East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
Caroline Sinclair

East Dunbartonshire HSCP Performance, Audit & Risk Committee Meeting
Thursday 31st March 2022 12 noon.
Meeting will be held virtually via MS Teams

AGENDA

No.	Item	Lead	Document
1.	Welcome and Introductions	Councillor Goodall	
2.	Minutes of Last Meeting – 21st January 2022 2021	Councillor Goodall	
3.	HSCP Internal Audit Update to Feb 2022 and Internal Audit Planning 2022/23	G McConnachie	
4	HSCP Audit Scotland Action Plan Update 2020/21	J Campbell	
5.	HSCP Delivery Plan 2021 22 Update	J Campbell	
6.	Mental Welfare Commission Report – Care & Treatment for People with Alcohol Related Brain Damage in Scotland (2021)	D Aitken	
7.	Audit Scotland Report – Drug & Alcohol Services March 2022	D Aitken	
8.	Audit Scotland Report – Social Care Briefing	C Sinclair	
9.	Audit Scotland Report – NHS in Scotland 2021	C Sinclair	
10.	For Information – Proposed Auditors 2022/23 – 2026/27	J Campbell	
11.	HSCP PAR Agenda Planner June 2021 – June 2022	All	
12.	A.O.C.B	Councillor Goodall	
13.	Date of next meeting – 28th June 2022	Councillor Goodall	

East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
Caroline Sinclair

Agenda Item Number: 2

Minutes of
East Dunbartonshire HSCP Performance, Audit & Risk Committee Meeting
Date: Thursday 21st January 2021, 10am
Location: Via MS Teams

Present:	Jim Goodall (Chair)	**JG**	Ketki Miles	**KM**
	Jean Campbell	**JC**	Gillian McConnachie	**GM**
	Alan Moir	**AM**	Caroline Sinclair	**CS**
	Ian Ritchie	**IR**	Marie McFadden	**MM**
	Peter Lindsay	**PL**	Jacquie Forbes	**JF**
	Derrick Pearce	**DP**		
Minutes :	Christina Burns	**CB**		

No.	Topic	Action by
1.	**Welcome and Apologies**	**JG**
	The chair welcomed the Committee members to the meeting.	
2.	**Minutes of last meeting**	**JG**
	Minutes of the meeting held on the 28th October 2021 approved for factual accuracy, all matters covered within the agenda.	
3.	**Audit Scotland Proposed Annual Audit Report 2021/22**	**PL**
	Audit Planning work has only recently commenced for 2021/22. The annual audit plan will be issued once this is complete. PL confirmed the audit fee was agreed with JC recently. Details of the new external auditors will be communicated within the next few months and will most likely be the same auditors as the Local Authority. The deadline for the Audit sign off for 2021/22 Annual accounts is the end of October, this is a lengthier process due to accounts being audited remotely. There will be an aim to have this completed as early as possible. The annual audit plan will be available as soon as the planning work is finished and this will hopefully be submitted to the next PAR meeting. Further to a discussion with PL the group agreed to schedule a PAR meeting in Septembers and should this become unsuitable a further special meeting will be set up in October to sign off the accounts.	
4.	**HSCP Internal Audit Update**	**GM**
	This report provides an update on the internal activity across the HSCP and partnership organisations across East Dunbartonshire. In terms of HSCP specific work, a detailed review of follow up actions has been completed. There are two high risk actions in progress in relation to the HSCP and relate to contractual issues and are expected to be addressed through restructure and recruitment within the planning & commissioning team. With regards to the conclusion of the interim follow up work, it is positive that the HSCP and EDC have been able to close off a number of high risk actions during the pandemic. The remaining high risk actions should be	

	prioritised in line with the revised deadlines agreed for 2022/23. The report indicated that the Home Care audit will be deferred. Partial reliance can be put on the care at home inspection last year to avoid duplication as this does provide a degree of assurance the service is meeting the objectives and needs of services users. GM therefore expects to be able to provide a year-end audit opinion in line with expectations. GM also highlighted an error in Appendix 1 in relation to data cleansing and requested the due date is correctly noted as the 31st December 2022.	
5.	**HSCP Delivery Plan 2021 22 Update**	**JC**
	This is an update on the annual delivery plan which the HSCP has undertaken to develop and support the Strategic and Financial Plan. The IJB agreed to take this plan forward this year and regular updates will be provided to the PAR around the progress of the actions within the plan. A Local Authorities approach has been replicated around reporting on projects and this has been refined further through the suggestions of members at previous meetings through categorising each of the actions and the intent for delivery. Actions have been categorised as efficiencies, improvement to service delivery, statutory responsibilities, corporate priority or sustainability and enhancement to assets. In terms of the project themselves there has been no further movements since the last meeting. RAG Status for projects are as follows: 24 projects Green: 3 Amber and 0 Red. Items identified as in Amber status relate to: The Primary Care Improvement Programme, Fair access to community Care and the PDS review. Following clarification from Scottish Government (SG) on the outstanding areas awaited, the public dental service review can now restart and is now back on track for completion by the end of the financial year. **ACTION: JF requested that Appendices are numbered.** JF discussed the Highlight reports in appendix 1. JF suggested there are inconsistencies between appendices and suggested some of the actions should be in amber due to their fast approaching deadlines. **ACTION: JF is also keen to understand what happens if timescales are not met and suggested adding some narrative to detail actions will be carried forward.** JC discussed the House project and explained that the HSCP would be keen for some investment in this area to carry this project on, this is being discussed. JC also advised the delivery plan relates to projects that can be delivered within the year however recognising some of these projects will have a longer life span with activity continuing into future years.	
6.	**Care at Home Service Inspection July 2021**	**DP**
	This is a summary of the outcome most recent inspection of the internal	

	Care at Home service from July last year. There has been some delays to the report. The report details the outcome of the inspection acknowledged that the service is in a process of continuous improvement. The continued improvements have been noted by the CI specifically in the relation to the revision of the operating model, the introduction of the leadership team and also the consistency positive feedback from users of the service. The outcome of the inspection was however disappointing for the service as despite the improvements noted, the overall public grading did not change and remained at 3 (adequate). Some dimensions of the grading criteria did improve however these were not reflected on the overall grading which is determined by the lowest grade achieved. DP explained this was a particularly bruising outcome for the service given the delivery of the service through extremis. CS highlighted additional winter monies were identified and used to strengthen some of the weaknesses identified. DP informed the PAR Committee pandemic caused a backlog of reviews and explained going forward reviews will be monitored weekly and additional review staff have been implemented to undertake this through the winter monies highlighted by CS. DP is hopefully this will provide the CI with some assurance around the quality assurance programme is in place.	
7.	**HSCP PAR Agenda Planner June 2021 – June 2022**	**JC**
	IR is keen meetings are held prior to HSCP Board meetings. JC explained there are challenges around some dates due to the sign off of annual accounts as well as the availability of draft accounts and council recess. However dates are being amended and reviewed were possible. JC advised admin teams have been provided with an Adobe package which will hopefully allow the combining of PAR Committee papers for the next meeting.	
8.	**A.O.C.B.**	**JG**
	No further business for discussion.	
9.	**Date of next meeting**	**JG**
	Thursday 31st March 2022 at 12:00pm.	

East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
AGENDA ITEM NO: 3

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING:	**31st MARCH 2022**
REPORT REFERENCE:	**HSCP/310322/03**
CONTACT OFFICER:	**JEAN CAMPBELL, CHIEF FINANCE & RESOURCES OFFICER (07583902000)**
SUBJECT TITLE:	**HSCP INTERNAL AUDIT UPDATE TO FEB 2022 AND INTERNAL AUDIT PLANNING 2022/23**

1.1 PURPOSE

1.2 The purpose of this Report is to advise Committee of the internal audit work completed in the period, as work on the 2021/22 plans continued.

1.3 This report presents a consolidated summary of the internal audit work completed by both East Dunbartonshire Council's in-house internal audit team on the HSCP and the Council and also the work performed by Azets, the NHSGGC's internal audit providers.

1.4 This is the fourth monitoring report of 2021/22. The report additionally summarises the risk classifications where appropriate and provides detail on key internal audit findings.

1.5 The information contained in this report relating to East Dunbartonshire Council or NHSGGC audits has been presented to the Council's Audit & Risk Management Committee (A&RMC) and the NHSGGC Audit & Risk Committee (ARC) as appropriate, where it has received scrutiny. Once noted by the these committees, this report provides details on the ongoing audit work, for information, to the H&SCP Performance, Audit & Risk Committee and to allow consideration from the perspective of the H&SCP.

2.1 RECOMMENDATIONS

2.2 The Performance, Audit & Risk Committee is asked to:

- Note the Update on Internal Audit Progress.
- Approve the Internal Audit Planning document for 2022/23.
- Request the Chief Finance & Resources Officer to submit performance monitoring reports detailing progress against Plan and audit results to future meetings of the Committee.

CAROLINE SINCLAIR
INTERIM CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.1 BACKGROUND / MAIN ISSUES

3.2 HSCP INTERNAL AUDIT PROGRESS

3.2.1 Since the last Performance, Audit and Risk Committee meeting, work on a number of areas has continued. The following outputs have been completed since the last PAR:

3.2.2 *Residential Accommodation - Financial Assessments* - Auditors concluded that the control environment around the area of Financial Assessments is generally satisfactory. However, Auditors highlighted one Medium risk and two Low risk actions to be taken forward to enhance assurances in the area. With regards to the Medium risk, Auditors noted that there was no requirement for a Financial Assessment Form to be completed in instances where a self-funder's capital fell below the threshold and so individuals were now seeking HSCP funding. Correspondence from the Power of Attorney or Solicitor was accepted as evidence of capital. A revised procedure has been agreed that a form will be completed in all instances when a client's funds drop below the threshold to ensure that all relevant information is obtained on a consistent basis and signed off as correct and complete.

3.2.3 Two low risks have also been identified, one relating to ensuring that financial assessment forms are fully completed before passing to Shared Services and the other to ensuring that only the most up to date procedure documents are available on the Council's intranet (the Hub).

3.2.4 A target date of the end of April 2022 has been set for implementing the agreed action plan.

3.2.5 *Adults with Incapacity – Access to Funds* – Auditors have carried out a review of the recently drafted East Dunbartonshire HSCP Adults with Incapacity (Scotland) Act 2000, Access to Fund Scheme Protocol. The purpose of the review was for auditors to provide an independent opinion on the adequacy of the proposed control environment in this area. The Adults with Incapacity (Scotland) Act 2000, covers situations involving adults who are unable to manage their financial affairs or to make decisions about their care. Auditors found the procedures to be generally sound; however, made the following recommendations for improvement:

- *Cash Transactions Procedures* – A procedure covering cash withdrawals and security of remaining cash should be agreed. This should take consideration of existing procedures within both the Council and HSCP for cash handling of clients' monies.

- *Independent Reconciliations* – The protocol should include further detail as to the timing of such reconciliations (e.g. monthly) and by which team, to ensure this area is not overlooked. Such reconciliations should be performed independently of those administering the account (for example by Shared Services).

- *Document Retention* – Responsibilities for document retention, by both the Social Work Team Manager and Shared Services Finance team, should be clearly set out.

3.2.6 Following the audit, the procedures were updated for all of the points highlighted by auditors and so the action plan is considered complete for this audit.

3.2.7 *Children's Services CSA* - The 2021/22 Internal Audit Plan also included provision for a Children's Services review. It was agreed with the Interim Head of Children's Services & Criminal Justice that the format of the review would be a review of Ferndale Children's Residential Unit, through a Control Self-Assessment (CSA). The Internal Audit team use the CSA exercise as an alternative to the traditional Regularity Audit visits to Council establishments, which would have seen auditors carry out on site sample testing of the control environment.

3.2.8 The CSA was in the form of a questionnaire, which was completed by the establishment Manager. The exercise assisted in identifying and evaluating the effectiveness of the internal controls and encouraged consideration of any weaknesses and associated risks. Internal Audit have used the results of the CSA exercise to establish the extent to which internal controls are operating effectively and where improvement is required.

3.2.9 As this was the first CSA performed with regards to Children's Residential Services, auditors liaised with the Unit Manager of Ferndale during the completion of the questionnaire. This enabled the format to be clarified and allowed further feedback to be received from the Manager.

3.2.10 Auditors concluded that, from the information supplied, key controls around financial management, the imprest petty cash system and inventory management are in place and operating well, with only one area noted as requiring further attention, once the easing of pandemic restrictions allow. Due to the impact of the Covid-19 pandemic the last physical check of the inventory against items held was carried out at Ferndale in March 2019. This should ordinarily be carried out annually. However, it was confirmed by the Manager that this piece of work will take place once the pandemic restrictions are lifted, with a target date set of August 2022 for this being reintroduced.

3.2.11 *Consultancy Advice – HSCP Grant Awarding Advice Note* – Members may recall that in January 2021, Auditors received notification of embezzlement of funds to a value of approximately £2,000 in a third party following the award of a Community Grant from East Dunbartonshire Council. Following this notification, Auditors completed a Consultancy Note in May 2021 that included detail on the following:

- The Grant award and approval process,
- Grant Monitoring arrangements, and;
- The highlighting of improvement actions.

3.2.12 One such improvement action was for HSCP Management to ensure that they have adequate controls and assurances over the awarding of grants, and that related documentation is retained for an appropriate period.

3.2.13 The previous report was limited to both a specific instance and was in relation to the Community Grants Fund.

3.2.14 Auditors have now issued a further Consultancy Note with more detailed guidance in respect of expectations in relation to the awarding and monitoring of grants and anticipated controls in general terms. As this advice was generic and high level it may be appropriate for further audit work in this area at a point in future to support further improvements in this regard.

3.2.15 Internal Audit Planning 2022/23 - An Internal Audit Planning update is included at *Appendix 1* to detail planned Internal Audit activity for 2022/23, for approval by this committee, subject to approval of available internal audit resources at the Council's Audit & Risk Management Committee.

3.3 EAST DUNBARTONSHIRE COUNCIL INTERNAL AUDIT PROGRESS

3.3.1 Work continues towards completion of the 2021/22 Internal Audit Plan. Progress against the plan will be reported in the first instance to the Council's Audit & Risk Management Committee (A&RMC). Following reporting to the A&RMC, the HSCP's PAR committee will be appraised of any findings relevant to the HSCP. The A&RMC last met in December 2021 and the key points from that committee was communicated to this committee in January 2022. Following the emergence of the Omicron variant of Covid-19, the Council's A&RMCs meetings scheduled for February 2022 and March 2022 were cancelled. The next A&RMC is scheduled for 16th June 2022 and thereafter an update will be provided at the PAR on 28 June 2022.

3.4 NHSGGC INTERNAL AUDIT PROGRESS

3.4.1 No further update has been received on the NHSGGC's internal audit activity. This is expected imminently and an update will be provided at the PAR on 28 June 2022.

