overall resources available.	strategic plan's priorities? • Supporting people and culture to ensure new ways of working • Clarity as to how managers, communities, providers will be supported to do this • Establishment of robust project management and accountability arrangements so that services are transformed.	
• Continue to provide support to IAs as they become fully operational, including leadership development and sharing good practice, including sharing the lessons learned from the pilots of GP clusters.	The Framework will include measures to allow us to monitor our progress in achieving the strategic priorities and shifts identified in the Plan, as well as our improvement against the National Outcomes		
Integration authorities should:			

Appendix 1			
Recommendation	**Perth and Kinross IJB Position**	**Action Proposed**	**Timescale**
• Provide clear and strategic leadership to take forward the integration agenda; this includes: o developing and communicating the purpose and vision of the IJB and its intended impact on local people o having high standards of conduct and effective governance, and establishing a culture of openness, support and respect	The strategic plan, which was widely circulated for comments during its formal consultation, has a clear vision and purpose. The final version is available to the public and staff and engagement and communication on the aspirations and key actions will continue to be managed through the Engagement, Communication and OD Group. The 'Join the Conversation' initiative will continue to be promoted through locality teams, with local people and staff working in partnership to deliver the plan's ambitions. The partnership's Organisational Development plan will be used as a key vehicle for promoting high standards of conduct, a positive culture of innovation, openness and commitment to person-centred care and support The strategic plan highlights the need for professional, listening and learning, being open and transparent and respecting and caring. The IJB has adopted a Participation and Engagement Strategy which sets out principles which will ensure that the voices of service users, carers, staff and communities are heard, recognised and valued	Continue to communicate the vision and purpose of the IJB and performance in meeting expected outcomes for individuals and the community through its Communication and Participation and Engagement Strategies. Ensure the continued development of the IJB's Workforce and Organisational Development Strategy and Participation and Engagement strategy provides a focus on the delivery of improved outcomes as outlined in the vision	June 2016
• Set out clearly how governance arrangements will work in practice, particularly when disagreements arise, to minimise the risk of confusing lines of accountability, potential	Roles and responsibilities of all parties are reflected in the Integration Scheme including arrangements for Clinical and Care Governance	A number of focussed IJB development sessions have been held for members including roles and responsibilities, Due Diligence and Standing Orders in addition to	Ongoing

Appendix 1			
Recommendation	**Perth and Kinross IJB Position**	**Action Proposed**	**Timescale**
conflicts of interests and any lack of clarity about who is ultimately responsible for the quality of care and scrutiny. This includes: o setting out a clear statement of the respective roles and responsibilities of the IJB (including individual members), NHS board and council, and the IJB's approach towards putting this into practice o ensuring that IJB members receive training and development to prepare them for their role, including managing conflicts of interest, understanding the organisational cultures of the NHS and councils and the roles of non-voting members of the IJB	and Professional Governance As noted above, recommendations to the IJB will have been scrutinised against a range of governance areas (e.g. clinical and care governance arrangements) before being presented to the IJB. Through the Workforce and Organisational Development strategy and focus on co-production within the Participation and Engagement Strategy, support will be provided to staff and the public to engage in the process of service redesign and change. Through the Clinical and Care Governance Strategy, a range of advisory mechanisms are in place to support the evidence in decision making The IJB has a programme of training and development which will continue.	Strategic Planning. IJB Chair & Vice Chair have participated in the National Development Programme.	
• Ensure that a constructive working relationship exists between IJB members and the chief officer and finance officer and the public. This includes: o setting out a schedule of matters reserved for collective decision-making by the IJB, taking account of relevant legislation and ensuring that this is monitored and updated when required o ensuring relationships between the IJB, its partners and the public are clear so each	Standing Orders in place to govern the business of the IJB.	IJB to continue to develop and agree roles and responsibilities as partnership arrangements evolve and new challenges faced Develop and progress further IJB leadership and development sessions for IJB members	Ongoing

Appendix 1			
Recommendation	**Perth and Kinross IJB Position**	**Action Proposed**	**Timescale**
knows what to expect of the other			
• Be rigorous and transparent about how decisions are taken and listening and acting on the outcome of constructive scrutiny, including: o developing and maintaining open and effective mechanisms for documenting evidence for decisions; o putting in place arrangements to safeguard members and employees against conflict of interest and put in place processes to ensure that they continue to operate in practice; o developing and maintaining an effective audit committee; o ensuring that effective, transparent and accessible arrangements are in place for dealing with complaints; o ensuring that an effective risk management system is in place	• Participation & Engagement Strategy developed which sets out the framework for ongoing dialogue and developing shared understanding of issues • IJB Standing Orders highlights Code of Conduct and Conflicts of Interest for members of the Integration Joint Board. Employees will continue to operate under existing policies of their respective organisations • Complaints procedure for the IJB developed • Integration Scheme states intention to develop and adopt a risk management strategy • Clear vision, priorities and proposed actions to deliver these described in the draft Strategic Plan	Ensure business is continuously conducted in line with the principles and values expressed within the Participation and Engagement Strategy Proposals to be developed to agree most appropriate method of provision of internal scrutiny of the IJB Complaints procedure to be formally tabled at the IJB Risk management process and risk register to be developed	Ongoing
• Develop strategic plans that do more than set out the local context for the reforms; this includes: o how the IJB will contribute to delivering high-quality care in different ways that better meet people's needs and improves outcomes o setting out clearly what resources are required, what impact the IJB wants to achieve, and how the IA will monitor and	As noted above, highlighted as key to improving outcomes. This strategic plan has a clear vision and an aspiration to transform services to meet future needs and challenges. It is about working together, with people, communities, the third and private sectors, to deliver innovative ways of meeting people's needs and enabling them	The strategic plan focus on three locality areas and work needed within them to address the specific needs of local areas to improve people's health and well being. The locality networks will be further developed to prepare clear locality plans which will reflect the ambitions and commitment of the strategic	Ongoing

Appendix 1			
Recommendation	**Perth and Kinross IJB Position**	**Action Proposed**	**Timescale**
publicly report progress o developing strategies covering the workforce, risk management, engagement with service users and data sharing, based on overall strategic priorities to allow the IA to operate successfully in line with the principles set out in the Act and ensure these strategies fit with those in the NHS and councils o clear links between the work of the IA and the Community Empowerment (Scotland) Act and Children and Young People (Scotland) Act	to live healthy lives at home or in a homely setting. Actions within the Strategic Plan note how these will be achieved. As mentioned above, although the plan describes the IJB's strategic priorities, it needs work to identify and agree future commissioning arrangements to meet its vision and aspirations. Resources will have to be shifted to support the commitment to prevention and early intervention, to prevent later, costly interventions. As one of the Community Planning Outcome Delivery Groups, the IJB is a full member of the Perth and Kinross Community Planning Partnership (CPP) and works closely with Integrated Children's Services in Perth and Kinross and will continue to work across the CPP with the implementation of the Community Empowerment Bill and new locality planning partnerships.	plan and which will reflect the wider CPP priorities and actions. Continue to develop strong links with the Chief Social Work Officer and Integrated Children's Services. And align locality planning arrangements across all partnerships	
• Develop financial plans that clearly show how IAs will use resources such as money and staff to provide more community-based and preventative services. This includes: o developing financial plans for each locality, showing how resources will be matched to local priorities o ensuring that the IJB makes the best use of resources, agreeing how Best Value will be	Move to locality planning models of budgeting and allocating resources through using methodologies such as the Integrated Resource Framework to identify local population resource consumption and need. As part of the financial monitoring and performance management framework, develop range of indicators to reflect how well resources	Development of clear plans for locality working and locality management is a key first to the the development of supporting locality financial plans which consider resources and local priorities. A further key aspect of locality development will be the agreement of performance information that will demonstrate	Ongoing

Appendix 1			
Recommendation	**Perth and Kinross IJB Position**	**Action Proposed**	**Timescale**
measured and making sure that the IJB has the information needed to review value for money and performance effectively	are being utilised (e.g. benchmarking frameworks)	value for money and performance.	
• Shift resources, including the workforce, towards a more preventative and community-based approach; it is important that the IA also has plans that set out how, in practical terms, they will achieve this shift over time.	Strategic Plan highlights a shift to community based and preventative services as key to improving outcomes.	Workforce and Organisational Development and Participation and Engagement Strategies developed and to be presented to the IJB meeting Ensure that the Workforce and Organisational Development Strategy continues to reflect the changing needs of changing service delivery models Implement the key actions of the strategic plan, including developing integrated care teams.	Ongoing – dependent on timing of shifts to new locality models of service provision
Integration authorities should work with councils and NHS boards to:			
• Recognise and address the practical risks associated with the complex accountability arrangements by developing protocols to ensure that the chair of the IJB, the chief officer and the chief executives of the NHS board and council negotiate their roles in relation to the IJB early on in the relationship and that a shared understanding of the roles and objectives is maintained;	Integration Scheme and Standing Orders reflect the respective roles and accountability arrangements	High level group to be formed consisting of the CO, Chair and Vice Chair of the IJB, Chair of the NHS Board and the Chief Executives of Perth and Kinross Council and NHS Tayside	April 2016

Appendix 1			
Recommendation	**Perth and Kinross IJB Position**	**Action Proposed**	**Timescale**
• Review clinical and care governance arrangements to ensure a consistent approach for each integrated service and that they are aligned to existing clinical and care governance arrangements in the NHS and councils;	Clinical and Care Governance framework has been recognised by the IJB	Further work to be undertaken by the local Perth and Kinross Clinical and Care Governance Group, supported by the Chief Social Work Officer and clinical advisors to the IJB to agree how this is implemented in practice	April 2016
• Urgently agree budgets for the IA; this is important both for their first year and for the next few years to provide IAs with the continuity and certainty they need to develop strategic plans; this includes aligning budget-setting arrangements between partners;	The Intergrated Joint Board have agreed the budget to be devolved by Perth & Kinross Council for 2016/17. The Integrated Joint Board have not agreed the budget proposed by NHS Tayside. It has been accepted on an indicative basis only subject to the development of a financial recovery plan over the next 3 months which the Board will consider at a specially convened meeting on 1st Of July 2016. It has been agreed by the IJB that a Budget Review Group be established to support the development of longer term financial plans for Perth & Kinross IJB and specifically support the alignment of budget setting/planning timeframes	The CO/CFO and management team will work with NHS Tayside to develop a financial recovery plan to be considered by the IJB on the 1st of July. CFO to take forward the set up of a Budget Review Group and in parallel, to work closely with senior finance colleagues and wider Executive Teams to develop aligned planning arrangements.	July 2016 Ongoing
• Establish effective scrutiny arrangements to ensure that councillors and NHS non-executives, who are not members of the IJB board, are kept fully informed of the impact of integration for people who use local health and care services;	Proposals developed by Head of Democratic & Legal Services, Perth and Kinross Council with regards to future IJB reporting arrangements to Perth and Kinross Council	Perth and Kinross Council reporting arrangements to be presented recommending that scrutiny of the IJB's functions and also the Council's functions in delivering services commissioned by the IJB should be added to the remit of the Strategy, Policy and Resources	July 2016