4.1 IMPLICATIONS

The implications for the Committee are as under noted.

4.2 Relevance to HSCP Strategic Plan – None

4.3 Frontline Service to Customers – None

4.4 Workforce (including any significant resource implications) – None

4.5 Legal Implications – Legal risks are presented in the body of internal audit reports with reference to relevant legislation where appropriate

4.6 Financial Implications - Internal Audit reports are presented to improve financial controls and aid the safeguarding of physical and intangible assets.

4.7 Procurement - Where applicable these are referenced in the body of internal audit reports with associated management actions for improvement.

4.8 ICT - None

4.9 Economic Impact – None

4.10 Sustainability - None

4.11 Equalities Implications – None

4.12 Other - None

5.0 MANAGEMENT OF RISK

The risks and control measures relating to this report are as follows:

5.1 Risks are highlighted to management in audit reports. The risks are addressed through agreed action plans, appended to internal audit reports.

6.0 IMPACT

6.1 **EAST DUNBARTONSHIRE COUNCIL** – The risks identified in the internal audit reports relevant to East Dunbartonshire Council have been highlighted to the Council's Audit & Risk Management Committee.

6.2 **NHS GREATER GLASGOW & CLYDE** – The risks relevant to the NHS Greater Glasgow & Clyde identified in the internal audit reports have been highlighted to the NHSGGC's Audit & Risk Committee.

6.3 **DIRECTIONS REQUIRED TO COUNCIL, HEALTHBOARD OR BOTH** – No Direction required.

7.0 POLICY CHECKLIST

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.0 APPENDICES

8.1 Appendix 1 – Internal Audit Planning 2022/23

APPENDIX 1

East Dunbartonshire Council
Internal Audit Services

Internal Audit
Planning Update
2022/23

Gillian McConnachie
Audit & Risk Manager
East Dunbartonshire Council

Internal Audit Planning Update 2022/23

Background

The Annual Internal Audit Plan is prepared on an annual basis, detailing the HSCP Internal Audit work planned for year ahead. Planning the work is important to demonstrate that Internal Audit is proactive and that the activities are targeted to areas of risk and need. The Plan also has to be flexible so that Internal Audit can react to events that might happen during the course of the year.

The Annual Internal Audit Plan is prepared and presented to the Performance, Audit & Risk Committee to allow review and approval of the planned Internal Audit activity for the year ahead.

Planning Process

The Plan reflects not only our understanding of systems and controls but also the HSCP's objectives, the ongoing impact of Covid-19, the national context and current economic climate. The following alternative sources of assurance are also considered at the planning stage: external reports on the HSCP, the HSCP's performance, the risk registers, how the HSCP manages its risks and where improvements are required. For the most part 'need' equates to 'risk' but consideration is also given to other aspects such as Internal Audit's reporting history, expected future HSCP changes and local demographics.

The Internal Audit Team is required to work to a set of rules – Public Sector Internal Audit Standards (PSIAS). These rules apply to all public sector internal auditor teams. Internal Audit is required to abide by them and conduct a self assessment against these every year. Internal audit is also required to be externally audited at least every five years. The last external assessment was completed in 2018 and the Internal Audit service was assessed as being in full conformance with all standards and sections, with the exception of Independence and Objectivity, where the service was found to Generally Conform. Two actions were proposed by the external assessor, asking for minor changes to the Internal Audit Charter and for a strengthening of the Declaration of Interest form. These actions have been completed by the Audit & Risk Manager. Since the external review, the Independence and Objectivity of the Internal Audit function was further enhanced by the 2019 strategic portfolio review, which resulted in operational responsibilities relating to Corporate Performance & Research and Health and Safety previously held by the Audit & Risk Manager, moving elsewhere in the organisational structure.

The Audit and Risk Manager and Senior Auditors in the team all have an accounting or internal audit qualification and Auditors are provided with comprehensive training to enable them to be effective in their roles. When one of our stakeholders reads an Internal Audit Report they can be assured that is has been prepared with due recognition of the all the best practices, ethics and professional responsibilities, as is required.

Having worked through all of the above, Internal Audit have a considerable amount of information and potential areas for review. Internal Audit cannot cover all areas of risk and we need to make sure what we plan to do is manageable and balanced.

The Plan for 2022/23 includes nine areas of need to be reported on as outputs – see *Table 1* at the end of this document. This is fewer than the 12 outputs that were planned for 2021/22, due to 2021/22 Plan including completion of audits that were in progress from the previous year as a result of the pandemic.

Audit days are allocated in the Plan to each assignment, based on an assessment of the relative risks of the audits planned and the expected complexities involved in undertaking the audit work. The work has been planned to enable us to draw conclusions on the HSCP.

Key areas of Audit Focus

Our planning work has identified the following as key areas for review. These will be reviewed across the period to March 2023.

- Interim Care Home Funding
- Self Directed Support – Overpayment Process
- Self Directed Support – Transitions
- HSCP Bad Debt Provisions.

In addition to the above, follow up work on previous internal audit recommendations will be performed, year end reports including the Annual Internal Audit Report and the governance statement will be prepared.

Plan

The plan for 2022/23 has been prepared to provide adequate evidence relating to the HSCP's systems to enable the Council's Audit & Risk Manager to provide a year end opinion. There is a degree of contingency in the Plan, allowing for consultancy advice, and changes to be made to the Plan if emerging risks are identified. The Performance, Audit and Risk Committee will be kept informed of any material proposed changes to the Plan in the course of the year.

Internal Audit Plan – Working to a Standard

The above summary is based on the provisions within the Public Sector Internal Audit Standards (PSIAS). The work of the Internal Audit Team is aligned to these provisions, which are also reflected in the Internal Audit Manual. For the 2022/23 financial year, the following standards have been applied with respect to Internal Audit Planning.

The Internal Audit Plan (Public Sector Internal Audit Standard 2010)

The Plan for 2022/23 is based on a documented risk assessment process. The process uses the HSCP's existing Risk Registers, the expectations of stakeholders and input from Senior Officers whilst considering the HSCP Performance Management Framework and outcomes.

The HSCP's risk management framework is well established, with auditors placing reliance on the actions being taken to manage key risks, as well as using the corporate risk register as a source for identifying areas of potential audit activity.

The Plan takes into account the requirement to produce an annual audit opinion. This opinion is delivered through the statement on the adequacy and effectiveness of the HSCP's framework of governance, risk management and internal controls. This statement is used to inform the governance statement included in the annual accounts.

The Plan is linked to the internal audit mission statement, charter and strategy, ensuring that activities are consistent with existing direction, organisational objectives and priorities.

The Internal Audit team also provides consultancy work on the basis that these assignments improve management of risks, add value and improve the HSCP's operations. Provision for the completion of one consultancy note is included in the planned activities for the year.

Audit Resources (PSIAS Standard 2030)

The Audit & Risk Manager can confirm that, in her opinion, the planned resources are appropriate and sufficient and will be effectively deployed to provide the required assurances to stakeholders.

PSIAS provides further definitions of each of the above requirements with appropriate reference to the mix of knowledge, skills and other competencies needed to perform the Plan. Sufficient refers to the quantity of resources needed to accomplish the Plan. Resources are effectively deployed when they are used in a way that optimises the achievement of the approved Plan.

The Plan is developed to ensure that staff availability, qualifications, experiences and skills are sufficient and appropriate. The process is supported by the Council's Performance Development Review (PDR) framework providing an ongoing mechanism to assess the effectiveness of staff in their roles and supporting future developments through training. The Audit & Risk Manager continually reviews the available resources to ensure that the Plan continues to be achievable. The impact of uncertain or unanticipated resource changes may need to be reported to Members where this affects the ability of the team to deliver the plan.

Staff training and coaching are being used to good effect to aid in delivery of the Plan. In addition, the budgeted allocation for administrative time has been reviewed to ensure that the application of resources continues to be reasonable.

Policies and Procedures (PSIAS 2040)

The Internal Audit Manual serves as the Internal Audit Team's policies and procedures. The Internal Audit Manual is aligned to the provisions of the Public Sector Internal Audit Standards and, in complying with the manual, the team are demonstrating compliance with the standards.

The Manual is reviewed on an ongoing basis with significant reviews taking place following changes in guidance, good practice or prevailing standards.

Coordination with External Scrutiny Bodies (PSIAS Standard 2050)

The Audit & Risk Manager is required to share information with other providers of assurance and consulting services to ensure proper coverage and minimise duplication of efforts.

In preparing the Plan, the Audit & Risk Manager met with External auditors in January 2022 to ensure that external auditors place reliance on Internal Audit's work where possible, to reduce duplication of effort.

Reporting to Senior Management and the Board (PSIAS 2060)

As part of this plan, the Audit & Risk Manager will prepare and present regular update reports to the Performance, Audit & Risk Committee over the course of the financial year. The internal audit monitoring reports will review progress against the original plan in the interests of consistency and accountability.

Ongoing reporting will also highlight specific issues as they relate to risk exposures, control issues, fraud, governance or any other matters that the Audit & Risk Manager deems appropriate for consideration by the Committee. Significant issues will also be captured within the annual internal audit report.

On an annual basis, the Audit & Risk Manager will provide a report that will include the purpose, authority and responsibilities relative to the plan but also any significant issues noted in the above.

2022/23 Audit Work (PSIAS Standard 2100)

The planned number of days allocated to each audit area and corresponding outputs are shown below in *Table 1*.

Internal Audit activity evaluates and contributes to the improvement of governance, risk management and control processes using a systematic and disciplined approach as outlined in the Internal Audit Charter.

Planned audit work includes consideration of a number of different types of audit assignments including systems, regularity, and consultancy. This varied application of audit resources ensures that different aspects of HSCP business have been subjected to testing, with assurances being sought over a range of activities.

Internal Audit Plan – Allocations and Activities

TABLE 1 – Planned Days and Outputs by Audit Area

Outputs	Area	Review	Planned Days	Status	Rationale	Priority
1	System	**Interim Care Home Funding**	25	New	Interim funding provided by HSCP when individual is temporarily unable to complete a financial assessment. Review of process to ensure appropriate controls are in place and consistently applied.	2
2	System	**Self Directed Support - Overpayment Process**	20	New	Review of process for identifying and reclaiming overpayments, including the appropriateness of timescales.	2
3	System	**Self Directed Support - Transitions**	20	New	Review of processes relating to the transition of children to adult services when these individuals are in receipt of direct payments.	3
4	Regularity	**Annual Audit Report**	3	Recurring	Annual report	1
5	Regularity	**Annual Follow Up**	5	Recurring	Follow up on previously issued recommendations	1
6	Regularity	**Annual Governance Statements**	3	Recurring	Annual requirement for accounts and to support Annual report	1
7	Regularity	**Interim Follow Up**	5	Recurring	Follow up on previously issued recommendations	2
8	Regularity	**Internal Audit Plan 2023/24**	2	Recurring	Preparation of following year's internal audit plan	1
9	Consultancy	**Bad Debt Provision**	20	New	Bad debt provision review with focus on Care Home Deferred payments and policy applied to these. Also potential consideration of recovery process.	2
	Total Days		**103**			

East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
AGENDA ITEM NO: 4

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING:	**31st MARCH 2022**
REPORT REFERENCE:	**HSCP/310322/04**
CONTACT OFFICER:	**JEAN CAMPBELL, CHIEF FINANCE & RESOURCES OFFICER (07583902000)**
SUBJECT TITLE:	**PROGRESS UPDATE – AUDIT SCOTLAND 2020/21 EAST DUNBARTONSHIRE IJB ANNUAL AUDIT ACTION PLAN**

1.1 PURPOSE

1.2 The purpose of this report is to update the committee on the delivery of the action plan developed in response to the Audit Scotland Annual Audit report for 2020/21.

2.0 RECOMMENDATIONS

It is recommended that the Performance, Audit & Risk Committee:

2.1 Note the progress in delivering the action plan developed in response to the Audit Scotland Annual Audit report for 2020/21.

2.2 Approve the updated financial regulations for the HSCP.

CAROLINE SINCLAIR
INTERIM CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.1 BACKGROUND/MAIN ISSUES

3.2 The Audit Scotland Annual Audit report for 2020/21 presented a summary of the key findings arising from the 2020/21 audit across a range of themes including:-

- Financial Sustainability
- Financial Management
- Governance and Transparency
- Value for money

3.3 An action plan was developed within the partnership to take forward the audit recommendations; this has been updated for progress and included as **Appendix 1.**

3.4 The Joint Board's Financial Regulations were due for review in March 2020 however this review was not undertaken. The regulations require to be reviewed periodically to confirm that they remain fit for purpose for the operations of the Joint Board. The updated regulations are included as **Appendix 2**.

4.1 IMPLICATIONS

The implications for the Committee are as undernoted.

4.2 Relevance to HSCP Board Strategic Plan – All. The annual audit report sets out a number of areas for improvement in financial governance, management, sustainability and assurance on value for money across the HSCP financial landscape. This ensures the partnership delivers on these key aspects which in turn supports the continued delivery of priorities set out within the strategic plan.

4.3 Frontline Service to Customers – None

4.4 Workforce (including any significant resource implications) – None

4.5 Legal Implications – None

4.6 Financial Implications – The Annual Audit report provides an opinion on the annual accounts for the partnership and considers the wider audit dimensions that frame the scope of public sector audit requirements including financial management arrangements, financial sustainability, governance and transparency and value for money.

4.7 Procurement – None

4.8 Economic Impact – None

4.9 Sustainability – None

4.10 Equalities Implications – None

4.11 Other – None

5.1 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.2 The report sets out the key risks for the partnership and an action plan which mitigates these risks.

6.1 **IMPACT**

6.2 **EAST DUNBARTONSHIRE COUNCIL** - None

6.3 **NHS GREATER GLASGOW & CLYDE** - None

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction Required

7.1 **POLICY CHECKLIST**

7.2 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.1 **APPENDICES**

8.2 Appendix 1 – Audit 20-21 Action Plan – Update March 2022

8.3 Appendix 2 – HSCP Financial Regulations

East Dunbartonshire Health & Social Care Partnership

APPENDIX 1

East Dunbartonshire HSCP

ED IJB Annual Audit Report 2020/21 – Action Plan

Audit Issue	Audit Recommendation	Actions	Person Responsible	Timescales	Update – Mar 2022
1. Accounts Inspection Advert – the accounts inspection advert inaccurately advised objections could be sent to IJB officers when these should be directed to the auditor only. The advert also did not state when the inspection period was ending, and the objection end date was one working day too early.	The IJB should ensure it has procedures in place to ensure the accounts inspection advert is published in line with criteria set out in the Local Authority Accounts (Scotland) Regulations 2014.	• The accounts inspection advert will be updated in line with the relevant guidance ahead of the Annual Accounts process for 2021/22.	Jean Campbell , CFRO	June 2022	• Draft letter updating in preparation for Year-end process 2021/22
2. Management Commentary - The 2020/21 management commentary included a significant amount of detailed	Management should review the format and content of the 2021/22 management commentary to make it more accessible for readers of the accounts.	• The management commentary will be reviewed and updated to ensure better accessibility for readers in preparation for the Annual Accounts for 2021/22.	Jean Campbell , CFRO	June 2022	• Ongoing – will commence at draft annual accounts preparation

East Dunbartonshire Health & Social Care Partnership

APPENDIX 1

narrative. This can obscure the key messages for the reader.					
3. Review of Financial Regulations - The Joint Board's Financial Regulations were due for review in March 2020 however this review was not undertaken. The regulations should be reviewed periodically to confirm that they remain fit for purpose for the operations of the Joint Board.	The Joint Board should ensure that governance documents including the financial regulations are periodically reviewed to ensure they remain fit for purpose to the operation of the Joint Board.	• The financial regulations will be reviewed and updated within current legislation and guidance to ensure these remain relevant and fit for purpose.	Jean Campbell , CFRO	March 2022	• Financial regulations updated and presented to PAR Committee 31/03/22 for approval.
Audit Issue	Audit Recommendation	Action	Person Responsible	Timescales	
4. Governance & Transparency - The IJB Board and Performance, Audit and Risk (PAR) Committee papers are available on the	The Joint Board should ensure committee papers and details of committee meetings are made readily available to the public	• Ensure that reports are available ahead of IJB and PAR meetings taking place..	Jean Campbell , CFRO	March 2022	• Complete – report formats updated and accessibility arrangements in place which should ensure that reports are available ahead of IJB and PAR meetings taking place.

IJB website. However, the Board should ensure these papers and details of meetings are made available to the public in advance of Committee meetings.	in advance of all meetings.				This will continue to be reviewed.
5. The IJB agreed to develop a long-term financial plan as part of its Strategic Plan 2018-2021, approved by the IJB Board in April 2018. A draft five-year financial plan has been discussed at Senior Management Team, however this has yet to be completed and reviewed by the IJB Board.	The medium 5-year financial strategy was presented to the Board on 24 June 2021. This covers the period 2022/23 to 2027/28. We would recommend this is revisited to take account of the longer-term financial challenges facing the Board. This will help the IJB Board to demonstrate the longer-term financial sustainability of planned services.	• The IJB Medium Term Financial Plan will be reviewed in the context of emerging impacts from the Covid-19 pandemic both in terms of medium / longer term cost pressures as well as new ways of working which may be captured through transformation and service redesign.	Jean Campbell , CFRO	Ongoing – subject to regular review	• Complete - Draft 5 year financial plan reviewed as part of Budget 2022/23 process, updated and presented to IJB on 24th March 2022 for approval.

East Dunbartonshire Health & Social Care Partnership

APPENDIX 1

6. Efficiency Savings - For 2020/21 the board is required to deliver £6.072 million of efficiency savings. The board has yet to identify £2.1 million of the savings required for next year. Of those savings identified to date, some £0.52 million are considered high risk and may not materialise.	The IJB reported an underspend of £12.040 million in 2020/21 due to additional Covid-19 funding The board should ensure that saving plans are developed identifying how the shortfall in the delivery of efficiency savings will be addressed in the future.	• To be considered as part of the annual and medium-term financial plans going forward.	Jean Campbell , CFRO	Ongoing	• Complete – savings programme agreed as part of the Budget 2022/23 process to deliver a balanced budget position for the HSCP.

East Dunbartonshire Health & Social Care Partnership

APPENDIX 2

East Dunbartonshire Health and Social Care Partnership

Health & Social Care Partnership Board Financial Regulations

Version	**Integration Joint Board Draft Financial Regulations 2022**
Lead Manager	**Jean Campbell**
Approved by	**Health & Social Care Partnership Board (Performance, Audit & Risk Committee)**
Date Approved	**31/03/2022**
Date for Review	**01/03/2025**
Replaces Previous Version	**N/A**

Financial Regulations – Index

The Health & Social Care Partnership positively promotes the principles of sound corporate governance within all areas of the Board's affairs. These Financial Regulations are an essential component of the corporate governance of the Health & Social Care Partnership Board.

1. What the Regulations Cover

1.1 The Health & Social Care Partnership Board (HSCP Board) is a legal entity in its own right created by Parliamentary Order, following ministerial approval of the Integration Scheme. It is accountable for the stewardship of public funds and is expected to operate under public sector best practice governance arrangements, proportionate to its transactions and responsibilities. Stewardship is a major function of management and, therefore, a responsibility placed upon the appointed members and officers of the Health & Social Care Partnership Board.

1.2 These financial regulations should be read in conjunction with the Standing Financial Instructions of NHS Greater Glasgow and Clyde and the Financial Regulations and Codes of Financial Practice of East Dunbartonshire Council.

1.3 The Regulations set out the respective responsibilities of the Chief Officer and the Chief Finance & Resources Officer of the HSCP Board.

1.4 It will be the duty of the Chief Officer assisted by the HSCP Board Chief Finance & Resources Officer to ensure that these Regulations are made known to the appropriate persons within the Health & Social Care Partnership Board and to ensure that they are adhered to.

1.5 If it is believed that anyone has broken, or may break, these Regulations, this must be reported immediately to the Chief Finance & Resources Officer, who may then discuss the matter with the Chief Officer, NHS Greater Glasgow and Clyde Chief Executive, East Dunbartonshire Council Chief Executive or another nominated or authorised person as appropriate to decide what action to take.

1.6 These Regulations will be the subject of review by the HSCP Board Chief Finance & Resources Officer, every three years or more regularly if required, in consultation with the NHS Greater Glasgow and Clyde Director of Finance and the Council's Section 95 Officer, and where necessary, subsequent adjustments will be submitted to the HSCP Board for approval.

2.0 Financial Management and Performance

2.1 The Integration Scheme sets out the detail of the integration arrangement agreed between NHS Greater Glasgow and Clyde and East Dunbartonshire Council. In relation to financial management it specifies:

- The financial management arrangements including treatment of budget variances;
- Reporting arrangements between the HSCP Board, NHS Greater Glasgow and Clyde and East Dunbartonshire Council;
- The method for determining the resources to be made available by NHS Greater

Glasgow and Clyde and East Dunbartonshire Council;
- The functions which are delegated to the HSCP Board by NHS Greater Glasgow and Clyde and East Dunbartonshire Council.

Responsibility of the Chief Officer

2.2 The Chief Officer is the accountable officer of the Health & Social Care Partnership Board in all matters except finance. The Chief Officer will discharge their duties in respect of the delegated resources by:
- Ensuring that the Strategic Plan meets the requirement for economy, efficiency and effectiveness;
- Engaging with NHS Greater Glasgow and Clyde and East Dunbartonshire Council on strategic intentions which include service change/service redesign/investment/disinvestment, considering scope and scale, finance, impact and timescales;
- Giving directions to NHS Greater Glasgow and Clyde and East Dunbartonshire Council that are designed to ensure resources are spent in accordance with the plan; it is the responsibility of the Chief Officer to ensure that the provisions of the directions enable them to discharge their responsibilities in this respect within available resources.

2.3 The Chief Officer will also hold an operational role in NHS Greater Glasgow and Clyde and East Dunbartonshire Council for the management of the operational delivery of services as directed by the Integration Joint Board. In this operational role the Chief Officer has no "accountable officer" status but is:
- Accountable to the Chief Executive of NHS Greater Glasgow and Clyde for financial management of the operational budget; and
- Accountable to the Chief Finance Officer(Section 95 Officer) of East Dunbartonshire Council for financial management of the operational budget; and
- Accountable to the Chief Executive of NHS Greater Glasgow and Clyde and the Chief Executive of East Dunbartonshire Council for the operational performance of the services managed by the Chief Officer.

Responsibility of the Chief Finance & Resources Officer

2.4 The Chief Finance & Resources Officer is the accountable officer for financial management and administration of the HSCP Board. The Chief Finance & Resources Officer will be line managed by the Chief Officer and formally supported by the Council Section 95 Officer and the Health Board Director of Finance.

2.5 The Chief Finance & Resources Officer will discharge his/her duties in respect of the delegated resources by:
- Establishing financial governance systems for the proper use of the delegated resources; and,
- Ensuring that the Strategic Plan meets the requirement for best value in the use of the Integration Joint Board's resources.
- Working with both organisations financial information systems and finance support teams to produce financial reports and forecasts in order to monitor the overall financial performance of the approved HSCP Board's revenue budget.

- Providing each meeting of the HSCP Board with budget monitoring reports along with explanations for any significant variations from budget and actions planned to deal with them.

Responsibility of the NHS Board Accountable Officer/ NHS Board Director of Finance/Council Section 95 Officer

2.6 The NHS Board Accountable Officer and the Council's Section 95 Officer discharge their responsibility, as it relates to the resources that are delegated to the Integration Joint Board, by setting out in the Integration Scheme the purpose for which resources are used and the systems and monitoring arrangements for financial performance management. It is their responsibility to ensure that the provisions of the Integration Scheme enable them to discharge their responsibilities in this respect.

2.7 The NHS Board Director of Finance and the Chief Finance Officer (Section 95 Officer) of East Dunbartonshire Council will provide specific advice and professional support to the Chief Officer and Chief Finance & Resources Officer to support the production of the Strategic Plan and also to ensure that adequate systems of internal control are established by the Integration Joint Board.

Responsibility of Budget Holders

2.8 Budget holders will be accountable for all budgets within their control as directed by the HSCP Board in line with its Strategic Plan. The HSCP Board will ensure appropriate arrangements are in place to support good financial management and planning.

3.0 Financial Planning

Strategic Plan and Integrated Budget

3.1 The Health & Social Care Partnership Board is responsible for the production of a Strategic Plan which sets out the services for their population over the medium term (3 years). The resources within scope of the Strategic Plan are:

- The payment made to the Health & Social Care Partnership Board by East Dunbartonshire Council for delegated social care services;
- The payment from NHS Greater Glasgow and Clyde to Health & Social Care Partnership Board for delegated primary and community healthcare services and for those delegated hospital services managed by the Chief Officer.
- The amount set aside by NHS Greater Glasgow and Clyde for delegated services provided in large hospitals for the population of the Integration Joint Board.

NHS Greater Glasgow and Clyde and East Dunbartonshire Council will work to provide indicative three year rolling funding allocations to the Health & Social Care Partnership Board to support the Strategic Plan and medium term planning process. Such indicative allocations will remain subject to annual approval by both organisations.

3.2 The Chief Officer and the Chief Finance & Resources Officer will develop revenue estimates for the integrated budget based on the Strategic Plan and present it to NHS

Greater Glasgow and Clyde and East Dunbartonshire Council for consideration and agreement as part of each organisation's annual budget setting process. The revenue estimates should be evidence based with full transparency on its assumptions and take account of:

- **Activity Changes**. The impact on resources in respect of increased demand e.g. demographic pressures and increased prevalence of long term conditions, and for other planned activity changes;
- **Cost Inflation**. Pay and supplies cost increases including contractual uplifts;
- **Efficiencies**. All savings (including increased income opportunities and service rationalisations/cessations) should be agreed between the Integration Joint Board, East Dunbartonshire Council and NHS Greater Glasgow and Clyde as part of the annual rolling financial planning process to ensure transparency;
- **Performance on outcomes**. The potential impact of efficiencies on agreed outcomes must be clearly stated and open to challenge by East Dunbartonshire Council and NHS Greater Glasgow and Clyde;
- **Legal requirements**. Legislation may entail expenditure commitments that should be taken into amount in adjusting the payment;
- **Transfers to/from the notional budget for hospital services** set out in the Strategic Plan;

3.3 The Strategic Plan will determine the budgets allocated to each operational partner for operational service delivery in line with the Plan. Strategic plans will take account of all resources available to the Chief Officer, including capital assets owned by the Health Board and the Council used or occupied by staff delegated to the HSCP. The Health & Social Care Partnership Board will publish its Strategic Plan as soon as practicable after finalisation of the plan.

Limits on Expenditure

3.4 No expenditure will be incurred by the Integration Joint board unless it has been included within the approved Integration budget and Strategic plan except:

I. Where additional funding has been approved by NHS Greater Glasgow and Clyde and/or East Dunbartonshire Council and the Integrated budget/strategic plan has been updated appropriately;
II. Where a supplementary budget has been approved by the Integration Joint Board;
III. In emergency situations in terms of any scheme of delegation;
IV. Where the application of reserves (as defined within the reserves policy) has been approved by the HSCP Board; and
V. As provided in paragraph 3.5 below (Virement).

Virement

3.5 Virement is defined by CIPFA as "the transfer of an under spend on one budget head to finance additional spending on another budget head in accordance with the Financial Regulations". In effect virement is the transfer of budget from one main budget heading (employee costs, supplies and services etc.) to another, or a transfer of budget from one service to another. Where resources are transferred between the two operational arms of the Integrated Budget this will require in-year balancing adjustments to the allocations

from the Integration Joint Board to East Dunbartonshire Council and NHS Greater Glasgow and Clyde i.e. a reduction in the allocation to the body with the underspend and a corresponding increase in the allocation to the body with the overspend.

3.6 Virements require approval by the Chief Finance & Resources Officer and the HSCP Board and they will be permitted subject to any Scheme of Delegation of the Integration Joint Board as follows:

- Virement must not create additional overall budget liability. One off savings or additional income should not be used to support recurring expenditure or to create future commitments including full year effects of decisions made part way through a year.
- The Chief Officer will not be permitted to vire between the Integrated Budget and those budgets that are managed by the Chief Officer, but are outwith the scope of the Strategic Plan, unless agreed by East Dunbartonshire Council and NHS Greater Glasgow and Clyde.
- Any virement considered material and more than £100,000 requires the approval of the Integrated Joint Board.
- Any virement over £100,000 that are based on redeterminations from the Scottish Government can be applied automatically with an update to the HSCP Board as soon as is practicable on the application of this additional funding.

Budgetary Control

3.7 It is the responsibility of the Chief Officer and Chief Finance & Resources Officer to report regularly and timeously on all budgetary control measures, comparing projected outturn with the approved financial plan, to the Integration Joint Board and other bodies as designated by NHS Greater Glasgow and Clyde and East Dunbartonshire Council.

3.8 The NHS Greater Glasgow and Clyde Director of Finance and the Section 95 officer of East Dunbartonshire Council will, along with the HSCP Chief Finance & Resources Officer put in place a system of budgetary control which will provide the Chief Officer with management accounting information for both arms of the operational budget and for the Integration Joint Board in aggregate.