Appendix 1			
Recommendation	**Perth and Kinross IJB Position**	**Action Proposed**	**Timescale**
		Committee Proposals to be developed by NHS Tayside to agree scrutiny arrangements back to the NHS Board.	
• Put in place data-sharing agreements to allow them to access the new data provided by ISD Scotland.	Data sharing arrangements already in place and data currently being accessed to assist with the development of the Strategic Plan and associated performance framework	Review effectiveness of data sharing arrangements to ensure comprehensive enough to access the range of information required to inform the IJB of current performance and future needs	April 2016

Appendix 2	Changing Models of Health and Social Care March 2016		
Recommendation	**Perth and Kinross IJB Position**	**Action Proposed**	**Timescale**
New models of care could avoid unnecessary admissions to hospital, or quicker discharge when admission is needed to improve quality of care and make better use of resources	Range of models outlined in the strategic plan and actions reflect these. Role out of Integrated Care Teams fundamental to this, as are key reviews: pharmacy, district nursing, AHPs, development of enhanced care models, technology enabled care, housing support, organisational development and work with communities and the Third Sector. System wide review of the patient journey. Roll out of early intervention and prevention strategies in localities as part of Enhanced Community support Optimisation of flow through acute care through attention to the causes of delays.	Implement the transformation programme to deliver set of key service reviews and transformation Day of Care Audit PRI Rapid improvement event PRI	 April 2016 April 2016 Ongoing
Widespread support for the 2020 Vision, which aims to enable longer, healthier lives at home or in a homely setting and evidence that new approaches to health and care are being developed in parts of Scotland	Fundamental principle for future redesign embedded in the P&K Strategic Plan	Prioritisation of key actions in 2016/17, including developing integrated care teams, progressing with reviewing AHPs, district nursing, residential care, day care, communities first, technology enabled care, local hubs, work with communities	May 2016
The change is not happening fast enough to meet growing need, and new models of care are generally small-scale and not widespread	Building on existing good work in P&K. Specific and significant effort to introduce locality working	Audit of progress in P&K against objectives of Strategic plan	September 2016 March 2017
NHS boards and councils, are challenged to work with integration authorities, to facilitate change including having a better understanding of the needs of their local	Council and NHS have informed the development of the Strategic Plan and agreed its priorities, which are based on detailed locality needs assessment and	Progress with the key actions in the strategic plan Agreement to collaborate for mutual	Ongoing

populations, evaluating new models and sharing learning; specifically by focusing funding on community-based models and workforce planning to support new models	engagement with local communities about their priorities. Plan includes promotion of new models of care and new ways of working to meet future needs and priorities. Focus is around 9 national outcomes, 5 strategic priorities based within 3 localities. Quarterly meeting of IJB and NHS Board Chairs, Chief Executives and Chief officers across Tayside	achievement of organisational objectives	
Scottish Government should			
Provide a clear framework by the end of 2016 of how it expects NHS boards, councils and integration authorities to achieve the 2020 Vision, outlining priorities and plans to reach its longer-term strategy up to 2030	No specific action for Perth and Kinross	Chief officers across Scotland developing an effective network to influence Scottish policy	
Estimate the investment required to implement the 2020 Vision and the National Clinical Strategy	No specific action for Perth and Kinross	Chief Officers and Chief Finance Officers will support planning processes	
Recommendation	**Perth and Kinross IJB Position**	**Action Proposed**	**Timescale**
Ensure that long-term planning identifies and addresses the risks to implementing the 2020 Vision and the National Clinical Strategy	P&K IJB has a developing risk register. Matters specific to the 2020 vision and implementation of the National Clinical strategy will be included as the partnership develops National clinical strategy priorities reflected in the Strategic Plan	Ensure there is mutual understanding of the clinical strategy across all the partners represented in P&K IJB. Work locally to:- • Identify opportunities to shift the balance of care towards community models of practice • Ensure continued attention to the deliverables in the strategic plan through defining timescales and holding service leaders to account • Ensure the involvement of GP leaders in planning and delivery of services across	

		clusters and localities	
Ensure learning from new care models is shared effectively to increase the pace of change.	P&K will share learning and will learn from other Board areas	• Quantify timescales, costs and resources required to implement new models, including staff training and development • Use data for evaluation of impact and outcomes • Describe how funding was secured • Identify key success factors, including how models are scaled up and made sustainable	
Work to reduce barriers that prevent implementing longer-term plans,	P&K will share learning and will learn from other Board areas	• identifying longer-term funding to develop new sustainable care models • work to agree future commissioning and decommissioning of services to meet the priorities of the strategic plan and reflect these in the Strategic Commissioning Plan • identifying a mechanism for shifting money and staff, from hospital to community settings • defining in practice the appropriate balance of care between acute and community-based care to support local areas to implement the 2020 Vision • raising public awareness about why services need to change • addressing the gap in cost information and evidence of impact for new models.	

Recommendation	Perth and Kinross IJB Position	Action Proposed	Timescale
NHS boards and councils should work with integration authorities during their first year of integration to			
Carry out a shared analysis of local needs, and use this as a basis to inform their plans to redesign local services, drawing on learning from established good practice	This was done as part of the development of the strategic plan. Separate needs and locality profiles document and analysis available which will continue to be updated	Further develop IRF Data and locality profiles within 3 localities to inform local developments and service changes. Use this data as part of the annual review of the strategic plan.	Ongoing
Ensure new ways of working, based on good practice from elsewhere, are implemented in their own areas to overcome some of the barriers to introducing new care models	Included as part of the key actions of the strategic plan and the Organisational Development and Engagement and Participation Plans. Also progressed as part of the locality network meetings. Quarterly meeting of IJB and NHS Board Chairs, Chief Executives and Chief officers across Tayside Fortnightly meeting between Director of Operations NHST and three IJB COs	Strategic planning and influence of change to improve models of care and release resources for community based services	Ongoing
Move away from short-term, small-scale approaches towards a longer-term approach to implementing new care models	Deliberate strategy to align activities with Localities, Community and Local Community planning Partnerships	IJB involvement with CPP and LCPP Planning process across PKC and P&K IJB	Ongoing
Ensure, when they are implementing new models of care, that they identify appropriate performance measures from the outset and track costs, savings and outcomes	Development of minimum data set to reflect national recommendations and local needs to describe activity and to inform changes to models of practice	Minimum data set in development Requirement for improved data in mental Health services	Ongoing
Ensure clear principles are followed for implementing new care models	Support change through use of transformation and organisational change expertise	Considering investment to save	June 2016
Information Services Division (ISD) should:			
Ensure it shares and facilitates learning across Scotland about approaches to analysing data and intelligence, such as using data to better understand the needs	P&K closely aligned with ISD and much of the data set is built upon intelligence and learning from Perth and Kinross	Maintain close alliances with ISD	Ongoing

of local populations.			

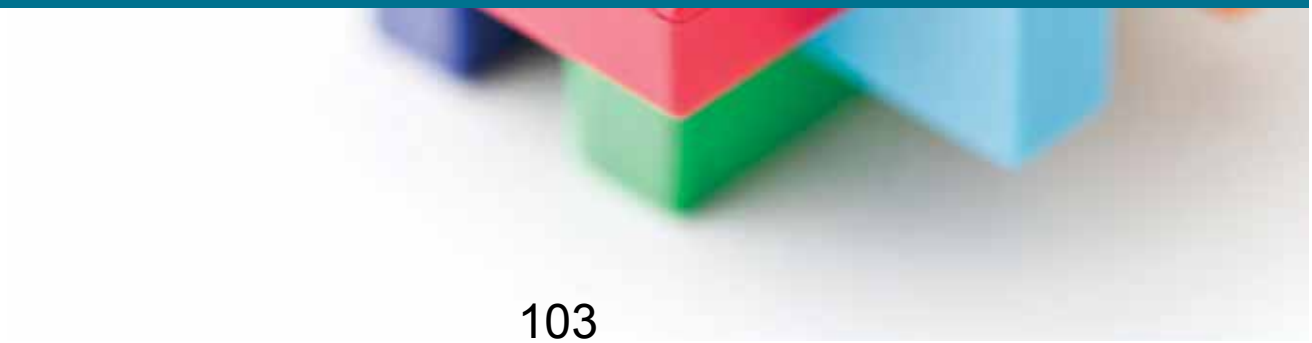
Health and social care series

Health and social care integration

ACCOUNTS COMMISSION

AUDITOR GENERAL

Prepared by Audit Scotland
December 2015



The Accounts Commission

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

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

Our work includes:

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

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

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 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/ags

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

Contents

Key facts

Over **£8 billion**
Health and social care resources will be delegated to integration authorities in 2016/17

18-29 per cent
Scottish Government estimate of the increase in the need for health and social care services between 2010 and 2030

31
Integration authorities are required to be operating by April 2016

£138-£157m
Scottish Government estimates of annual savings from integration

9
National outcomes that integration authorities are required to contribute towards

Summary

Key messages

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

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

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

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

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

Recommendations

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

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

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

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

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

Background

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

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

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

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

About this audit

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

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

7. We gathered audit evidence by:

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

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

Appendix 1 provides further information on our audit approach.

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

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

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

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

Part 1

Expectations for integrated services

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

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

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

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

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

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

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

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

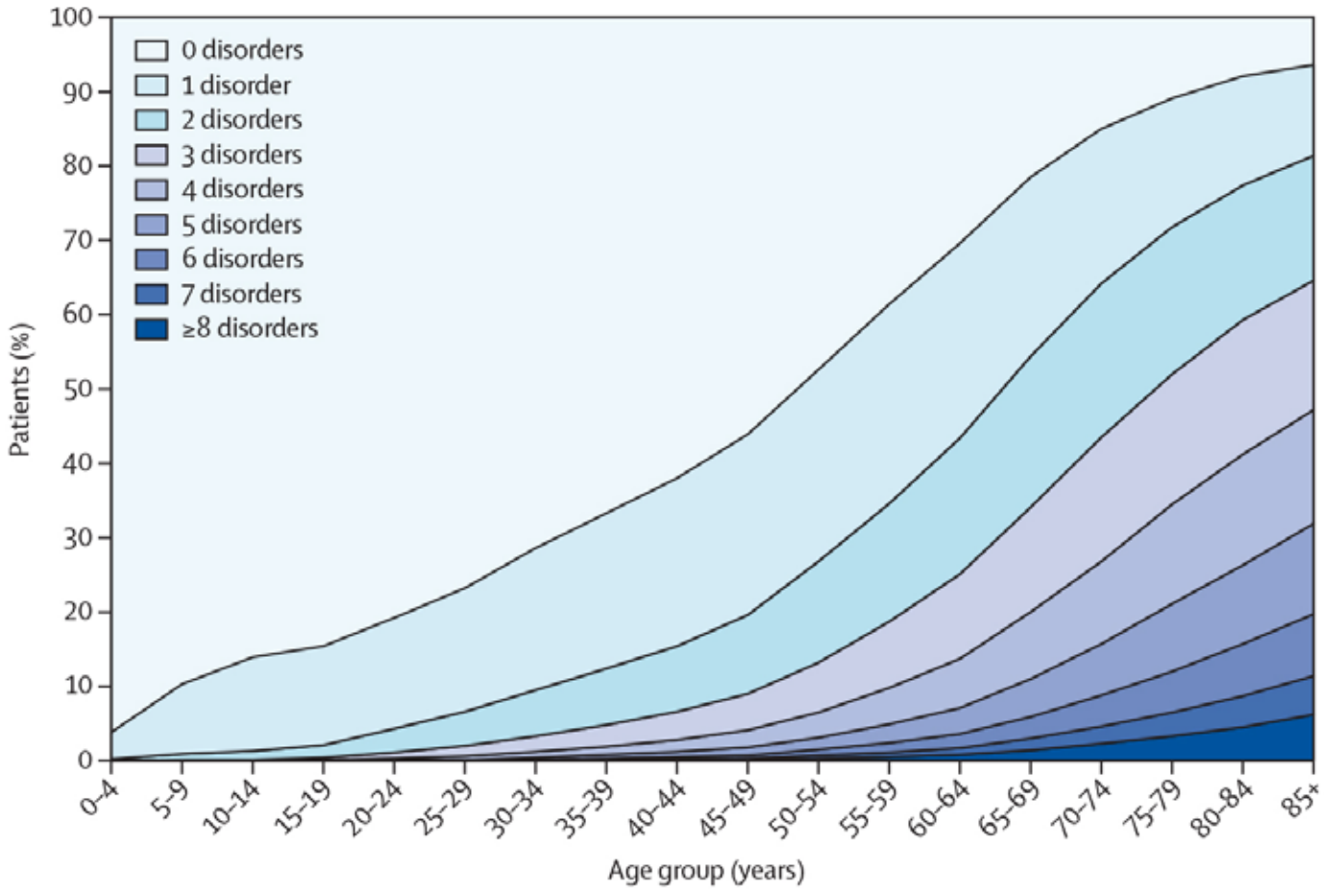
- A patient's discharge from hospital may be delayed when they are judged to be clinically ready to leave hospital but unable to leave because arrangements for care, support or accommodation have not been put in place. In 2014/15, this led to the NHS in Scotland using almost 625,000 hospital bed days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

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

Exhibit 1

Long-term conditions by age

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



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

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

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

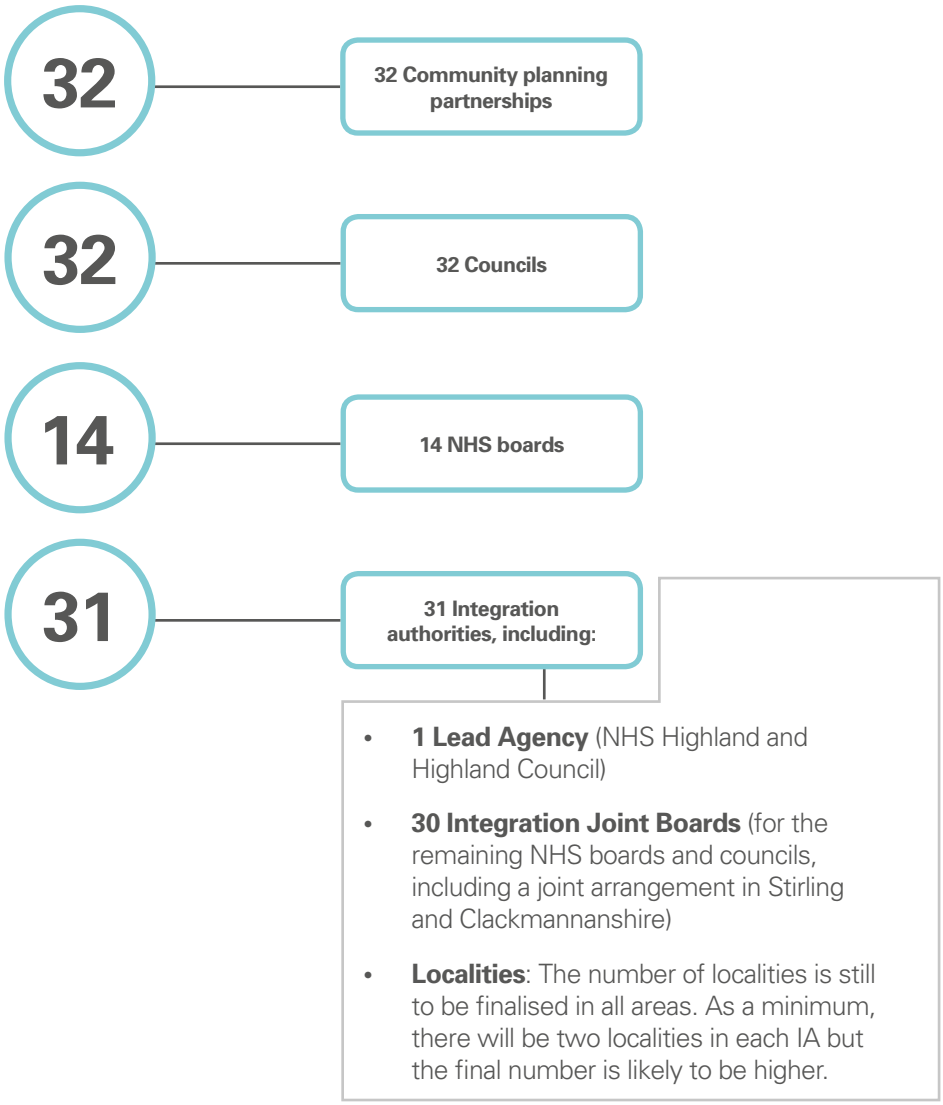
Exhibit 2
A brief history of integration in Scotland

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

Source: Audit Scotland

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

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



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

Source: Audit Scotland

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

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

Timing for establishing the new integration authorities

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

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

Scope of services to be integrated

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

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

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

How IAs are structured

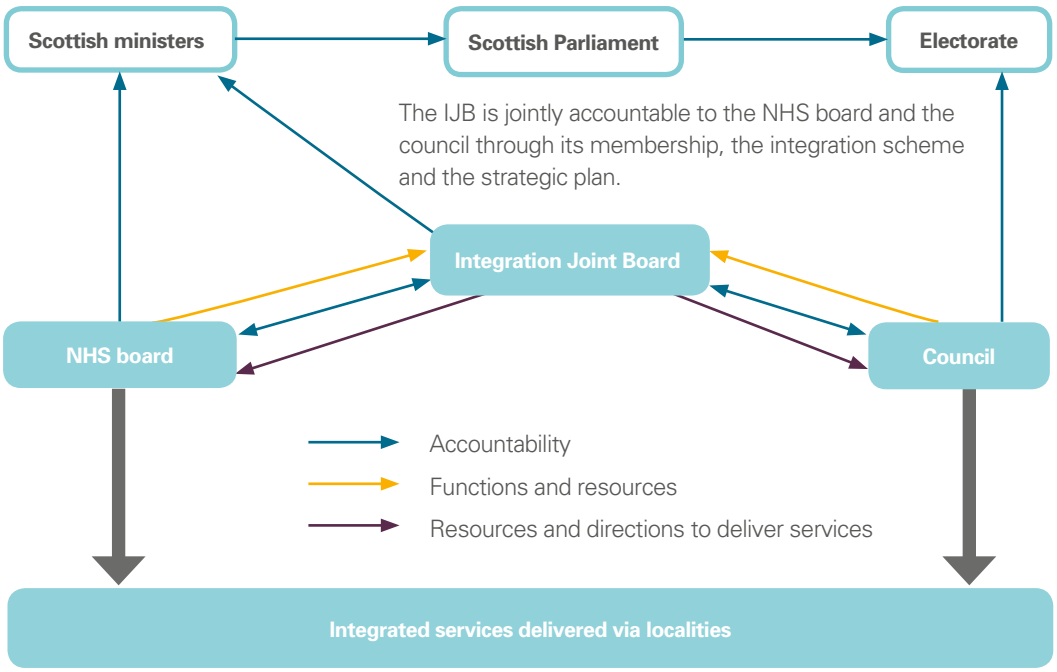
21. IAs will be responsible for overseeing certain functions that are delegated from the local NHS board and council(s). IAs can follow one of two main structural models (Exhibit 4, page 14).