3.9 It is the responsibility of the Integration Joint Board Chief Finance & Resources Officer, in consultation with the NHS Greater Glasgow and Clyde and the Chief Finance Officer (section 95) of East Dunbartonshire Council, to agree a consistent basis and timetable for the preparation and reporting of management accounting information.

3.10 The Integration Scheme specifies how in year over/under spends will be treated. Where it appears that any heading of income or expenditure may vary significantly from the Financial Plan, it will be the duty of the Chief Officer and the Chief Finance & Resources Officer, in conjunction with the NHS Board Director of Finance and the Section 95 Officer of the Council, to report in accordance with the appropriate method established for that purpose by the Integration Joint Board, NHS Board and Council, the details of the variance and any remedial action required. All actual or forecast variances over £50,000 will be reported to the Integrated Joint Board in financial monitoring reports.

Capital Planning

3.11 The HSCP Board does not receive a capital funding allocation. Capital projects are funded by either the Council or the Health Board and expenditure will be controlled in accordance with their financial regulations.

3.12 The Chief Officer will be a member of the Council and Health Board's Capital Planning Groups and in consultation will consider where capital investment is required to deliver the Strategic Plan. Business Cases will be prepared with appropriate professional support by the partners and be submitted through the planning approval groups and be submitted to the HSCP Board for endorsement.

3.13 The HSCP Board will receive financial monitoring reports from the Council and Health Board which include information on capital expenditure against approved schemes relevant to the services delegated to the HSCP Board.

Reports to Integration Joint Board

3.14 All reports to the Integration Joint Board and sub-committees thereof must specifically identify the extent of any financial implications. These must have been discussed and agreed with the Integration Joint board Chief Finance & Resources Officer prior to lodging of reports.

4.0 Financial Reporting

Accounting Procedures and Records

4.1 All accounting procedures and records of the HSCP Board will be as specified in applicable legislation and regulations. Financial Statements will be prepared following the Code of Practice on Local Authority Accounting in the UK. Statements will be signed as specified in under Local Authority Regulations 2014.

4.2 The financial statements must be completed to meet the audit and publication timetable specified in accordance with legislation (The Local Authority Accounts (Scotland) Regulations 2014 as modified by the Coronavirus (Scotland) Act 2020), and so far as is compatible with that legislation, in accordance with proper accounting practices (section 12 of the Local Government in Scotland Act 2003). It is the primary responsibility of the Chief Finance & Resources Officer to meet these targets; and of the Chief Officer to provide any relevant information to ensure that the Health Board and Council meet their respective statutory audit and publication requirements for their individual and group financial statements.

4.3 The HSCP Chief Finance & Resources Officer will agree the financial statements timetable with the external auditors of the HSCP Board, NHS Greater Glasgow and Clyde and East Dunbartonshire Council.

4.4 The accounts of the Partnership Board will be hosted by East Dunbartonshire Council.

5.0 Legality of Expenditure

5.1 It will be the duty of the Chief Officer to ensure that no expenditure is incurred, or included within the Strategic Financial Plan unless it is within the power of the Integration Joint board. In cases of doubt the Chief Officer should consult the respective legal advisers of the NHS Board and Council before incurring expenditure. The legality of expenditure on new service developments, initial contributions to other organisations and responses to emergency situations which require expenditure must be clarified prior to being incurred.

6.0 Reviewing the Financial Regulations

6.1 The Health & Social Care Partnership Board will consider and approve any alterations to these Financial Regulations. The Integration Joint Board may also withdraw these financial regulations. If so, this will come into force from the first working day after the end of the Health & Social Care Partnership Board meeting at which the change or withdrawal was approved.

7.0 Reserves

7.1 Legislation, under Section 106 of the Local Government (Scotland) Act 1973 as amended, empowers the Integration Joint Board to hold reserves which should be accounted for in the financial accounts and records of the Integration Joint Board.

7.2 The Integration Joint Board has an approved reserves policy and a reserves strategy which includes the prudent level of reserves required and their purpose. This will be agreed as part of the annual budget setting process and will be reflected in the Strategic Plan agreed by the integration Joint Board.

8.0 VAT

8.1 HM Revenues & Customs (HMRC) has confirmed that there is no requirement to have a separate VAT registration for the Integration Joint Board as it will not be delivering any services within the scope of VAT. This situation should be kept under review by the Chief Finance & Resources Officer should the operational activities of the HSCP Board change and a need to register be established. HMRC guidance will apply to Scotland which will allow a VAT neutral outcome.

9.0 Procurement/Commissioning of Services

9.1 Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014/285 provides that the HSCP Board may enter into a contract with any other person in relation to the provision of goods and services to the Integration Joint Board for the purpose of carrying out the functions conferred in it by the Act.

9.2 As a result of specific VAT and accounting issues associated with Integration Joint Board contracting directly for the provision of goods and services the Chief Officer is required to consult with the NHS Board Director of Finance, the Chief Finance Officer (Section 95 Officer) of the Council and the Chief Finance & Resources Officer prior to any direct procurement exercise being undertaken.

10.0 Internal Audit

Responsibility for Internal Audit

10.1 It is the responsibility of the Health & Social Care Partnership Board to establish adequate and proportionate internal audit arrangements for review of the adequacy of the arrangements for risk management, governance and control of the delegated resources. This will include determining who will provide the internal audit service for the Health & Social Care Partnership Board and nominating a Chief Internal Auditor.

10.2 The operational delivery of internal audit services within NHS Greater Glasgow and Clyde and East Dunbartonshire Council will be covered by their respective internal audit arrangements as at present.

10.3 A Chief Internal Auditor, from either the Health Board or the Council, will be appointed to act as Integration Joint Board Chief Internal Auditor in addition to their role as Chief Internal Auditor of their respective authority.

10.4 The Internal Audit Service will undertake their work in compliance with the Public Sector Internal Audit Standards.

10.5 On or before the start of each financial year the Chief Internal Auditor, in consultation with the Chief Officer and Chief Finance & Resources Officer, will prepare and submit a strategic risk based audit plan to the HSCP Performance, Audit & Risk Committee for approval. The internal audit plan will be considered and link with:

- The Strategic Plan and planning process;
- The financial plan underpinning the Strategic Plan;
- The operational delivery of those integrated services delegated to the HSCP Board (except for NHS acute hospital services), and
- Relevant issues raised from the partner Health Board and Local Authority.

10.6 The HSCP Chief Internal Auditor will report to the HSCP Performance, Audit & Risk Committee on the annual audit plan, delivery of the audit plan and any recommendations and will provide an annual internal audit report including the audit opinion.

10.7 The Chief Finance & Resources Officer will work with the internal auditors of both the Health Board, Local Authority and the Chief Internal Auditor of the HSCP Board to

ensure that there is clarity and consistency of appropriate scrutiny of the work of the HSCP Board and the Health & Social Care Partnership; and that the internal audit plans of the three audit committees provide necessary assurance over activities under the strategic direction of the HSCP.

10.8 The Health & Social Care Partnership Board annual internal audit plan and internal audit report will be shared with the Audit Committees of NHS Greater Glasgow and Clyde and East Dunbartonshire Council.

10.9 Reports on each internal audit engagement will be submitted to the Chief Officer and the Chief Finance & Resources Officer.

11.0 External Audit

11.1 The Accounts Commission will appoint the Auditors to the Health & Social Care Partnership Board. This is specified under Section 13 of the legislation.

11.2 The Health & Social Care Partnership Board should make appropriate and proportionate arrangements for consideration of external audit reports including those relating to the annual financial statements to ensure that they are compliant with relevant statutory provisions and Accounting Codes of Practice.

11.3 Reports on external audit engagements will be submitted to the Chief Officer and the Performance, Audit & Risk Committee for scrutiny.

12.0 Performance, Audit & Risk Committee

12.1 The Health & Social Care Partnership will put in place a Performance, Audit & Risk Committee to ensure that an effective assurance process is in place that assesses the objectives, risks and performance of the Partnership. This will include consideration of any reports from auditors.

12.2 It will be the responsibility of the HSCP Board to agree the membership having regard to the agreed remit, skills and good practice for a Performance, Audit & Risk Committee. It is anticipated that members of the HSCP Board will serve in this capacity.

13.0 Risk Management and Insurance

Responsibility for Insurance and Risk

13.1 The Health & Social Care Partnership Board will make appropriate insurance arrangements for all activities of the Health & Social Care Partnership Board in accordance with the risk management strategy.

The Chief Officer will arrange, taking such specialist advice as may be necessary, that adequate insurance cover is obtained for all normal insurable risks arising from the activities of the Health & Social Care Partnership Board and for which it is the general custom to insure. This will include the provision of appropriate insurance in respect of

Members of the Health & Social Care Partnership Board acting in a decision making capacity.

The NHS Board Director of Finance and the Chief Finance Officer (section 95) of the Council will ensure that the Chief Officer has access to professional support and advice in respect of risk management.

Risk Strategy and Risk Register

13.2 The Chief Officer will be responsible for developing and implementing the HSCP Board's approved risk management policy and strategy. This will include arrangements for maintaining and reporting on a Strategic Risk Register that will identify, assess and prioritise risks related to the preparation and delivery of the Strategic Plan; and identify and describe processes for mitigating those risks. This will be presented to the HSCP Board for approval on an annual basis and shared with the Council and Health Board. The Performance, Audit & Risk Committee will regularly scrutinise the Strategic Risk Register and be provided with evidence of the impact of mitigating actions. Any subsequent changes will be referred back to the HSCP Board for final approval

13.3 The NHS Greater Glasgow and Clyde and East Dunbartonshire Council will continue to identify and manage within their own risk management arrangements any risks they have retained under the integration arrangements. The NHS Board and Council will continue to report risk management to the existing committees including the impact of the integration arrangements.

Notification of Insurance Claims

13.4 The Chief Officer and the HSCP Board Chief Finance & Resources Officer will put in place appropriate procedures for the notification and handling of any insurance claims made against the Integration Joint Board.

14.0 Economy, Efficiency and Effectiveness (Best Value)

14.1 The Chief Officer will ensure that arrangements are in place to maintain control and clear public accountability over the public funds delegated to the Health & Social Care Partnership Board. This will apply in respect of:

- The resources delegated to the Integration Joint Board by NHS Greater Glasgow and Clyde and East Dunbartonshire Council; and
- the resources paid to NHS Greater Glasgow and Clyde and East Dunbartonshire Council by the Health & Social Care Partnership Board for use as directed and set out in the Strategic Plan.

14.2 The Health & Social Care Partnership Board has a duty to put in place proper arrangements for securing Best Value in the use of resources and delivery of services. There will be a process of strategic planning which will have full Member involvement, in order to establish the systematic identification of priorities and realisation of Best Value

in the delivery of services.

14.3 It will be the responsibility of the Chief Officer to deliver the arrangements put in place to secure Best Value and to co-ordinate policy in regard to ensuring that the HSCP Board provides Best Value.

14.4 The Chief Officer will be responsible for ensuring implementation of the strategic planning process. Best Value should cover the areas of human resource and physical resource management, commissioning of services, financial management and policy, performance and service delivery process reviews.

15.0 Board Members' Expenses

15.1 Payment of voting Board Members' allowances will be the responsibility of the Members' individual Council or Health Board, and will be made in accordance with their own Schemes.

15.2 Members are entitled to payment of travel and subsistence expenses relating to approved duties. Members are required to submit claims on the IJB's agreed expenses claim form and as far as practicable to provide receipts in support of any expenses claimed.

15.3 Non-voting members of the IJB will be entitled to payment of travel and other expenses, such as the cost of replacement care where they have caring responsibilities. Non-voting members are required to submit claims on the IJB's agreed expenses claim form and as far as practicable to provide receipts in support of any expenses claimed. The costs relating to expenses incurred by the non-voting members of the IJB will be shared equally by the Health Board and the Council.

15.4 The Chief Finance Officer will ensure that a record of all expenses paid under the Scheme is maintained, detailing name, amount and nature of payment.

East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
Caroline Sinclair

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING:	**31st MARCH 2022**
REPORT REFERENCE:	**HSCP/310322/05**
CONTACT OFFICER:	**JEAN CAMPBELL, CHIEF FINANCE & RESOURCES OFFICER (07583902000)**
SUBJECT TITLE:	**HSCP DELIVERY PLAN 2021/22 UPDATE**

1.1 PURPOSE

1.2 The purpose of this report is to update the Committee on the delivery of the HSCP Delivery Plan for 2021/22.

2.1 RECOMMENDATIONS

It is recommended that the Performance, Audit & Risk Committee:

2.2 Note the update to the HSCP Delivery Plan for 2021/22.

CAROLINE SINCLAIR
INTERIM CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.0 BACKGROUND/MAIN ISSUES

1.1 The HSCP Board agreed the HSCP Delivery Plan 2021/22 at the IJB meeting on the 24th June 2021. The HSCP Delivery Plan draws together our strategic development priorities for the year, informed by the Strategic Plan's development priorities, the NHS Moving Forward Together Strategic Plan, the priorities of East Dunbartonshire Council as set out in the Community Planning Partnership's Local Outcome Improvement Plans, new statute and policy drivers, and identified areas for transformation change and our savings requirements.

HSCP Delivery Plan 2021/22

1.2 The onset of the pandemic (Covid-19) and the impact of this on the delivery of health and social care services continues to have an impact on the delivery of aspects of the HSCP Delivery Plan.

1.3 The Delivery Plan is monitored through the HSCP Delivery Plan Board comprising the Interim Chief Officer, Chief Finance & Resources Officer, HSCP Heads of Services and organisational development, transformation and HR support from both the Council and NHS.

1.4 The projects within the Annual Delivery Plan have been classified to more clearly identify where these relate to efficiencies, improvements to service delivery, statutory / legal responsibilities, corporate priorities, sustainability and enhancement to assets. Each of the HSCP Delivery planning priorities has been classified according to these criteria and this is reflected within the highlight report for each priority. Some priorities will have more than one classification as a project may deliver efficiencies as well as improving services and outcomes for patients and service users.

1.5 The dashboard setting out progress on delivery of the projects to be delivered during 2021/22 is attached as **Appendix 1** with a more detailed update on each project attached as **Appendix 2.** The projects which have been completed and closed during 2021/22 is attached as **Appendix 3.**

1.6 The delivery of the transformation aspects of the Delivery plan for 2021/22 included as part of the Budget 21/22 is indicating a shortfall of £0.16m at this point in the year. This means that the HSCP expects to achieve £1.2m (£0.7m related to the approved savings programme for 2021/22) of transformation savings during 2021/22. A copy of the financial implications of projects approved as part of the Budget 2021/22 including historical savings from the previous financial year are included as **Appendix 4.**

1.7 There were a total of 27 projects to be delivered within the Delivery Plan for 2021/22:-

- 19 (24) are considered at Green status – on track
- 1 (3) are considered Amber status (at risk) – work is underway with some risk or delay to delivery.
- 1 (0) are considered Red status – more significant risks / delays to delivery.
- 6 projects have been closed in the previous period as these are now completed.