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

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

Exhibit 4
Integration authorities will follow one of two main models

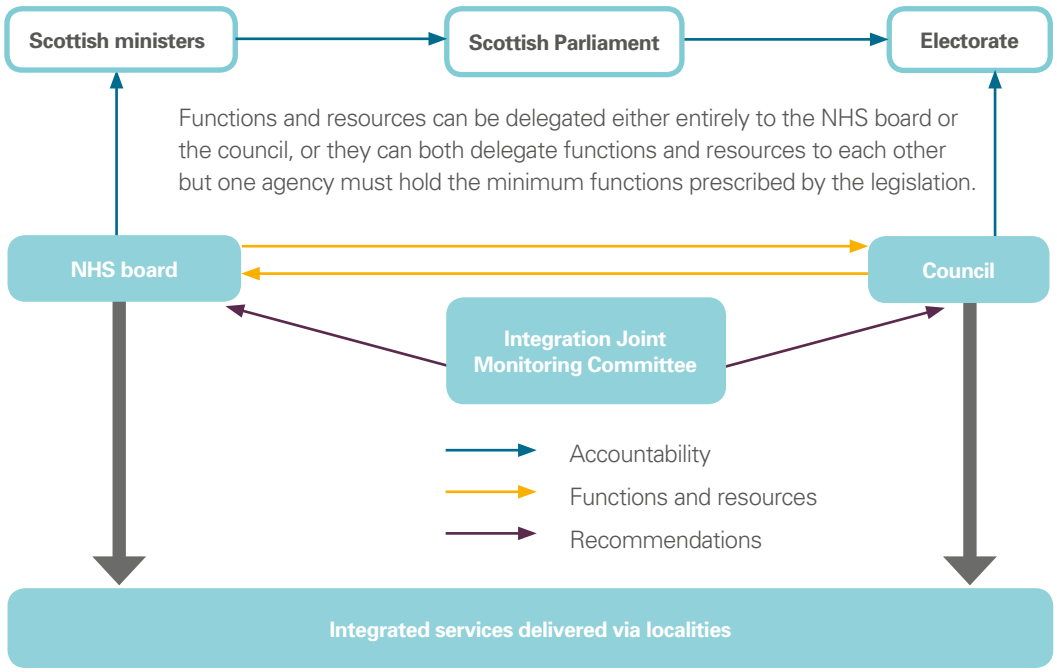
Body corporate or Integration Joint Board model



Body corporate

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

Lead agency model



Lead agency

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

Source: Audit Scotland

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

- A statutory duty of Best Value applies to IJBs.

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

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

Membership of Integration Joint Boards (IJBs)

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

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

Scrutinising integrated health and social care

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

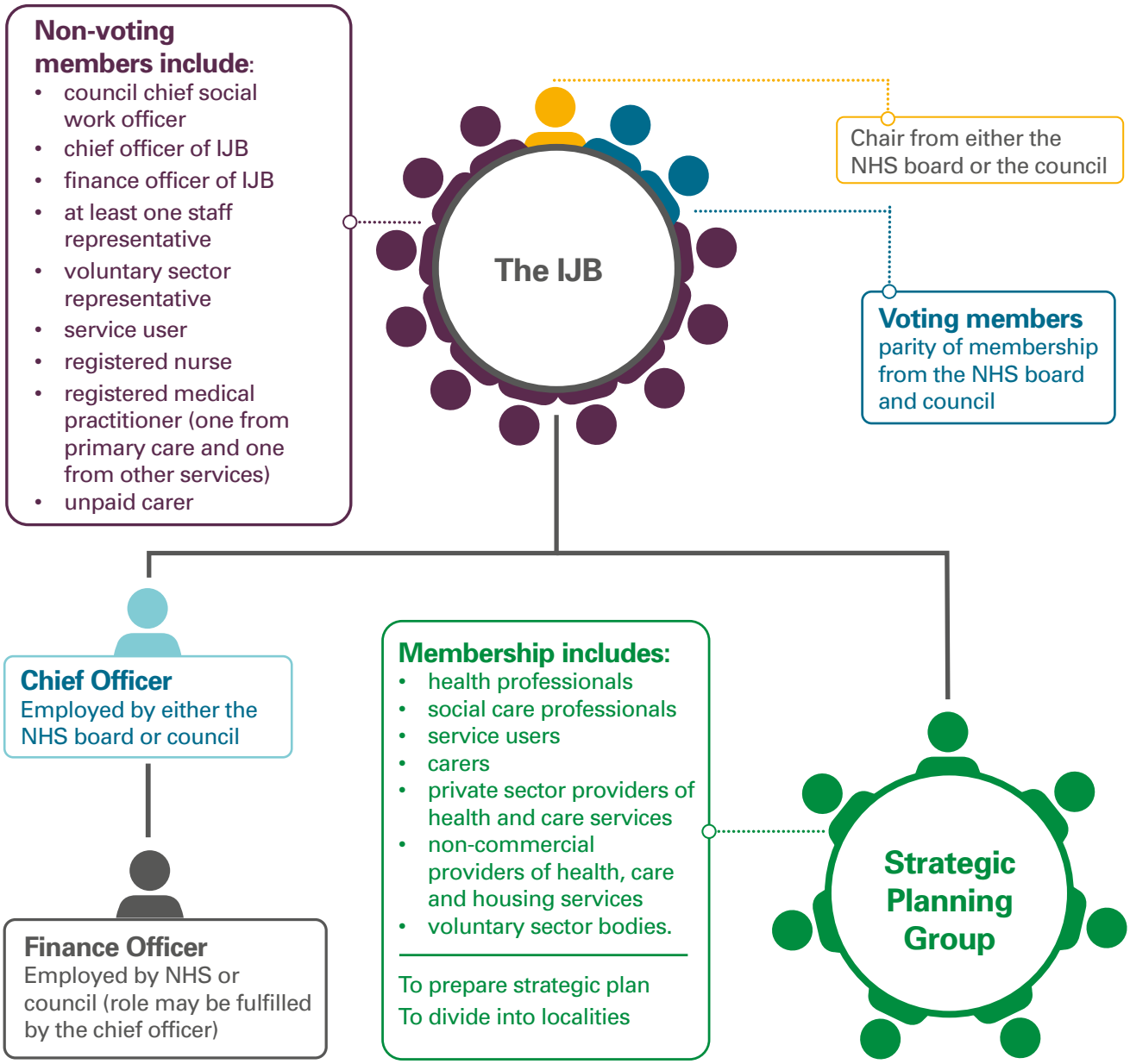
- The Accounts Commission is responsible for appointing auditors to IJBs and so has an interest in financial management and governance arrangements. As local government bodies, IJBs are also covered by the duty of Best Value as set out in the Local Government in Scotland Act 2003. The Accounts Commission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

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

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

Exhibit 5

Organisation chart for a typical IJB



Source: Audit Scotland

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

Implications for the public, voluntary and private sectors

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

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

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

Localities

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

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

Outcomes and performance measures

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

The Scottish Government is providing resources to help support integration

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

Exhibit 6

National health and wellbeing outcomes

IAs are required to contribute to achieving nine national outcomes.

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

Source: National Health and Wellbeing Outcomes, Scottish Government

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

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

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

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

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

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

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

Part 2

Current progress

Integration authorities are being established during 2015/16

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

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

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

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

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

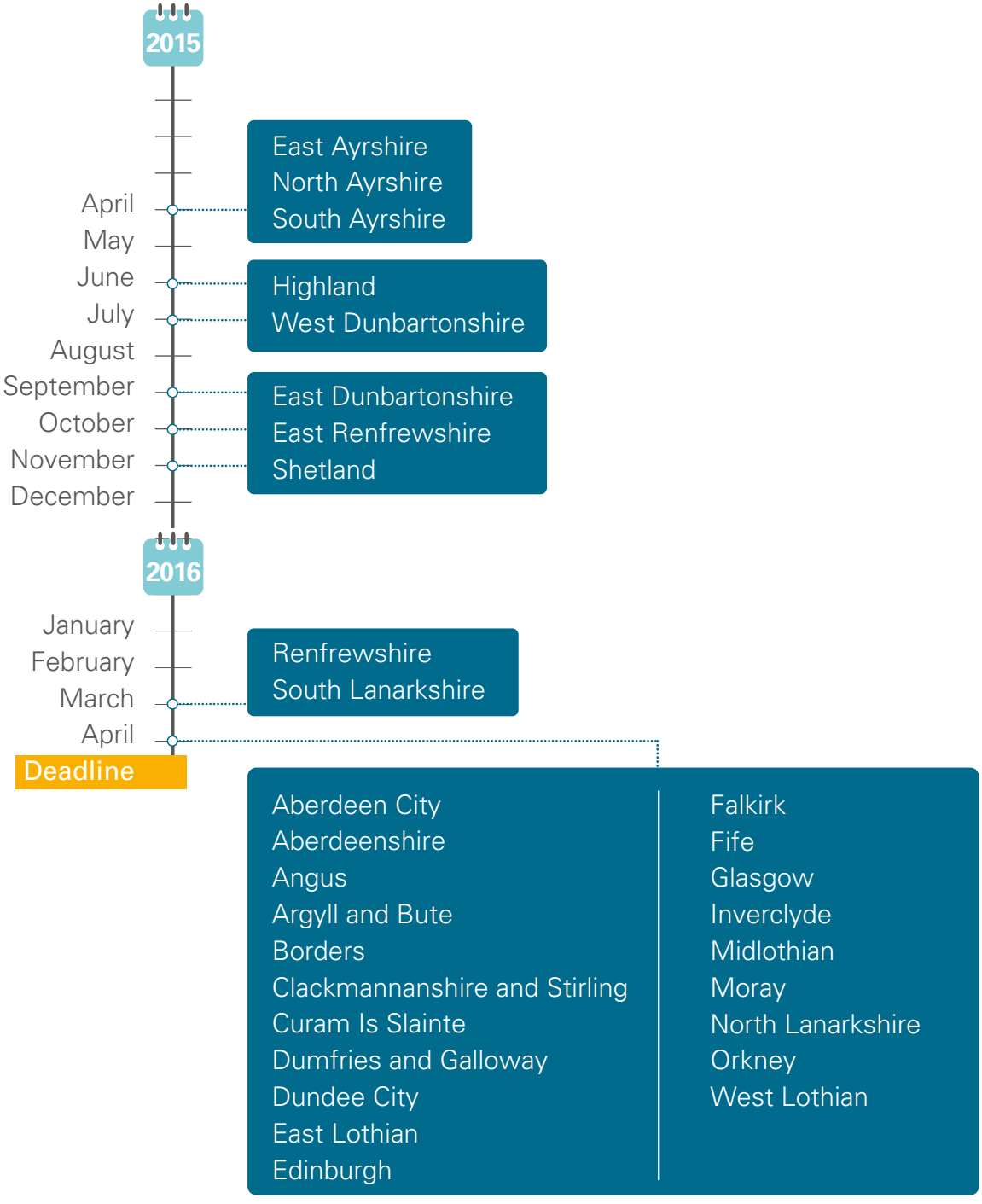
the scope of the services being integrated varies widely across Scotland

43. Among the variations the most notable are in Argyll and Bute IJB and Dumfries and Galloway IJB. These IJBs will oversee all NHS acute services, including planned and unplanned hospital services. In theory, this should allow these IJBs to better coordinate all health and care services in their area.