1.8 The project considered at red status relates to the implementation of the Fair Access to Community Care policy (HSCP-21-16) of which £200k savings were attributed to the review of care packages in the context of the new policy. Given the delays in recruitment and continued vacancies within the review team, re direction of staff to Covid response and limitations in interactions with service users, this has not delivered as planned in year. The savings have been achieved across care packages through other means for 2021/22 – a downturn due to the ongoing impact of the pandemic – however these packages continue to resume as we move forward with service recovery. The actions planned over the next period should put this onto a more secure footing moving into 2022/23 with further planned savings as part of the Budget 2022/23 approval.

1.9 There are a further 8 projects where these are now 100% completed and these will be closed and moved to the List of Completed Projects in the next cycle.

4.1 IMPLICATIONS

The implications for the Committee are as undernoted.

4.2 Relevance to HSCP Board Strategic Plan –All. The Strategic Plan sets out the priorities and ambitions to be delivered over the next three years to further improve the opportunities for people to live a long and healthy life. The HSCP Delivery Plan sets out the priorities which will be delivered during 2021/22 in furtherance of the strategic priorities set out in the Strategic Plan.

4.3 Frontline Service to Customers – None

4.4 Workforce (including any significant resource implications) – None

4.5 Legal Implications – None

4.6 Financial Implications – The HSCP Delivery Plan includes the transformation and service redesign priorities for the year including the areas requiring investment and dis-investment.

4.7 Procurement – None

4.8 ICT - None

4.9 Economic Impact – None

4.10 Sustainability – None

4.11 Equalities Implications – None

4.12 Other – None

5.1 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.2 The risks to the delivery of each priority are set out in the highlight report specific to each area. The overall risks associated with the delivery of the plan comprise financial risk in the event that savings are not delivered as planned or areas highlighted for service improvement do not progress as planned.

6.1 **IMPACT**

6.2 **EAST DUNBARTONSHIRE COUNCIL** - None

6.3 **NHS GREATER GLASGOW & CLYDE** - None

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction Required

7.1 **POLICY CHECKLIST**

7.2 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.1 **APPENDICES**

8.2 Appendix 1 – HSCP Delivery Plan Dashboard March 2022
8.3 Appendix 2 – HSCP Delivery Plan Highlight Report March 2022
8.4 Appendix 3 – HSCP Closed Project List
8.5 Appendix 4 – HSCP Savings Update 2122 March 22

APPENDIX 1

HSCP TRANSFORMATION PROGRAMME 2021/2022								
Programme overview				**Summary of RAG Status**				
Projects 21		Decisions 0		On Track 19		At Risk 1		In Exception 1
Priority	Project Name	Previous Status	Current status	Progress	Reason for RAG Status	Original Project End Date	Forecast Project End Date	Decision Required
65	Delivery of Children's House Project	▶	▶	100%	Project Complete	31-Mar-2022	31-Mar-2022	There are no decisions required at this time
57	Learning Disability: service review, action plan and implementation	▶	▶	80%	Project is progressing as expected	31-Mar-2022	31-Mar-2022	There are no decisions required at this time
52	Digital Health & Care Action Plan: development and implementation	▶	▶	75%	Project is progressing as expected	31-Mar-2022	31-Mar-2022	There are no decisions required at this time.
51	Older people's Day Services: service review, action plan and implementation	▶	▶	80%	Project is progressing as expected	31-Mar-2022	31-Mar-2022	There are no decisions required at this time
47	Recovery Services commissioned service review, action plan and implementation	▶	▶	70%	Project is progressing as expected	31-Mar-2022	31-Mar-2022	There are no decisions required at this time
n/a	Covid-19:Critical Response, transition and recovery	▶	▶	90%	Project is progressing as expected	31-Mar-2022	31-Mar-2022	There are no decisions required at this time.
n/a	Strategic Plan 2022-25 development	▶	▶	95%	Project is progressing as expected .	31-Mar-2022	31-Mar-2022	There are no decisions required at this time.
n/a	Audit Action Plan(s): implementation	▶	▶	100%	Project is progressing as expected	31-Mar-2022	31-Mar-2022	There are no decisions required at this time.
n/a	Property Strategy: development and implementation	▶	▶	90%	Project is progressing as expected	31-Mar-2022	31-Mar-2022	There are no decisions required at this time.
n/a	Community Led Locality Services	▶	▶	55%	Project is progressing as expected	31-Mar-2022	31-Mar-2022	There are no decisions required at this time.

APPENDIX 1

n/a	Joint Commissioning Plan for Unscheduled Care			100%	Project Complete	31-Mar-2022	31-Mar-2022	There are no decisions required at this time.
n/a	Dementia Strategy			50%	Project is progressing as expected	31-Mar-2022	31-Mar-2022	There are no decisions required at this time.
n/a	Primary Care Improvement Plan			50%	Project is at risk.	31-Mar-2022	31-Mar-2022	There are no decisions required at this time.
n/a	Fair Access to Community Care Policy			33%	Project in exception	31-Mar-2022	31-Mar-2022	There are no decisions required at this time.
n/a	Continued implementation of Care at Home Improvement Agenda			100%	Project is progressing as expected	31-Mar-2022	31-Mar-2022	There are no decisions required at this time.
n/a	Children's emotional wellbeing and mental health-implement framework			95%	Project progressing as expected	31-Mar-2022	31-Mar-2022	There are no decisions required at this time.
n/a	Corporate Parenting			100%	Project Complete	31-Mar-2022	31-Mar-2022	There are no decisions required at this time.
n/a	Healthy Lifestyles for Children and Young People			100%	Project Complete	31-Mar-2022	31-Mar-2022	There are no decisions required at this time.
n/a	Unpaid Work Services			100%	Project Complete	31-Mar-2022	31-Mar-2022	There are no decisions required at this time.
n/a	Outcome focused approach to Justice delivery			80%	Project is progressing as expected	31-Mar-2022	31-Mar-2022	There are no decisions required
n/a	Redesign of Public Dental Services: strategy, action plan and implementation			100%	Project Complete	31-Mar-2022	31-Mar-2022	There are no decisions required at this time.

APPENDIX 2

HSCP TRANSFORMATION PROGRAMME

sustainable thriving achieving
East Dunbartonshire Council
www.eastdunbarton.gov.uk

PROJECT RAG STATUS UPDATE				
Project ID/ Project Name	**Previous Status**	**Current Status**	**Project Progress to Date**	**Reason for RAG Status**
HSCP-21-01-TRA Delivery of Children's House Project			100%	Project Complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

Improve services to support care leavers

Project Sponsor	Project Manager
Claire Carthy	Raymond Walsh

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• House Project has started working with 2nd cohort of young people.	• Project complete, no further actions

Key Issues and Risks Requiring Escalation

There are no significant risks or issues at this time

Decision Required

Transformation Board agreed closure of this project at meeting held on 03/03. This report will be removed from future highlight reports and added to closed list of projects.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
£330K	£330K	3	N/A	Better outcomes for Care Leavers. Fulfil duties as Corporate Parents.

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✓	✓	✓	✓	✓	✗

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-02-TRA Learning Disability: service review, action plan and implementation			80%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

Planning for transition to new Allander Service. Day care - development of infrastructure / community development approach. Project aims to develop informal community assets, social enterprise development, supported and substantive employment, opportunities and volunteering services

Project Sponsor	Project Manager
David Aitken	Richard Murphy

HIGHLIGHT REPORT

Actions completed within the last reporting period

- Project on target for this year - project will extend for minimum of two years with new building on Allander site due to open in October / November 2022.
- Project Steering Group established. Four workstreams/working groups now established with Leads.
- Last Steering Group meeting held on the 10th February 2022
- Funding now secured for Local Area Co-ordinator Learning Disability post to support employability/supported accommodation initiatives

Actions planned in the Next Reporting Period

- Project Lead appointed and due to take up post on the 21st February 2022.
- Recruitment of 2 LAAC posts to support project being taken forward; interviews scheduled for 18th February 2022. Posts part of jointly funded employment initiative.
- Development of project plan will be completed by new Project Lead. Potential support from Council transformation team limited due to current capacity issues. Papers prepared by Employability Workstream Lead and Transitions Workstream Lead with options paper for potential outlook / outreach model included.

Key Issues and Risks Requiring Escalation

Development of new resources/projects will require additional funding or re-modelled service delivery model which will be a challenge given time limitations and ongoing Covid 19 pandemic - Funding of £40k now confirmed through 'Skills For Learning, Life & Work' with Mental Health Action 15 funding secured to support 2 x LAAC posts. Potential risk to Action 15 funding should this not be continued/withdrawn by SG. Building completion date slippage, however remaining on-track at this time for October / November 2022 completion.

Decision Required

There are no decisions required at this time

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	5,6	N/A	

Drivers for Change					
Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔	✔	✔	✔	✘	✔

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-03-TRA Digital Health & Care Action Plan: development and implementation			75%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

Develop and initiate new digital health and care action plan

Project Sponsor	Project Manager
Derrick Pearce	Allyson Blue; Elaine Marsh

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Last Digital Health and Care Board held 01.02.22 • Leadership Forum workshop - 17.02.22 to progress Digital Maturity Assessment. Outcome awaited from Digital Office. • DMA and Action Plan will be completed by 31.03.22	• Further engagement with Digital Office to finalise Digital Maturity Assessment • Develop Digital Action Plan in line with new strategic plan and outcome of maturity assessment

Key Issues and Risks Requiring Escalation

There are no significant risks or issues at this time

Decision Required

There are no decisions required at this time. Note the need for investment through possible use of reserves to support spend to save / pilot initiatives. Note risk to delay of completion.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
£55k	£55k	5, 6	Digital Foundations	

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✓	✓	✗	✓	✓	✗

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-04-TRA Older people's Day Services: service review, action plan and implementation			80%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	30-Nov-2022	03-Dec-2021

Project Description

Undertake review of Day Care and daytime activity resources for Older People

Project Sponsor	Project Manager
Derrick Pearce	Kelly Gainty; Richard Murphy

HIGHLIGHT REPORT

Actions completed within the last reporting period

- Three possible options for delivery of social support for older people for 2023-28.
- Agreement reached with Council, HSCP Board and Providers for current day centres to continue to deliver in interim period to allow Strategy to be finalised and actions to be instigated.
- Options appraisal information and discussion sessions have taken place. Options appraisal discussion sessions planned for Day Centre staff teams in March 2022.
- Equalities Impact Assessment completed.
- Majority of Strategy is in draft format awaiting finalisation of preferred outcome.

Actions planned in the Next Reporting Period

- Finalise interim commissioning arrangements and take to Full Council for sign off in February 2022.
- Options appraisal discussion sessions are planned for the Day Centre staff teams in March 2022
- Option appraisal information and discussions sessions planned for different stakeholder groups during April and May 2022
- Draft Strategy to be submitted to Senior Management Team on 25/05, and to HSCP Board on 30/06; thereafter Draft Strategy to be publicised for comments

Key Issues and Risks Requiring Escalation

Risk to interim commissioning arrangements due to provider challenge on proposed contract value and service levels - being mitigated and actions to address are in place.

Decision Required

There are no decisions required

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
£50,000		6		

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✓	✓	✓	✓	✗	✗

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-05-TRA Recovery Services commissioned service review, action plan and implementation			70%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

Re shape commissioned Services for MH / Alcohol and Drug Services

Project Sponsor	Project Manager
David Aitken	Gillian Healey; Stephen McDonald

HIGHLIGHT REPORT

Actions completed within the last reporting period

- Project Initiation Document Completed and draft Project Plan established. Initial consultation and engagement sessions with HSCP Staff, and Council completed. Initial Provider Forum held and support secured from IHub to take forward a Collaborative / 'Alliance' Commissioning model.
- Consultation and Engagement process with service users - Agreement from MH Network and Scottish Drugs Foundation to work on a collaborative basis to engage with and secure views from those who use commissioned services.
- Work to complete MH locality strategy initiated.

Actions planned in the Next Reporting Period

- Joint / integrated engagement plans to be developed with SDF & MH Network due to be reported end March 2022.
- Strategic Commissioner Post funded from Carers Funding to be progressed to recruitment, development of project group to take forward programme of work.
- Workshops to be arranged with commissioned service providers to develop Alliance contract thinking and collaborative approach as part of stakeholder engagement
- Mental Health Strategy is currently (February 2022) being prepared with outline Commissioning / Delivery plan to set strategic direction for these services
- Financial framework to be developed.

Key Issues and Risks Requiring Escalation

Progression of Strategic Commissioner Post which is becoming more critical as the project proceeds - Action 15 funding secured but requires recruitment by 31st March 2022 to secure funding on a recurring basis. Limited support available to project, commissioning resource limited at this time.

Decision Required

There are no decisions required at this time

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	4, 5	N/A	

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔	✔	✔	✔	✘	✘

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-06 Covid-19:Critical Response, transition and recovery	▶	▶	90%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Feb-2022

Project Description

Delivering health and social care services in new ways taking account the lessons learned during Covid-19

Project Sponsor	Project Manager
Caroline Sinclair	Alan Cairns

HIGHLIGHT REPORT

Actions completed within the last reporting period

- Service/Team Business Continuity Plans (BCP) reviewed and updated.
- HSCP overarching BCP updated.
- Covid-19 annex updated with revised essential services prioritisation and team consolidation arrangements.
- Model for developing Covid-19 Impact Analysis agreed and first in series of issues almost finalised for circulation.

Actions planned in the Next Reporting Period

- Monitor business continuity activation levels and governance arrangements.
- Finalise first issue of Covid-19 Impact Analysis and circulate. This issue will cover acute hospital care impacts.
- Next issue to be commenced.

Key Issues and Risks Requiring Escalation

There are no significant issues or risks at this time

Decision Required

There are no decisions required at this time

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	3, 4, 5, 6	N/A	

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✘	✘	✔	✔	✘	✘

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-07 Strategic Plan 2022-25 development			95%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

Strategic Plan 2022 - 2025 approved by IJB following development, consultation and engagement processes by 31/03/22

Project Sponsor	Project Manager
Caroline Sinclair	Alison Willacy

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Draft strategic plan agreed at IJB and permission given to undertake second statutory engagement and consultation. • Plan updated based on feedback and awaiting sign off at IJB on 24th March.	• Expectation is that completion deadline of 31 March will be met

Key Issues and Risks Requiring Escalation

There are no significant risks or issues at this time

Decision Required

There are no decisions required at this time

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	1, 2, 3, 4, 5, 6		

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✗	✗	✓	✗	✗	✗

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-10 Audit Action Plan(s): implementation			100%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

All outstanding actions due to be completed in 21/22, completed in-year

Project Sponsor	Project Manager
Jean Campbell	Gillian McConnachie

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• The due dates for 2 outstanding audit actions linked to the implementation of the new planning & development structure deferred until 22/23, therefore all actions due to be completed in 21/22 now complete.	

Key Issues and Risks Requiring Escalation

There are no significant risks or issues at this time

Decision Required

Transformation Board agreed closure of this project at meeting held on 03/03. This report will be removed from future highlight reports and added to closed list of projects.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	3,5,6		

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✗	✗	✓	✓	✗	✗

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-11 Property Strategy: development and implementation			90%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

Property Strategy for the HSCP

Project Sponsor	Project Manager
Jean Campbell	Vandrew McLean

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Workshops with key stakeholders progressing, options for accommodation within Auchinairn / Bishopbriggs and Milngavie / Bearsden progressing with NHS Estates colleagues. Anticipated date for completion now August 2022, therefore action will feature in Annual Service Delivery Plan for 22/23	• Finalise strategy and present for approval to IJB, progress options for accommodation to support delivery of strategic objectives across West and East Locality. Work with strategic partners and stakeholders to develop a coherent strategy to support the delivery of health and social care services going forward.

Key Issues and Risks Requiring Escalation

Funding identified in short terms which require further consideration in longer term. Options for integrating teams in the West Locality require Council approval and support to progress further planning.

Decision Required

There are no decisions required

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	5		

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
					

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-12 Community Led Locality Services			55%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

Implement East and West MDT teams case management operationally. Identify temporary West and Bishopbriggs/ Auchinairn staff location

Project Sponsor	Project Manager
Derrick Pearce	Kathleen Halpin; Fiona Munro

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Accommodation - progressing development of staff accommodation base in West Locality to support colocation and increased locality working/ management options. • Additional locality advanced practice roles coming on stream throughout 2022 to increase scope of locality MDT management of complex cases. This will increase reach and co-ordination of locality practitioner collaboratives. • Locality Planning Groups to be reconvened from April 2022 with renewed focus on locality responses to needs identified by locality practitioner collaboratives for community health and care, with scope to include wider discussion around services for children/families and adults with complex needs.	• Extend MDT discussions within 3rd locality

Key Issues and Risks Requiring Escalation

There are no significant risks or issues at this time.

Decision Required

There are no decisions required

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	5,6		

Drivers for Change					
Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✗	✗	✗	✓	✗	✗

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-13 Joint Commissioning Plan for Unscheduled Care			100%	Project complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

Initiate HSCP level programme of unscheduled care joint commissioning plan actions

Project Sponsor	Project Manager
Derrick Pearce	Fiona Munro; Alison Willacy

HIGHLIGHT REPORT

Actions completed within the last reporting period

- Financial gap closed via Winter System Pressures Funding.
- Designa and Delivery Plan finalised, presented in draft to IJB in Jan and for formal sign off in March 2022.
- Local Action Plan and tracker in place - all actions progressing.
- Local UCC Group last met 16.02.22.

Actions planned in the Next Reporting Period

- Awaiting feedback from all other GCC HSCP IJBs
- Joint commission plan and financial framework with be updated as appropriate to reflect feedback from all GGC HSCP IJBs.
- Updated reports will be presented to IJB
- Ongoing delivery and review of current service models.

Key Issues and Risks Requiring Escalation

There are no significant risks or issues at this time

Decision Required

Transformation Board agreed closure of this project at meeting held on 03/03. This report will be removed from future highlight reports and added to closed list of projects.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	5, 6		

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
					

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-14 Dementia Strategy			50%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

Increase the capacity of the post diagnostic support service

Project Sponsor	Project Manager
Derrick Pearce	Fiona Munro

HIGHLIGHT REPORT

Actions completed within the last reporting period

- Work in abeyance during pandemic response and due to gap in key leadership personnel.
- Operational work continued but strategy group stood down.
- OPMH manager post now evaluated and to progressing to recruitment - will take the lead for dementia strategic work

Actions planned in the Next Reporting Period

- Progress to recruitment
- Undertake review of service model and adjust as required - immediate action in next period to close off on financial review with Alzheimer's Scotland for their element of delivery
- Awaiting new national strategy to refresh policy base
- PDS service to be reviewed in line with new wider look at wellbeing/MH support in the community - data collection progressing.

Key Issues and Risks Requiring Escalation

There are no significant risks or issues at this time

Decision Required

There are no decisions required

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	6		

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
					

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-15 Primary Care Improvement Plan			50%	Amber - Project at risk

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

Review progress against current plan, refresh PCIP for 21/22 and consult of refreshed PCIP

Project Sponsor	Project Manager
Derrick Pearce	Derrick Pearce

HIGHLIGHT REPORT

Actions completed within the last reporting period

- Additional capital allocation from SG will address accommodation challenges allowing core MOUs to progress.
- Winter PC pressures funding approved - plan at final stage for implementation.
- All MOUs progressing in line with latest position reported to IJb and SG.
- Last PCIG was 19.01.22

Actions planned in the Next Reporting Period

- Implement outcome of pressures funding bid - £270K in 2021/22
- Take tracker and winter pressures bid outcome to IJB

Key Issues and Risks Requiring Escalation

Ability to deliver on this year's commitments constrained by insufficient funding to deliver full extent of MOU commitments, accommodation issues and ongoing pandemic response.

Decision Required

There are no decisions required

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	5, 6		

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✗	✓	✓	✓	✗	✗

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-16 Fair Access to Community Care Policy			33%	Red - Project in exception

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

Continue to implement, Transport Policy, Review of sleepovers and consistent application of existing charging policies

Project Sponsor	Project Manager
David Aitken	Stephen McDonald

HIGHLIGHT REPORT

Actions completed within the last reporting period

- Progress made review team has been adversely affected by Covid 19, reduced staff capacity and structural issues working through congregate services which have not fully resumed following pandemic shut down.

Actions planned in the Next Reporting Period

- Monthly progress reporting arrangements established.
- Reviews are now completed within all supported accommodation LD providers. This was completed by the end of 2021.
- Focus for next phase of project is on community packages and application of Fair Access Policy, and in supporting Learning Disability Strategy re Day Service Reviews.
- Full implementation of charges, alternative service provision and removal of duplication of service provision (i.e., 24/7 residential care + five day daycare) being targeted.

Key Issues and Risks Requiring Escalation

'Schedule of Rates' requires to be prepared to equip the team with the tools they need to best facilitate the move to reviews of community packages from the start of 2022, and in order to generate greater savings.
Team affected by turnover and currently (Feb 2022) Team Lead is absent (long term sickness absence); interim arrangements have been established by Service Manager but further limits potential of project to achieve anticipated savings. Covid 19 has further restricted success of project as service provision has not returned to full pre pandemic levels and challenges in returning to face to face reviews to take forward difficult/challenging conversations.

Decision Required

There are no decisions required

Benefits				
Target £ (Indicate Year)	**Actual Predicted (Indicate Year)**	**LOIP (Specify Numbers)**	**Digital Transformation**	**Other Intended Benefits**
£200,000	£65k achieved to date (further £15k identified)	5, 6		Significant potential savings have been identified which could be achieved with the possible decommission of a Quarriers Service with alternative placements provided from existing / future voids which could achieve significant savings – will require further review and engagement with relevant stakeholders and LD & Planning/Service Development Teams.

Drivers for Change					
Improved efficiency	**Corporate priorities**	**Statutory & Legal**	**Service Delivery**	**Sustainability**	**Maintenance & Enhancement of core assets**
✔	✘	✔	✔	✘	✘

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-17 Continued implementation of Care at Home Improvement Agenda			100%	Project complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

Conclude benefits realisation stage of strategic review. Delivery of Inspection Action Plan. Develop Commissioning Delivery Plan 22/25. Implement Quality Assurance Framework. Implementation Action Plan

Project Sponsor	Project Manager
Derrick Pearce	Donna Gibson; Richard Murphy

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Improvements fully delivered. • Benefits realisation report complete and actions implemented via Winter System Pressures Funding and associated business case to EDC. • Inspection 18.01.22 outcome - Good overall	• Progress next stages of care at home commissioning, benefits realisation meeting set up to evaluate project delivery.

Key Issues and Risks Requiring Escalation

There are no significant risks or issues at this time.

Decision Required

Transformation Board agreed closure of this project at meeting held on 03/03. This report will be removed from future highlight reports and added to closed list of projects.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	6		

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✘	✘	✔	✔	✘	✘

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-18 Children's emotional wellbeing and mental health- implement framework			95%	Green - Project on track

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

Framework implemented

Project Sponsor	Project Manager
Claire Carthy	Claire Carthy

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Second outcome report submitted to SG. • SG grant funding for year 2 agreed.	• Submit year 2 action plan to SG. • Agree actions with DCYPP

Key Issues and Risks Requiring Escalation

There are no significant risks or issues at this time.

Decision Required

There are no decisions required

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	3		• Improve outcomes for children and young people. • Ensure children and young people suffering from poor mental health get the right help at the right time.

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✓	✓	✓	✓	✓	✗

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-19 Corporate Parenting			100%	Project complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

Implement the Corporate parenting Action Plan. Children and Young People Scotland Act 2014. The Promise - outcome of independent care review into Children's Residential Care. PID refreshed.

Project Sponsor	Project Manager
Claire Carthy	Raymond Walsh

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Commitment to Corporate parenting ongoing. • Promise Co-ordinator appointed and steering group formed. • Work carries on into next financial year.	• Lead professional to oversee implementation of The Promise has been appointed. • Champion's Board established.

Key Issues and Risks Requiring Escalation

There are no significant risks or issues at this time.

Decision Required

Transformation Board agreed closure of this project at meeting held on 03/03. This report will be removed from future highlight reports and added to closed list of projects.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	3		• Improve outcomes for LAAC children.

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔	✔	✔	✔	✔	✘

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-21 Healthy Lifestyles for Children and Young People			100%	Project complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

Deliver health improvement objectives of Integrated Children's Services Plan

Project Sponsor	Project Manager
Claire Carthy	David Radford

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Work continues and links to the CYPMHW Framework.	• Continue to implement the Children and Young People's Mental Health Framework. • Continue to develop Sexual Health Services for young people.

Key Issues and Risks Requiring Escalation

There are no significant risks or issues at this time

Decision Required

Transformation Board agreed closure of this project at meeting held on 03/03. This report will be removed from future highlight reports and added to closed list of projects.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	3		• Improve outcomes for children and young people.

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔	✔	✔	✔	✘	✘

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-22 Unpaid Work Services			100%	Project complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

Clear backlog of Court Cases (UPW and Supervision) and bring service back in line with pre-Covid service provision

Project Sponsor	Project Manager
Claire Carthy	Alex O'Donnell

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period

Key Issues and Risks Requiring Escalation

No risks to escalate at present, outstanding hours are closely monitored.

Decision Required

Transformation Board agreed closure of this project at meeting held on 03/03. This report will be removed from future highlight reports and added to closed list of projects.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	n/a	4	Digital Services	

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
					

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-24 Outcome focused approach to Justice delivery	▶	▶	80%	Project progressing as expected

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

Improve performance reporting and develop a methodology to measure the outputs and outcomes of the Community Justice Partnerships

Project Sponsor	Project Manager
Claire Carthy; Derrick Pearce; Alison Willacy	Claire Carthy; Alex O'Donnell; Derrick Pearce

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Carejust now hosted in EDC.	• Establish a reporting and analytical group.

Key Issues and Risks Requiring Escalation

No issues require escalation at this stage.

Decision Required

There are no decisions required at this time

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
N/A	N/A	4	Digital Foundations	

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
✔	✔	✘	✔	✔	✘

PROJECT RAG STATUS UPDATE

Project ID/ Project Name	Previous Status	Current Status	Project Progress to Date	Reason for RAG Status
HSCP-21-26 Redesign of Public Dental Services: strategy, action plan and implementation			100%	Project complete

Original Project End Date	Forecast Project End Date	Date of last project board
31-Mar-2022	31-Mar-2022	03-Dec-2021

Project Description

Action plan to support redesign of PDS. Engagement with staff and stakeholders. EQIA for further public engagement undertaken

Project Sponsor	Project Manager
Derrick Pearce	Alison Willacy

HIGHLIGHT REPORT

Actions completed within the last reporting period	Actions planned in the Next Reporting Period
• Programme Board approved completion on 17th January 2022	• Project complete, no further actions

Key Issues and Risks Requiring Escalation

None, project complete

Decision Required

Transformation Board agreed closure of this project at meeting held on 03/03. This report will be removed from future highlight reports and added to closed list of projects.

Benefits

Target £ (Indicate Year)	Actual Predicted (Indicate Year)	LOIP (Specify Numbers)	Digital Transformation	Other Intended Benefits
n/a	n/a	3, 5		

Drivers for Change

Improved efficiency	Corporate priorities	Statutory & Legal	Service Delivery	Sustainability	Maintenance & Enhancement of core assets
					

HSCP Transformation Programme 2021/22

Completed/Concluded Projects

Ranking from Highest Priority to Lowest – Assessed by the Priority Scoring Matrix

APPENDIX 3

Priority Scoring	Title	Current Due Date	Comments	Indicative Full Year Financial Benefit	Estimated Financial Benefit 2020/21
-	Medium Term Financial Plan 2022-2027	March 2022	Completed and approved through IJB in June 2021. Project Board agreed closure of this project at the meeting held on 3 December 2021.	£0	£0
-	Joint Inspection for Adult Services Action Plan(s): Implementation	March 2022	Action completed on start date. UC Commissioning plan updated and notified through IJB. Project Board agreed closure of this project at the meeting held on 3 December 2021.	£0	£0
-	Keeping Children Safe – Barnahaus Project	March 2022	Project completed. Project Board agreed closure of this project at the meeting held on 3 December 2021.	£0	£0
-	Extend the range of diversionary activities	March 2022	Project completed and recommendations made to Scottish Courts. Project Board agreed closure of this project at the meeting held on 3 December 2021.	£0	£0
-	Adult Social Care Assurance and Support	March 2022	Project completed, infrastructure in place and being used. Project Board agreed closure of this project at the meeting held on 3 December 2021.	£0	£0
-	Strengthen the Primary Care Dental Service Leadership	March 2022	Project completed; structure established and working well. Project Board agreed closure of this project at the meeting held on 3 December 2021.	£0	£0

East Dunbartonshire HSCP

Financial Planning 2021/22 - Savings Programme **APPENDIX 4**

Workstream	Action	Lead	Full Year Impact 21/22	Saving Achieved 21/22	Comments
	Service Redesign (19/20 Savings Cfwd)				
Policy	Fair Access to Community Care	David	200	200	In Exception - achieved in part through implementation of policy and through a downturn in care packages due to impact of Covid on daycare / respite care.
Service Change	Review of Daycare	Derrick	50	50	On Track
			250	250	
	Service Redesign (20/21 savings c/fwd)				
Assets	Children's Services 'House' Project Development	Claire	400	400	On Track
Service Change	LD Supported Accomodation Review (In House Service)	David	0		
Service Change	LD Supported Accomodation Review (Commissioned Services)	David	0		
			400	400	
	TOTAL C/fwd Savings Programme 21/22		**650**	**650**	
	New Savings 21/22				
Efficiency	Review of Health Improvement Budgets (health)		26	26	On Track
	Total Approved Savings Programme 21/22		**676**	**676**	
Historic Savings	CM2000	Derrick	150	0	Block contracts awarded - will not progress, alternative to be scoped
- reflected in Budget 21/22	Voluntary Sector - 5% Efficiency	Gillian	185	46	Assume half year - capture efficiencies post Covid
	Sleepovers	David A	13	0	Fire safety risk impacting delivery of this proposal
	Fair Access to Community Care	David A	50	50	On Track
	Review of Mgt Structure	Caroline	25	0	Interim structure in place pending review - delay due to Covid
	House Project	Claire	200	200	On Track
	Review of Daycare East	Derrick	25	25	On Track - met through capacity in expenditure budgets
	Total		648	321	
	Un achieved Savings - Covid related			164	Included within LMP Return - assume funded through SG
	Total Savings 21/22		**1,324**	**1,161**	
	Shortfall			**163**	

East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 6

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING:	**31st MARCH 2022**
REPORT REFERENCE:	**HSCP/310322/06**
CONTACT OFFICER:	**DAVID AITKEN** **INTERIM HEAD OF ADULT SERVICES.**
SUBJECT TITLE:	**MENTAL WELFARE COMMISSION REPORT – CARE & TREATMENT FOR PEOPLE WITH ALCOHOL RELATED BRAIN DAMAGE IN SCOTLAND (2021)**

1.1 PURPOSE

1.2 The purpose of this report is to update the Committee on the Mental Welfare Commission's (MWC) report into the 'Care and Treatment for People with Alcohol Related Brain Damage in Scotland'. The report was published in September 2021 and there were four recommendations for response by the 15th December 2021.