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

Exhibit 7

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



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

Source: Audit Scotland

Exhibit 8

Additional integrated services

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

	Children's social work services	Criminal justice social work services	Children's health services	Planned acute health services
Argyll and Bute	✓	✓	✓	✓
East Ayrshire	✓	✓	✓	–
East Renfrewshire	✓	✓	✓	–
Glasgow	✓	✓	✓	–
Inverclyde	✓	✓	✓	–
North Ayrshire	✓	✓	✓	–
Orkney	✓	✓	✓	–
South Ayrshire	✓	✓	✓	–
West Dunbartonshire	✓	✓	✓	–
Aberdeen City	–	✓	✓	–
Aberdeenshire	–	✓	✓	–
Curam Is Slainte	–	✓	✓	–
East Lothian	–	✓	✓	–
Midlothian	–	✓	✓	–
Moray	–	✓	✓	–
Shetland	–	✓	✓	–
Highland	✓	–	✓	–
Dumfries and Galloway	–	–	✓	✓
Angus	–	–	✓	–
Borders	–	–	✓	–
Clackmannanshire and Stirling	–	–	✓	–
Dundee	–	–	✓	–
East Dunbartonshire	–	–	✓	–
Edinburgh	–	–	✓	–
Falkirk	–	–	✓	–
Fife	–	–	✓	–
North Lanarkshire	–	–	✓	–
Perth and Kinross	–	–	✓	–
Renfrewshire	–	–	✓	–
South Lanarkshire	–	–	✓	–
West Lothian	–	–	✓	–

Key

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

Notes:

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

Source: Scottish Government, 2015 and Audit Scotland, 2015

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

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

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

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

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

Chief officer accountability

47. Accountability arrangements for the IJB chief officer are complex and while there may be tensions in how these arrangements will work in practice, we have attempted to set out the technical arrangements as clearly as possible. The chief officer has a dual role. They are accountable to the IJB for the

responsibilities placed on the IJB under the Act and the integration scheme. They are accountable to the NHS board and council for any operational responsibility for integrated services, as set out in the integration scheme.

Accountability to the IJB

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

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

Accountability to the NHS board and council

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

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

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

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

Part 3

Current issues

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

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

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

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

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

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

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

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

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

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

Sound governance arrangements need to be quickly established

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

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

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

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

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

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

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

IJB members will have to manage conflicts of interest

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

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

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

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

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

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

- **Membership of IJBs**: Chairs, vice chairs and voting members are all nominated by NHS boards and councils.
- **The approval process to agree future budgets:** Guidance issued by the Scottish Government's Integrated Resources Advisory Group (IRAG) suggests that, for future years, each IJB develops a business case and budget request and submits this to the NHS board and council to consider.
- **Control of integration schemes:** NHS boards and councils can decide to resubmit their integration schemes, changing the terms under which the IJB operates, or replacing it with a lead agency approach.

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

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

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

- All 17 IJBs oversee the operation of non-acute integrated services, such as district nursing.
- To date, only Argyll and Bute, and Dumfries and Galloway IJBs will oversee the operation of the acute hospital integrated services in their areas, and

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

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

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

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

67. But this understanding of accountabilities could be tested when there is a service failure, either in the care of an individual or in meeting outcome targets. The consensus amongst those we spoke with during our audit is that responsibility would lie with the council or NHS board delivering the service. But it could also be argued that ultimate responsibility might lie with IJBs, which plan and direct councils and NHS boards in how services are to be delivered. All parties need to recognise this risk and set out clearly an agreed understanding of each other's roles and responsibilities. It is essential that the chief officer is clear about how this joint accountability will work in practice from the start.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Most IAs have still to produce supporting strategies

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

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

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

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

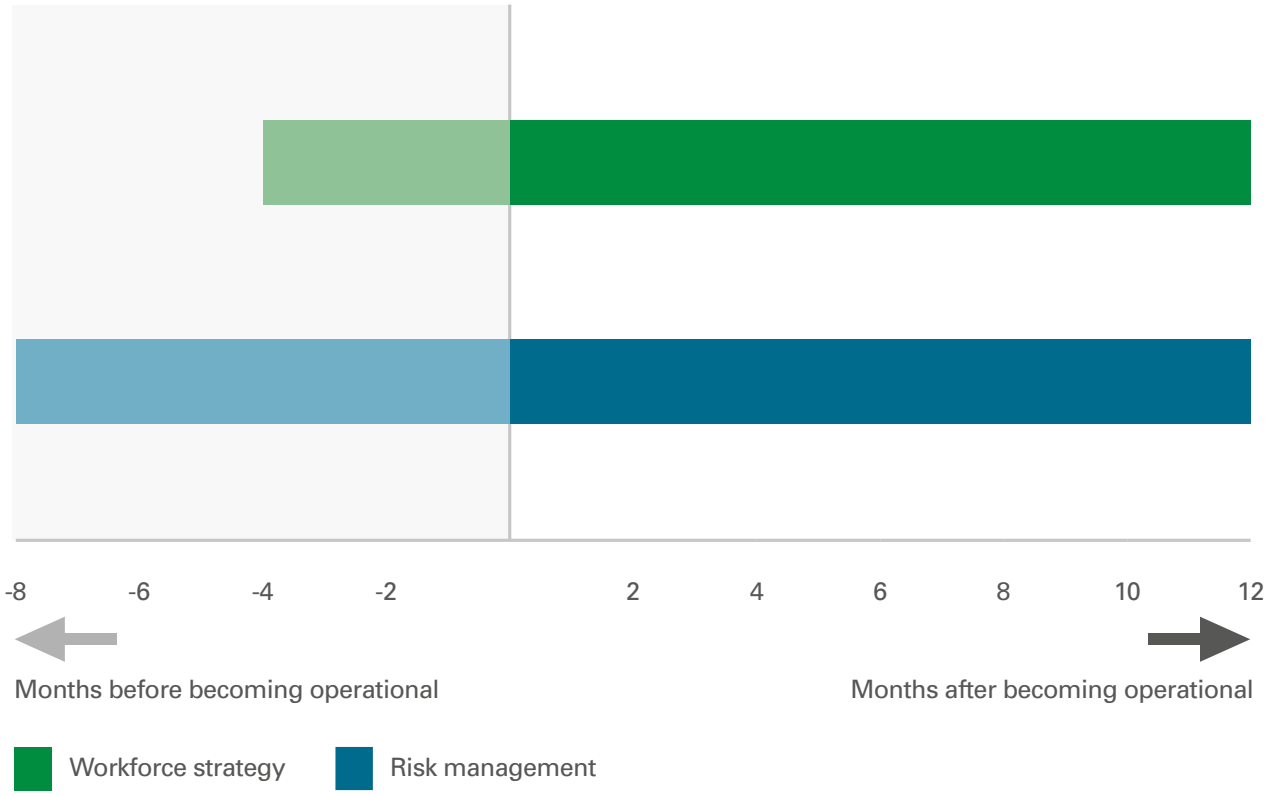
Equally, there are risks where the IA will not have plans in place until they have been operational for many months. It is important that IAs have clear strategic priorities and use these in developing:

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

Exhibit 9

Range of timescales for supporting strategies

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



Source: Audit Scotland analysis of available integration schemes

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

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

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

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

85. The following will add to these difficulties:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Exhibit 10

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

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

NL = North Lanarkshire map this to outcome

NA = North Ayrshire map this to outcome

AL = Neither map this to outcome

Source: Audit Scotland analysis of performance frameworks

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

The role of localities still needs to be fully developed

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

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

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

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

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

Part 4

Recommendations

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

The Scottish Government should:

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

Integration authorities should:

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

This includes:

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

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

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

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

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

Integration authorities should work with councils and NHS boards to:

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

Endnotes

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

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

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

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

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

6 *Scotland Performs*, Scottish Government, 2015.

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

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

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

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

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

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

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

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

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

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

17 East Dunbartonshire, Shetland and West Dunbartonshire.

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

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

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

21 Ibid.

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

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

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

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

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

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

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

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

30 Ibid.

Appendix 1

Audit methodology

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

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

We interviewed stakeholders in the following IA areas:

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

We drew on the work already carried out by:

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

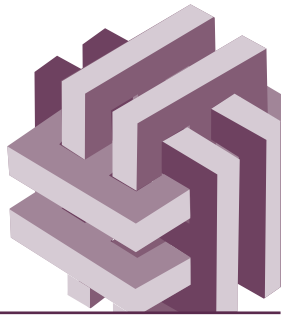
We also interviewed staff from:

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

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

Appendix 2

Scottish Government core integration indicators



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

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

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

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

* Indicates indicator is under development.

Health and social care integration

This report is available in PDF and RTF formats, along with a podcast summary at:
www.audit-scotland.gov.uk

If you require this publication in an alternative format and/or language, please contact us to discuss your needs: 0131 625 1500 or **info@audit-scotland.gov.uk**

For the latest news, reports and updates, follow us on:

AUDIT SCOTLAND

Audit Scotland, 4th Floor, 102 West Port, Edinburgh EH3 9DN
T: 0131 625 1500 E: **info@audit-scotland.gov.uk**
www.audit-scotland.gov.uk

ISBN 978 1 909705 76 0 AGS/2015/10

Health and social care series

Changing models of health and social care

ACCOUNTS COMMISSION

AUDITOR GENERAL

Prepared by Audit Scotland
March 2016

The Accounts Commission

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

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

Our work includes:

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

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

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 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/ags

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

Exhibit data

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

Key facts

Health budget in 2014/15

£11.86 billion

Scottish Government funding for councils in 2014/15

£10.8 billion

Number of people receiving ten or more hours of homecare per week in 2014

21,700

Number of hospital bed days from emergency admissions

3.91 million

Number of emergency admissions in 2013/14

553,000

Increase in population aged 85 and over between 2014 and 2030

64%

Proportion of GPs aged 50 and over in 2015

34%

Summary

Key messages

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

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

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

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

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

Recommendations

The Scottish Government should:

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

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

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

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

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

Information Services Division (ISD) should:

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

Background

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

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

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

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

About the audit

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

5. We gathered evidence for the audit by:

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

Part 1

Health and social care in Scotland

Health and social care services are facing increasing pressures

6. In recent years, demands on health and social care services have been increasing because of demographic changes. People are living longer with multiple long-term conditions and increasingly complex needs. At the same time, NHS boards and councils are facing increasingly difficult financial challenges. There is general recognition that changes are needed and that NHS boards and councils need to support more people in the community.

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

The proportion of older, frail people is increasing

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

Exhibit 1

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

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

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

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

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

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

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

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

The number of emergency admissions to hospital is increasing

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

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

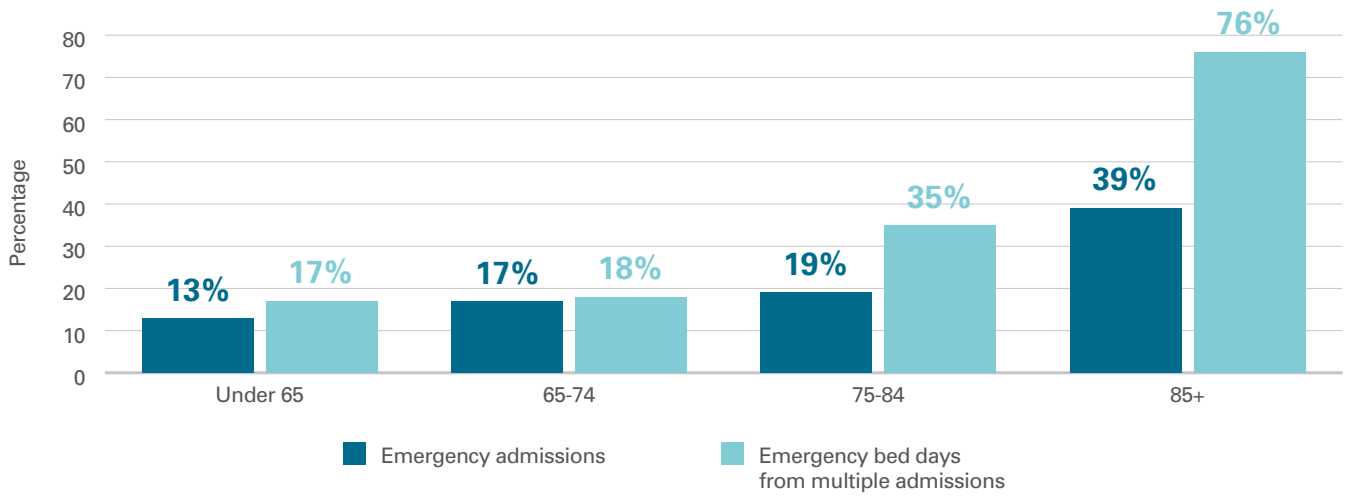
12. The number of emergency bed days for older people admitted to hospital three or more times in a year is increasing. Between 2005/06 and 2013/14, the number of bed days occupied by people aged 65 and over from multiple emergency admissions increased by 38 per cent to over 685,000 bed days. For people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

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

Exhibit 2

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

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



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

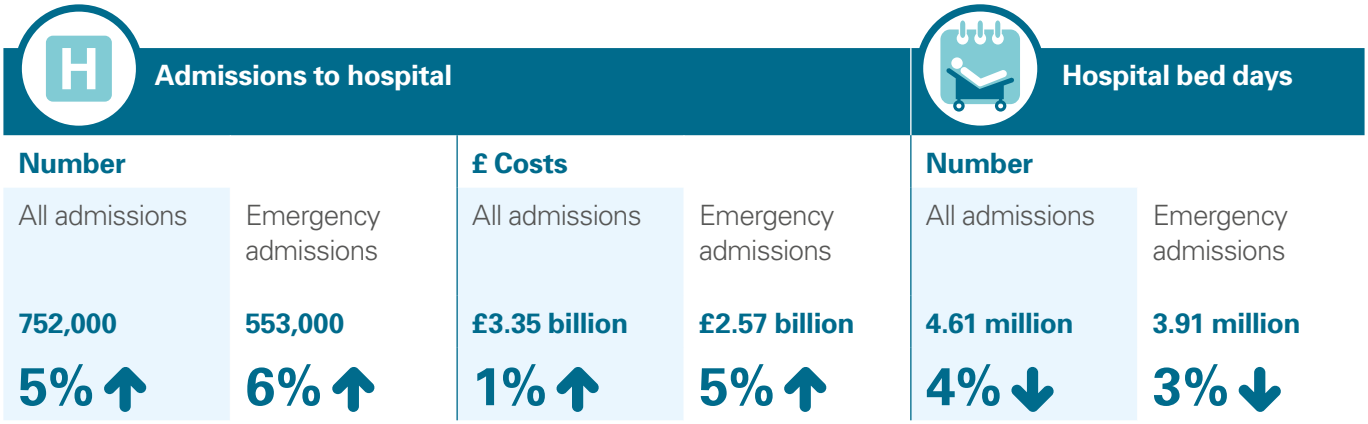
investigations or treatments are carried out. An emergency admission to hospital is more expensive than a planned admission. This means that although the percentage increases in the number of all admissions to hospital and in the number of emergency admissions are similar, the percentage increase in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

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

Exhibit 3

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

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



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

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

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

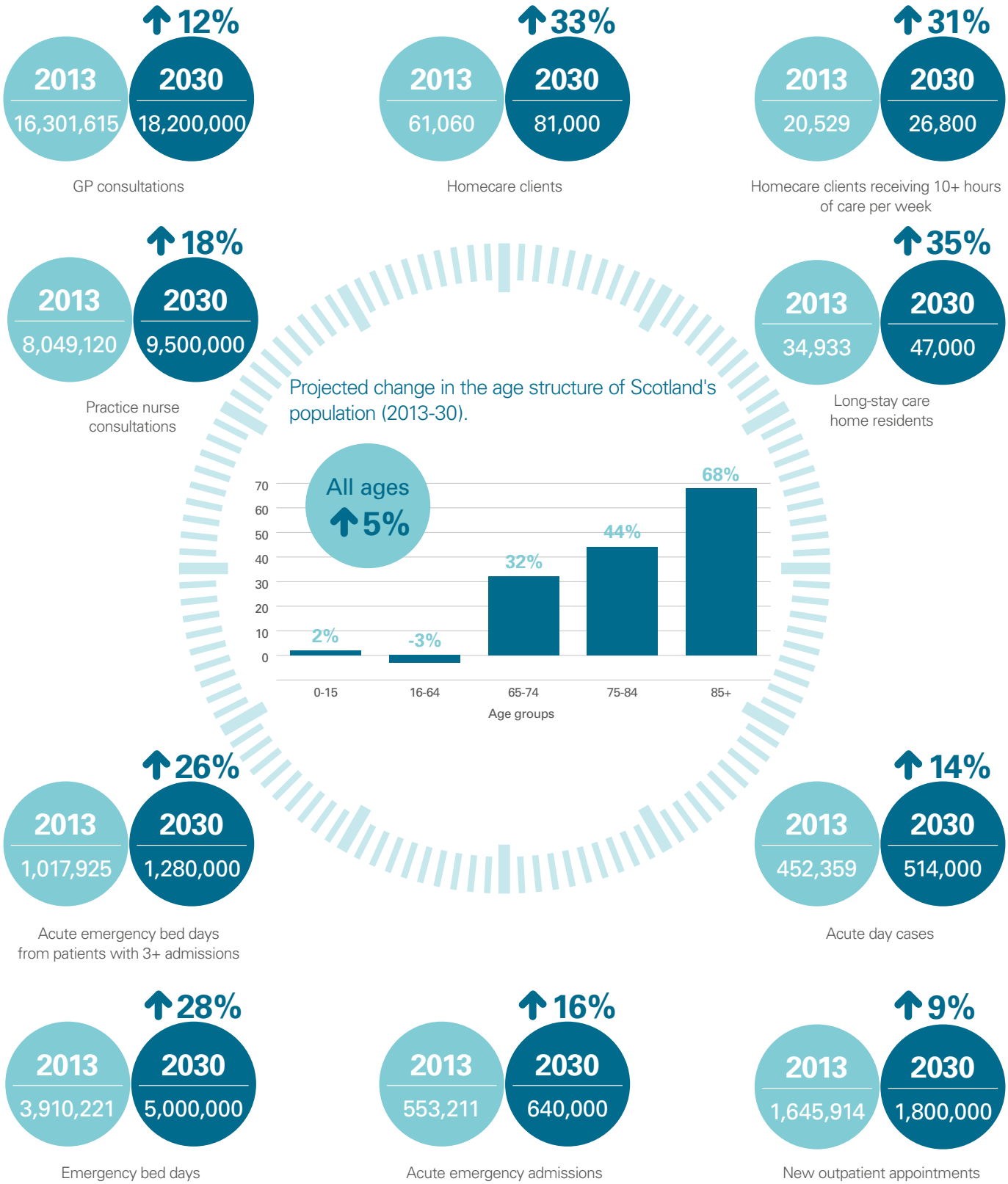
16. To help to explain the complexity of the health and social care system, and the potential impact changing demographics will have on services over the next 15 years, we have prepared Exhibit 4 (page 13). It shows projected rises in activity arising from a growing, ageing population. These are based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

- 1.9 million GP appointments and 1.5 million practice nurse appointments

Exhibit 4

Pressures on health and social care services, 2013-30

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



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

Source: Audit Scotland analysis, 2016

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

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

NHS boards and councils are facing increasing financial pressures

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

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

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

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

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

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

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

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

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

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

23. Health and social care services in Scotland are currently undergoing reform. Under these arrangements NHS boards and councils are required, as a minimum, to combine their budgets for adult social care, adult primary healthcare and aspects of adult secondary healthcare. This accounts for more than £8 billion of funding that NHS boards and councils previously managed separately. The new integration authorities are expected to coordinate health and care services and commission NHS boards and councils to deliver services in line with a local strategic plan. Over time, the intention is that this will lead to a change in how services are provided, with a greater emphasis on preventative services and

Exhibit 5

Indicators of building pressure in general practice

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

General practice activity

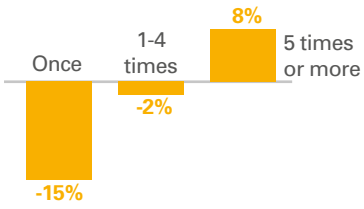
11% increase in patient contacts between 2003/04 and 2012/13 to 24.2 million

67% of contacts were with GPs in 2012/13

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

2003/04	2012/13
6.1 million	8.0 million

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



24.2 million GP contacts (2012/13)

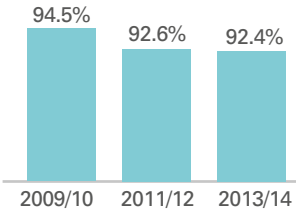
1.6 million A&E and Minor Injury Unit attendances (2012/13)

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

Patient experience 2013/14

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

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



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

2015 BMA survey of 1,800 GPs in Scotland

25% of GPs described their workload as unmanagable

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

a third would like to retire by 2020

17% of practices had at least one vacancy

Workforce

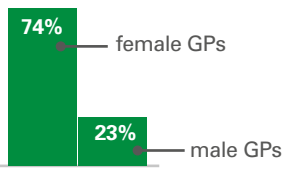
Around 1 in 2 community nurses were aged 50 and over, compared with 1 in 3 hospital nurses in 2015

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

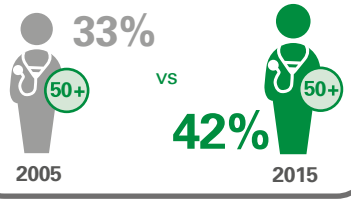
37% increase in female GPs over the ten-year period to 2015

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

Percentage of GPs working part-time in 2013



GP partners aged 50 and over



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

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

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

Part 2

New ways of providing health and social care

New approaches to delivering health and social care are emerging

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

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

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

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

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

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

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

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

New models need to be implemented and evaluated properly

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

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

More can be learned from the innovation of others

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

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

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

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

Multidisciplinary teams working together to keep people at home

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

Exhibit 6

New models of health and social care in Scotland

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

Community preventative approaches

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

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

Improved access to primary care and routine hospital treatments

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

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

Enhanced community care

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

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

Cont.