2.1 RECOMMENDATIONS

It is recommended that the Performance, Audit & Risk Committee:

2.2 Note the contents of the report. The report is provided for noting / information.

CAROLINE SINCLAIR
INTERIM CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.1 BACKGROUND / MAIN ISSUES

3.2 Alcohol related brain damage (ARBD) refers to the effects of changes to the structure and function of the brain resulting from long term misuse of alcohol. If a person with ARBD stops drinking alcohol and receives good support, they may be able to make a partial or even full recovery, and may regain much of their memory and cognitive skills / abilities, and their ability to do things independently.

3.3 The report highlighted that those aged under 65, who were significantly affected by alcohol related brain damage and unable to live independently were often inappropriately placed within older adult nursing / care homes where they were comparatively much younger than other residents, in a setting they would not have chosen which the report highlighted lead to the development of much greater dependency, isolation and adversely affected rehabilitation potential.

3.4 This report focused on people with a diagnosis of ARBD who are also subject to a Welfare Guardianship order. The report looked at care arrangements, at how the legal safeguards were being applied, and whether good practice was being followed.

3.5 In 2021 the Mental Welfare Commission interviewed 50 of the 553 people in Scotland who had an ARBD diagnosis and a Welfare Guardianship in place. Just over half were aged under 65, and half were 65 to 75. The Commission also contacted services and spoke to families and carers.

REPORT FINDINGS & RECOMMENDATIONS

3.6 There were a number of positive examples of good care highlighted in this report, but also areas of concern identified. The Mental Welfare Commission found many of the people they interviewed were living in care homes where they were much younger than the other residents and they had concerns that this could represent a breach of the person's human rights if compelled to live in a setting which they would not have identified or chosen had they retained capacity for decision making.

3.7 The report made four recommendations for Health and Social Care Partnerships (HSCP). The first is that the HSCP commission suitable, age appropriate, and where possible, specialist alcohol related brain damage services.

3.8 The second recommendation was that the role of the CSWO delegated officer in a local authority must be held by a named person who maintains regular contact with the individual subject to the restrictions of the guardianship order.

3.9 The third recommendation focused on multidisciplinary reviews for people with ARBD, which the MWC reflected should be a dynamic, coordinated process informed by the principles of the law, maximising both the contribution of the person and their relatives/carers where appropriate.

3.10 The final recommendation related to advocacy support, and seeking as assurance that this safeguard was consistently available to ensure respect for the rights, will and preferences of the person was protected.

LOCAL CONTEXT / EAST DUNBARTONSHIRE RESPONSE

3.11 In East Dunbartonshire there are currently only two adults who are placed within residential settings as a consequence of ARBD, and we have commissioned specialist ARRD resources for both individuals. Our Alcohol and Drug Recovery service are currently working with a small number of adults who are significantly affected by ARBD.

3.12 In East Dunbartonshire we have not utilised local older adult nursing / care home provision to provide care placements to those aged under 65 affected by ARBD, and have sought to ensure that service provision in each instance is personalised and truly reflects the individual and their needs.

3.13 In response to the Commission's second recommendation to ensure allocation of a delegated officer to named individuals in East Dunbartonshire, we have undertaken significant work over recent months to ensure enhanced oversight and improved management reporting in this regard. We have established monthly reporting on both private and local authority Welfare Guardianship orders, providing additional management information on supervisory and delegated arrangements and have taken forward work to review our Adults with Incapacity Procedures locally, and have named delegated officers ensuring that each order is meeting the person's outcomes in line with the principles of the 2000 Act.

3.14 The third recommendation in respect of community care review activity is one where we continue to improve practice and ensure that those involved are as fully engaged in, and can actively contribute within this process. Our Social Work review processes and Carefirst based forms were updated just prior to the Covid-19 pandemic with a focus on establishing greater levels of participation and outcome focused reporting and this has been reflected in updated Assessment and Care Management processes.

3.15 The final recommendation relates to the provision of advocacy services. In East Dunbartonshire we have a commissioned advocacy service; Ceartas Advocacy, which provides support across all care groups, including ARBD. The advocacy service is represented in a number of forums including service specific strategic groups, and Adult Protection Committee and we have long established and strong links with our local advocacy service. The provision of advocacy in East Dunbartonshire is accessible and actively promoted to support people's rights, choice and ability to maximise their quality of life.

SUMMARY

3.16 We welcome the Mental Welfare Commission's focus on this important area of work and support the establishment of simpler pathways and access to specialist and appropriate support.

3.17 In East Dunbartonshire we have not utilised local older adult nursing/care home provision to provide placements to those aged under 65, and all adults affected by ARBD in East Dunbartonshire who have required residential care have had their needs met within specialised ARBD provision.

3.18 We have taken steps locally to strengthen and enhance our approaches to the management of CSWO Welfare Guardianship orders, and have also established new review processes within our Social Work services.

3.19 Accessible provision of advocacy is well established within East Dunbartonshire which actively promotes people's rights, choice and ability to maximise their quality of life.

4.1 IMPLICATIONS

The implications for the Board are as undernoted:

4.2 Relevance HSCP Board Strategic Plan – Statutory Duty, provision of Social Work services.

4.3 Frontline Service to Customers – Provision of appropriate and personalised services.

4.4 Workforce (including any significant resource implications) – None

4.5 Legal Implications – Service provision in accordance with the principles and legislation within the Adults With Incapacity (Scotland) Act 2000.

4.6 Financial Implications – Cost of specialist ARBD services do exceed nursing care home provision but provide for much greater retention of independence and rehabilitation potential.

4.7 Procurement – In East Dunbartonshire we have consistently and appropriately commissioned specialist services where required.

4.8 ICT – None

4.9 Economic Impact – None

4.10 Sustainability – None

4.11 Equalities Implications – Discriminatory perceptions of a 'self-inflicted illness' which lead to people with a diagnosis of ARBD being further marginalised and socially excluded.

4.12 Other – None

5.1 MANAGEMENT OF RISK

The risks and control measures relating to this Report are as follows:-

5.2 Risk mitigated in East Dunbartonshire with specialist services commissioned to ensure that service provision reflects the individual and their needs. Risk further reduced with establishment of monthly reporting on both private and local authority Welfare Guardianship Orders, and recent review of Adults with Incapacity Procedures by Social Work and Legal Services.

6.1 IMPACT

6.2 EAST DUNBARTONSHIRE COUNCIL – None

6.3 NHS GREATER GLASGOW & CLYDE – None

6.4 DIRECTIONS REQUIRED TO COUNCIL/HEALTH BOARD - No Direction Required

7 POLICY CHECKLIST

7.1 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.0 APPENDICES

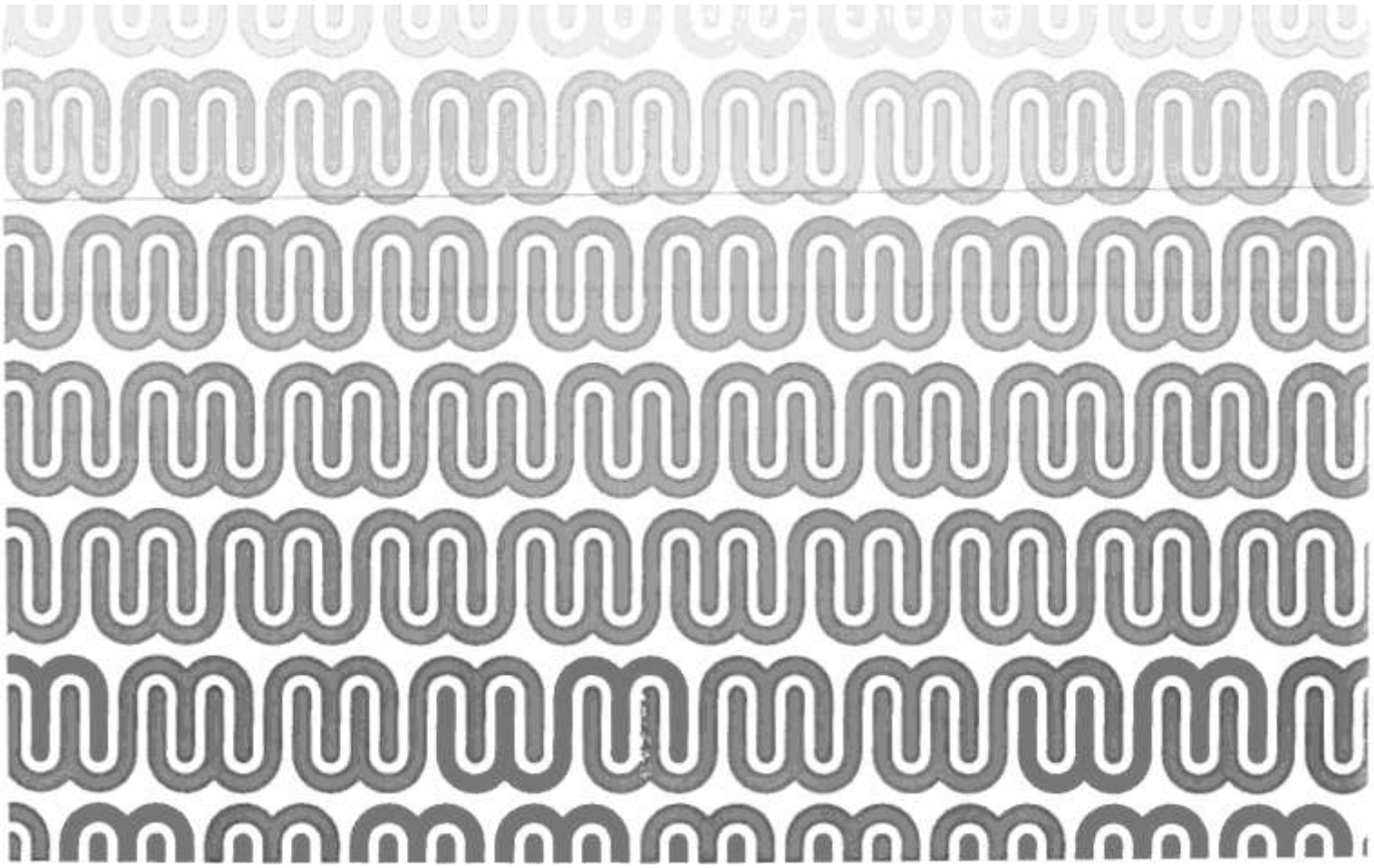
8.1 Appendix 1 – Mental Welfare Commission for Scotland: Care and Treatment for People with Alcohol Related Brain Damage in Scotland

mental welfare
commission for scotland

Care and treatment for people with alcohol related brain damage in Scotland

A report on visits to people and services across Scotland in 2021

September 2021



Our mission and purpose

Contents

Foreword - Julie Paterson, chief executive

"Discriminatory perceptions of a 'self-inflicted illness' can lead to people with a diagnosis of ARBD being extremely vulnerable, marginalised and socially isolated."

The Mental Welfare Commission has a statutory safeguarding role for people whose mental capacity to make decisions, or to take actions to promote or safeguard their welfare, is impaired. Alcohol-related brain damage (ARBO) is one such diagnosis that may lead to such impairment.

The pathway to a diagnosis of ARBO, and to getting specialist support to meet individual needs and outcomes, can be challenging and complex – both for the person affected and for those people important and close to them.

Discriminatory perceptions of a 'self-inflicted illness' can also lead to people with a diagnosis of ARBO being extremely vulnerable, marginalised and socially isolated.

For some people where there are concerns about their safety and judgement, guardianship orders - which allow a family member or a local authority to take decisions on the person's behalf - may be applied for under adults with incapacity legislation to address risks and to ensure appropriate treatment. care and support.

While guardianship orders can be very useful in helping manage issues for someone with alcohol related brain damage, we have long-standing concerns about the availability of specialist support for those people.

To help address those concerns, in 2019 we published a good practice guide on this subject, for use by health and social care services across Scotland.

This report is the next stage. It looks specifically at 50 cases where people have been given a diagnosis of ARBO and are also subject to a welfare guardianship order.

Our intentions here are to understand whether our ARBO good practice guidance is being followed by health and social care services, and to learn more about the care arrangements in place, and the application of the critically important principles of adults with incapacity law.

This report details some of the specific actions we took following our contacts with those 50 individuals (and their family/carers where appropriate) across 27 of Scotland's 31 Health and Social Care Partnerships (HSCPs).

We also report on our findings, a summary of which is noted below. There were many positive examples of good care, which we highlight in this report, but also areas of concern.

We found many of the people we met were living in care homes where they were much younger than the other residents. Those commissioning services must consider whether they are breaching the person's human rights if the person finds themselves compelled to live in a setting which they would never choose.

We make recommendations about areas of care and treatment we believe could and should work better, and we will follow those up.