Enhanced community care (continued)

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

Intermediate care

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

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

Reducing delayed discharges

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

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

Source: Audit Scotland

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

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

Nurse-led approaches that maximise the population's resilience

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

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

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

Longer-term strategic approaches

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

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

Taking a whole-system approach

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

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

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

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

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

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

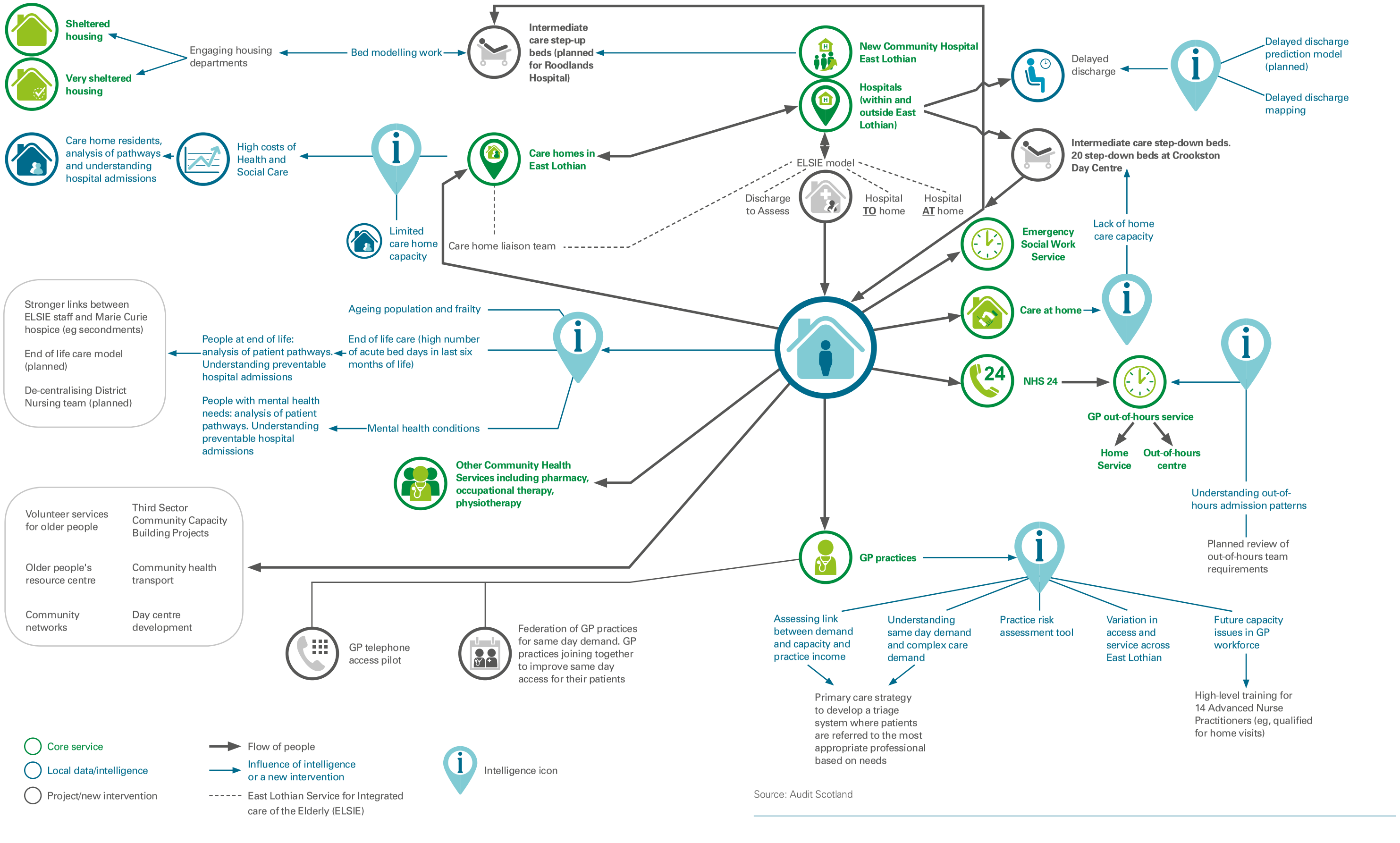
43. East Lothian is bringing together growing intelligence about its population, how people access services, and various strands of work which all aim to improve how it delivers services. This is allowing the partnership to build a comprehensive picture of the needs of its local population. It is also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

Exhibit 7

East Lothian's whole-system model

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

Exhibit 7 continued



Source: Audit Scotland

Part 3

Making it happen

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

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

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

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

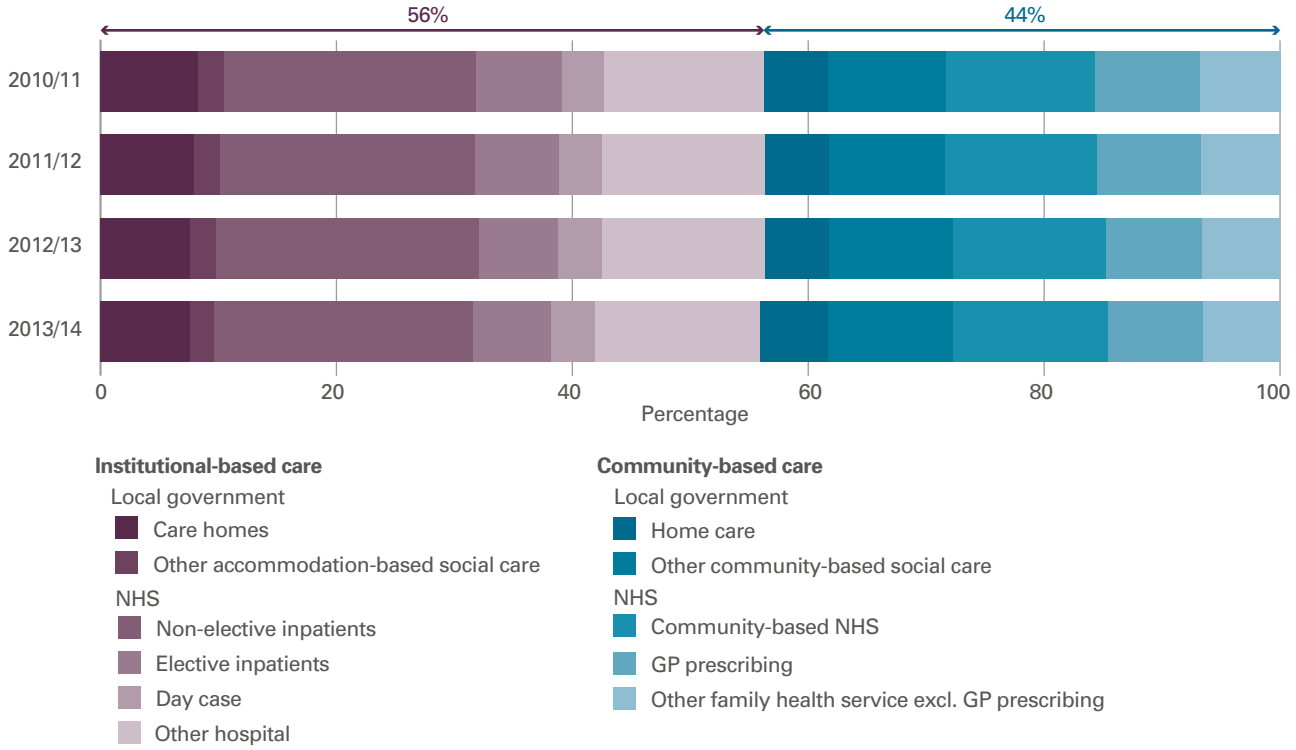
46. Over the four-year period from 2010/11 to 2013/14, the balance of expenditure on institutional services, such as hospitals and care homes, and on care at home or in community settings, has remained static. The percentage of total expenditure on adult health and social care (around £11.7 billion)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

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

Exhibit 8

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

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



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

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

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

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

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

50. The Scottish Government's overall aim of enabling everyone to live longer, healthier lives at home, or in a homely setting, by 2020 is widely accepted. In May 2013, the Scottish Government set out high-level priority areas for action during 2013/14.[26] This lacked a clear framework of how it expects NHS boards and councils to achieve this in practice, and there are no clear measures of success, such as milestones and indicators to measure progress. The cost implications of implementing the 2020 Vision are unknown and there is a lack of detail about the main principles of the policy (paragraph 22). There is also slow progress in developing the workforce needed for new models of care and a lack of information about capital investment to support the 2020 Vision.[27] The recently published National Clinical Strategy is intended to provide a clearer framework, but it does not detail how the high-level proposals will be implemented or contain any milestones or indicators or financial analysis.

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

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

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

The Scottish Government needs to identify priorities and risks

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

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

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

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

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

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

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

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

Exhibit 9

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

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

Source: Audit Scotland

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

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

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

58. There are tools that can facilitate the transfer of resources across a local system, demonstrated in the examples seen in Tayside, Glasgow and Highland (Case study 8 [PDF] and Case study 9 [PDF]). Scotland could apply learning from other countries. For example, Canterbury, New Zealand, shifted the balance of care through strong leadership, a clear vision, and a collaborative and whole-system approach. An important factor was its focus on 'one system, one budget'. It prioritised spending on those in greater need to reduce relying on residential care and to keep people in their own homes for longer. This had the effect of reducing demand and costs for hospital and other institutional care, and allowed for more investment in the community (Case study 10 [PDF]).

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

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

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

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

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

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

There is a lack of coordinated, clear and accessible learning

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

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

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

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

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

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

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

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

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

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

Funding needs to be focused on new community-based models

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

  – equipment to enable optometrists to screen people for glaucoma

  – changes to front-line services so that Allied Health Professionals, such as physiotherapists, can better support active and independent living

  – a leadership programme to equip GPs with the necessary skills to play a leading role in developing local integration work

  – additional research and training through the Scottish School of Primary Care.[45]

81. In February 2016, the Scottish Government announced a further £27 million investment over the next five years to develop the NHS workforce. This includes £3 million to train 500 advanced nurse practitioners and over £23 million to increase the number of medical school places and widen access to medical schools. A new entry-level programme will be introduced to support and encourage more people from deprived backgrounds to study medicine.

82. Many general practices are struggling to recruit and retain staff. During 2015, NHS boards had to support nine practices that were not able to continue as successful businesses and provide the services required to their local population. This may become an increasing problem in light of the building pressures we have outlined throughout this report what impact it has on. Where NHS boards have had to step, it is not clear what impact this has had on the performance of practices and the services provided to patients. The Scottish Government should monitor these practices for any improvements or deterioration in the way services are provided, and share any learning.

A better understanding of the needs of local populations is required

83. NHS boards, councils and partnerships need to have a good understanding of their local population and how people use different services so they can provide services that effectively meet local needs. This understanding can help to identify where resources, including money and staff, are being directed and if they are using these resources in the best way. It can also help to identify changes required to the way services are delivered and how resources can be redirected to priority areas.

84. We found that NHS boards, councils and partnerships are at varying stages with this kind of analysis and taking different approaches to it. However, integration authorities will all have to carry out needs assessments of their local population, and this is an important step in improving local analysis. The organisations that are making good use of their local data are starting to think differently about how they can best deliver and redesign services. They are identifying a small number of priorities to focus on, which is much more manageable than trying to fix everything at once. It is also more effective than having too many small-scale projects that are difficult to manage and unlikely to demonstrate a significant impact.

Health and social care data is improving

85. ISD is developing an extensive database of linked data on health and social care activity and costs and demographic information. It is making this information available to NHS boards, councils and partnerships to help them gain a better understanding of the needs of their local population, current patterns of care and how resources are being used. The Health and Social Care Data Integration and Intelligence Project (HSCDIIP), now known as Source, is a long-term project that aims to support integration authorities by improving data sharing across health and social care.[46] From April 2015, the central team has begun sharing local data in the form of an interactive dashboard that contains easy-to-read information summaries. This has required local areas to sign an information governance agreement to enable NHS boards and councils to view each other's data across a local population. Some partnership areas have taken some time to get these agreements in place and therefore gain access to the analysis. As at February 2016, five partnerships had finalised these agreements and undergone training for the software that will allow them to access and analyse the linked data for their local area (Angus, Borders, Dumfries and Galloway, East Renfrewshire, and Midlothian). This is the first time this linked data has been available and this is a valuable resource for partnerships.

86. ISD is also providing data and analytical support through a Local Intelligence Support Team (LIST) initiative. This allows partnerships to have an information specialist from ISD working with them in their local area. The central team can also provide additional support and tailored analysis. This includes forecasting costs, pathway analysis to show how individuals move from one service to another, and the resource associated with the use of different services at a local population level.

87. Some areas have made good use of the support provided by the Source team to better understand their population and also the data that has been made available to them. This includes Perth and Kinross, East Lothian, and West Dunbartonshire (Case study 12 [PDF]).

88. These examples demonstrate how detailed analysis of local data at a local area and individual level is crucial in understanding the needs of a population, how people are currently using services and how costs are incurred. This then provides local areas with the information they need to identify how services can be provided differently and more efficiently to provide better outcomes for people and reduce costs. Using this information to identify the individuals at most risk of their health deteriorating allows preventative measures to be put in place or for care to be provided in a more effective and efficient way. This has the potential to free up resources across the whole system. If local areas do not have this level of information, they will not be able to properly plan or transform services in the future.

89. ISD is in a good position, through the Source and LIST work, to share good practice about data analysis across all partnership areas. ISD held a conference in September 2015 to share early learning from across Scotland. ISD should continue to share good practice. This could include:

- hosting further national events
- publishing good practice examples on its website to illustrate how local areas are making good use of data
- developing toolkits to assist partnership areas to identify appropriate approaches to analysing and understanding local data.

Endnotes

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

2 There is a discontinuity in healthy life expectancy (HLE) data owing to a change in methodology to align with the European Union. This results in estimates of HLE at birth from 2009 onwards being over eight years lower than in 2008 for each sex.

3 *Healthy life expectancy: Scotland*, Scottish Public Health Observatory, December 2015.

4 *Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study*, K Barnett, S Mercer, M Norbury, G Watt, S Wyke and B Guthrie, Lancet, May 2012.

5 *Patient encounters in very deprived areas*, G Watt, British Journal of General Practice, January 2011.

6 *Frailty and the geriatrician,* Age and Ageing, vol 33, no 5, pp 429–30, Rockwood K, Hubbard R, 2004.

7 *Think Frailty: Improving the identification and management of frailty*, Health Improvement Scotland, April 2014.

8 *The care of frail older people with complex needs: time for a revolution*, The King's Fund, March 2012.

9 SMR01 activity analysis provided to Audit Scotland by ISD, November 2015.

10 Scottish Government analysis of projected health and social care expenditure. Provided to Audit Scotland in February 2016.

11 *NHS in Scotland 2015* [PDF], Audit Scotland, October 2015.

12 *Scotland's Spending Plans and Draft Budget 2016-17*, Scottish Government, December 2015.

13 *An overview of local government in 2015* [PDF], Audit Scotland, March 2015.

14 *IRF-NHS Scotland and Local Authority Social Care Expenditure-Financial Years 2010/11-2013/14*, ISD Scotland, March 2015.

15 *Stocktake of access to general practice in England*, National Audit Office, November 2015.

16 *2020 Vision: Strategic Narrative*, Scottish Government, September 2011.

17 http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Outcomes

18 *Core Suite of Integration Indicators*, Scottish Government, March 2015.

19 *Health and social care integration: Progress update* [PDF], Audit Scotland, December 2015.

20 *A Stronger Scotland: The Government's Programme for Scotland 2015-16*, Scottish Government, September 2015.

21 The ten test sites are in Glasgow, Edinburgh, Fife, Tayside, Forth Valley, Campbeltown, West Lochaber, Islay, Mid-Argyll, and Clackmannanshire.

22 *Place-based systems of care,* The King's Fund, November 2015.

23 *The Buurtzorg Nederland (homecare provider) model, Observations for the United Kingdom (UK)*, Royal College of Nursing, 2015.

24 *NHS in Scotland 2013/14* [PDF], Audit Scotland, October 2014; *Reshaping care for older people* [PDF], Audit Scotland, February 2014; *Review of Community Health Partnerships* [PDF], Audit Scotland, June 2011.

25 *NHS in Scotland 2015* [PDF], Audit Scotland, October 2015.

26 *Route Map to the 2020 Vision for Health and Social Care*, Scottish Government, May 2013.

27 *NHS in Scotland 2015* [PDF], Audit Scotland, October 2015.

28 *Evaluating integrated and community-based care: How do we know what works?*, Nuffield Trust, June 2013.

29 From 2015/16 to 2017/18, the Scottish Government is providing the following funding to local bodies to support improvements in health and social care: £300 million integrated care fund; £100 million to reduce delayed discharges; £30 million for telehealth; £60 million to support improvements in primary care; £51.5 million for a social care fund.

30 *Reshaping Care for Older People: A Programme for Change 2011-2021*, Scottish Government, August 2012.

31 *Reshaping Care for Older People* [PDF], Audit Scotland, February 2014.

32 *Making change possible: A Transformation Fund for the NHS*, The Health Foundation and the King's Fund, July 2015.

33 *Laying the Foundations for an integrated improvement resource,* Healthcare Improvement Scotland, Quality and Efficiency Support Team, Scottish Government and Joint Improvement Team, September 2015.

34 *NHS Scotland Staff Survey: National Report*, Scottish Government, November 2015.

35 *The 2014/15 audit of NHS Highland: Update on 2013/14 financial management issues* [PDF], Audit Scotland, October 2015

36 *NHS Fife 2014/15 annual audit report for the board of NHS Fife and the Auditor General for Scotland* [PDF], Audit Scotland, June 2015.

37 *Financial Monitoring Report for the 5 month period to 31 August 2015*, Board Papers, NHS Greater Glasgow and Clyde, October 2015.

38 *IRF-NHS Scotland and Local Authority Social Care Expenditure-Financial Years 2010/11-2013/14*, ISD Scotland, March 2015.

39 *A Blueprint for Scottish General Practice*, Royal College of General Practitioners Scotland, July 2015.

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

41 *Health and Social Care Datasets-Social Care Survey*, Scottish Government, 2015.

42 *Redesigning primary care for Scotland's communities*, BMA Scotland, December 2015.

43 *Main Report of the National Review of Primary Care Out of Hours Services*, Scottish Government, November 2015.

44 *Scottish Budget: Draft Budget 2015-16*, Scottish Government, October 2014.

45 *Primary care investment news release*, Scottish Government, June 2015.

46 http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Health-and-Social-Care-Integration/docs/health-and-social-care-information-flyer-141211.pdf

Changing models of health and social care

This report is available in PDF and RTF formats, along with a podcast summary at:
www.audit-scotland.gov.uk

If you require this publication in an alternative format and/or language, please contact us to discuss your needs: 0131 625 1500 or **info@audit-scotland.gov.uk**

For the latest news, reports and updates, follow us on:

AUDIT SCOTLAND

Audit Scotland, 4th Floor, 102 West Port, Edinburgh EH3 9DN
T: 0131 625 1500 E: **info@audit-scotland.gov.uk**
www.audit-scotland.gov.uk

ISBN 978 1 909705 83 8 AGS/2016/02