I hope our report will be widely shared and discussed, and others will join us in seeking improvements for this vulnerable group.

Summary findings and recommendations

Recommendation 1: Health and Social Care Partnerships should commission suitable, age appropriate and where possible specialist ARBO services.

As described in our good practice ARBO guidance and further evidenced in this programme of visits to people subject to guardianship orders, inappropriate community care home placements can precipitate dependency and isolation for individuals with ARBO. Despite the advent of self-directed support and our guidance we saw limited development of specialist, innovative approaches and services in Scotland to meet the needs of people with a diagnosis of ARBO. Where we did find this, more positive outcomes were clearly evidenced.

Those commissioning services must consider whether they are breaching the person's human rights if the person is compelled to live in a setting which they would never choose.

Recommendation 2: Health and Social Care Partnerships should ensure allocation of the delegated officer role to a named individual to ensure consistency and continuity.

The Chief Social Work Officer delegates the role of guardian to a delegated officer; the Chief Social Work Officer remains accountable however. We found that the critical role of delegated officer was not always held by a named officer who maintained regular contact with the person subject to the restrictions of the guardianship order. We do not consider this to be in line with the spirit of the legislation. Where a decision has been taken by the local authority to intervene in a person's life on a statutory basis, there should be a named delegated officer building a trusting relationship and ensuring that the order is meeting the person's outcomes in line with the principles of the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act').

Recommendation 3: Community care review activity within Health and Social Care Partnerships should be dynamic, coordinated processes which include review of personal outcomes, care plans, placement, the guardianship order and whether all or some of the powers remain relevant.

Multidisciplinary reviews should be dynamic, coordinated processes informed by the principles of the AWI Act, maximising both the contribution of the person and their carers/relatives where appropriate. We found that reviews did not always focus on outcomes, the placement and the powers of the order. It is important to ensure that those involved are not passive recipients of information but have ongoing relationships that allow them to actively contribute to the review process.

Recommendation 4: Health and Social Care Partnerships' strategic advocacy plans should include focus on accessibility of advocacy support at all stages of the care and support continuum.

We have highlighted the challenges of supporting the rights of people with a diagnosis of ARBO to live as they choose balanced with their rights to access support to maximise their quality of life. The offer of advocacy support is an important safeguard to ensure respect for

the rights will and preferences of the person and not what is considered by others to be in that person's best interests. Advocacy support is important prior to the guardianship application stage, post guardianship and throughout the provision of continuing care.

- Where recommendations are made to health and social care partnerships, this refers to the joint operational arrangements that exist in a council area between local authority social work services and health care services of the local health board.

Introduction

There are many different terms used for cognitive impairment as a result of alcohol misuse. An expert group, which included representation from the Mental Welfare Commission for Scotland ('the Commission'), produced the report *A Fuller Life* in 2004 [1] and used the collective term, alcohol-related brain damage (ARBO), and this is the term we use here. The definition is as follows:

> *Alcohol related brain damage (ARBD) refers to the effects of changes to the structure and function of the brain resulting from long term consumption of alcohol. There is no single cause of ARBD, which usually results from a combination of factors. These include the toxic effects of alcohol on brain cells, vitamin and nutritional deficiencies, head injury and disturbances to the blood supply to the brain.* (p.2) (1)

People with ARBO can require help to manage their alcohol use and to undertake skills of daily living. The Commission's published report in 2006, *Mr H,* highlighted the vulnerabilities and negative consequences for a man whose ARBO went unrecognised, despite many contacts with health and social work services. At that time,we also heard about a concerning lack of resources available to support people once a diagnosis of ARBO had been made [2].

The Commission undertook themed visits involving people with a diagnosis of ARBO in 201O [3) and in2019 we published a good practice guide aimed at those working in partnership with people with a diagnosis of ARBO [4].The guidance recognises the challenges of supporting the rights of this vulnerable group of people to live as they choose balanced with their rights to access support to maximise their quality of life.

People with a diagnosis of ARBO form a small but very significant vulnerable group in society. There may have been years of problem drinking for each individual, resulting in social, financial, occupational, physical. and forensic consequences. Family, friends or neighbours may have exhausted all efforts to provide support where the person lacks insight into their behaviours and impact. There may also be a stigmatised public perception that the difficulties are self- inflicted. As a result, they require outside agencies to provide support and to meet outcomes that are important to them.

It is against this backdrop that, this year, we chose to visit a number of people with a diagnosis of ARBO who are also subject to a welfare guardianship order. The intention of this themed programme of visits is to build on the Commission's ARBO good practice guidance and its key learning points and to look specifically at the way that guardianship and its principles are used in this context.

What we did

If an adult is unable to make key decisions or take necessary actions to safeguard their own welfare,a court can appoint a welfare guardian to do that for them. The welfare guardian can be a relative,friend or carer. The court can also appoint the chief social work officer of a local

authorjty-to-be-a personls-welfare-guardjan he law-that-sets-011t-the-role..-.nd r&iponsibilities of guardians is the Adults with Incapacity Act (Scotland) 2000.

Every year we look at how many people are subject to a welfare guardianship order on 31 March. We call this extant guardianships and this tells us the prevalence of welfare guardianships in Scotland. In 2020, there were 553 individuals with ARBO who were subject to a guardianship order. We used this information to help choose the people we wished to visit, selecting by local authority, gender, and order length to identify a sample of 50 individuals that broadly reflected the overall population of people with ARBO subject to a guardianship order.

We then made contact with those 50 people, across 27 local authorities/Health and Social Care Partnerships (HSCPs) in Scotland. Thirty per cent of the people we made contact with were female, 67% were male, and one preferred not to say. Fifty two per cent were under the age of 65 years and 48% were 65-75 years.

Given Covid-19 and the restrictions at the time, 54% of the contacts were undertaken virtually using technology and 46% of contacts were made face to face in the person's home. All 50 people had a confirmed diagnosis of ARBO with 30% of those people also having additional diagnoses, for example mental illness, epilepsy, learning disability. Twenty-nine people were able and willing to give us their views and respond to questions posed.

We are committed to meeting our requirements for equalities monitoring and ask people *we* meet about protected characteristics. Table 1 presents a breakdown of protected characteristics of the people we met with.

Table 1. Equalities Monitoring

Characteristic	Grouping	n (%)
Ethnicity	White Scottish	44 (91)
	White Other British or White Other	5 (7)
	Not provided	1 (2)
Transgender	Nothing recorded	30 (54)
	No	18 (40)
	Prefer not to say	2 (6)
Sexuality	Nothing recorded	20 (33)
	Heterosexual	19 (41)
	Prefer not to say	*
	Gay	*

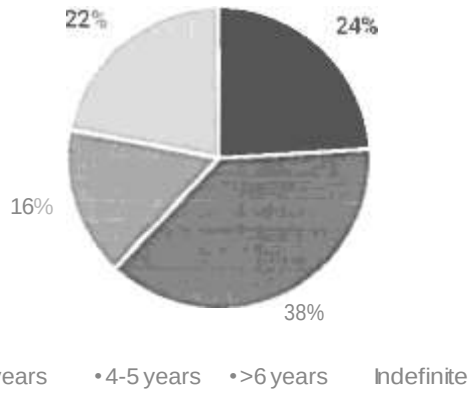
**n<S or secondary suppression*

Just over half of the people we made contact with (54%) had a local authority guardianship order in place, 43% had a private guardianship order, and 3% had a combination of the two. We found that guardianship arrangements were not always clear:

> *During the visit it became apparent that the* care *home were under the impression that the relative was the welfare guardian despite it being the Chief Social Work Officer (CSWO). Consequently they have been consulting the relative in all aspects of the person's care. While we agreed that it was good practice to consult, we discussed and explained the fact that decision making lay with the* CSWO.

Most guardianship orders were for five years or less (Figure 1). Fourteen (23%) of the people we made contact with had renewed orders whilst the other orders were new.

Figure 1. Length of guardianship order



Gapacity

What we expected to find

The Commission's good practice guidance explains that "There are particular challenges in carrying out capacity assessments with ARBO so assessments should be carefully planned and carried out by specialists wherever possibleH (p.33) [4]. For our sample of 50 people,we have assumed that careful planning and specialist assessments, where possible,were carried out at the outset to inform the diagnosis of ARBO given to support the welfare guardianship order application agreed by the Sheriff in each case.

If a person with ARBO stops drinking alcohol and receives good support, they may be able to make a partial or even full recovery. They may regain much of their memory and thinking skills, and their ability to do things independently. The Commission's best practice guidance states that "there are effective treatments for ARBO and legal interventions can often help to ensure these treatments can be delivered,and the chances of long term recovery maximised...." (p.33) [4]. Alcohol related brain damage does not, therefore, always get worse over time.

Anyone who is intervening in the person's life should be aware of the provisions of the Adults with Incapacity (Scotland) Act 2000 ('the AWi Act') and of people's right to liberty under the Human Rights Act 1998. Any restrictions should be legal, proportionate and regularly reviewed. We therefore would expect to see consideration of decision specific capacity assessments as integral to the dynamic care planning process, undertaken based on the individual needs and improvements, or otherwise, evidenced by the person subject to a welfare guardianship order.

The AWi Act ensures that people have access to advocacy and we would expect this service to continue to be offered post guardianship order,recognising the important role of advocacy in terms of long term support, care planning,review and supporting the person to claim their rights. This would include appropriate multidisciplinary reflection on whether the grounds of recall might be met (section 73(3) of the AWi Act).

What we found

Whilst we had assumed that challenges relating to assessments and capacity had been appropriately addressed to inform the original welfare guardianship applications,we found this not to be the case in all of our sample.This renders the order unsafe in our view and we will take appropriate action.

Less than half (42%) of the people we made contact with had received an updated formal capacity assessment since their original guardianship order was granted. Of these, 21 people whose capacity had been re-assessed,the majority (15 people) had received an assessment by a psychiatrist, while five had been assessed by their GP and one by their GP and nursing team.

Reassessments tended to be linked to the timing of renewal of orders,however we also saw active intervention by private welfare guardians at other times, seeking reassessments in light of obvious improvements made by their relatives following receipt of care and support.

The challenges of such capacity assessments were evidenced in one particular case where a reassessment was undertaken by a psychiatrist at the point of renewal of the order. The person was found to have regained capacity to make welfare decisions and the order was allowed to lapse. Three months later other medical staff questioned the person's capacity and the outcome was a further welfare guardianship application.The new order was subsequently granted for a 12 month period (eight months after the original order was allowed to lapse).

For the remaining 29 people who had not had their capacity to make decisions formally reassessed, we noted one person where this should have happened. A psychiatrist had recommended a formal capacity review within 12 months of the guardianship order being granted for this person and this had not happened eight years on. For three people we were told that a reassessment was not required. Examples where reassessment of capacity was not deemed to be required included where additional medical conditions evidenced further decline and/or life limiting illness.

Of the remaining 25 people who had not had their capacity assessed since their guardianship order was granted,we could only find two cases where there was a plan to formally reassess capacity. Where capacity had not been formally reassessed we found that there was generally consideration given to theissue of capacity at review meetings. Improvements in the person's ability, circumstances and skills were often referred to; however, capacity was not thought to have recovered.

As our guidance states, where it is established that capacity is recovered, professionals and relatives may ultimately have to accept that people have the right to make choices, even if this means resuming a previous chaotic lifestyle. Recall of the order, prior to its expiry date, would be expected in SiJch circumstances where capacity is recovered and the grounds of the orde1 are no longer met. Review of Commission records over the past five years confirms that only two guardianship orders have been recalled where the person had a diagnosis of ARBO.

Indeed we found that there have only been a total of 16 orders recalled across Edinburgh City, Aberdeen City, East Ayrshire, Aberdeenshire, South Lanarkshire, Glasgow, East Lothian and Fife. Twenty six other HSCPs have recalled no orders in the past five years. This may be entirely appropriate based on individual needs but it may also represent a lack of dynamic care planning and review of powers and orders required.

Currentli'ling situation

What we expected to find

The intention of the Social Care (Self-directed Support)(Scotland) Act 2013 is to offer choice, control and flexibility to enable people to receive the kind of support they want, where they want it and when they want it. Each person is a unique individual and people with ARBO who are subject to guardianship orders are no exception. By drafting individually framed powers. guardianship orders can facilitate personal outcomes focussed care.

Personal outcomes focussed care is reportedly more challenging for services than providing standardised 24 hour care in a care home setting, however many people with a diagnosis of ARBO are under 65 years and may not be suited to care home settings which are mostly registered for older people (median age 84 years) [SJ. nor do they fit well into units for young physically disabled people, or for younger people with a learning disability.

Following earlier reports and good practice guidance, we expected to see further development of specialist, innovative approaches and services in Scotland to meet the needs of people with a diagnosis of ARBO; like anyone else, people with an ARBO diagnosis are entitled to care provision which reflects their age and individual interests.

Whatwefound

Seventy percent of our total sample were living in care home settings, 12% were living in the family home and 18% were living in other settings e.g. hostel or supported accommodation. Fifty-two percent of our sample, 26 people, were aged under 65 years, the youngest in their 30s. Seventeen of the 26 people were reported as living in a care home setting. Following review of the Care Inspectorate's website, only one of these care homes was registered as a specialist service in relation to 'brain damage including alcohol related brain damage'.

Many of those with ARBO may find themselves living in a 24 hour care home setting with others who are decades older and who may be frail, have progressive dementia or other degenerative conditions of old age. The person with ARBO may feel out of place. One of the people we met, who was younger than 65 years, was living in a care home registered for older people and had retained skills of daily living. In his care plan it was noted they were Hindependent with all personal care tasks" and Hrequired minimal assistance". Information provided suggested that they were "not a mixer and preferred to sit in their room most of the time". Although we were told that this person "had never been a mixer", this setting did not really provide much in the way of opportunity to choose to do so. One carer told us their relative was:

> .too *young* to *be in* a *care home* so *we worked with social work and others to get them back to the community. They are much happier now in their own home.*

Those commissioning services must consider whether they are breaching the person's human rights if the person finds themselves compelled to live in a setting which they would never choose.

We had hoped to see the development of more bespoke, innovative approaches to care and support based on the specialist needs of people with ARBO. Our findings were unfortunately similar to our last themed visiting programme to people with AR BO in 2010, namely that some services had developed in response to demand,becoming specialists by expertise rather than designation [3].

We reviewed the websites of care homes to understand the detail of registration and specialisms advertised. In some cases we were surprised by the apparent range of age,needs and potential desired outcomes in one registered care setting.

What we expected to find

As discussed above,the majority of the people we met during this visit were either living in a registered service or receiving support from a registered service.We would therefore expect to see care plans in place which address the care,treatment and interventions that a person should receive to ensure that they get the right care at the right time for them.These care plans should focus on individual needs and the person's desired outcomes,recognising the potential for rehabilitation in each case as well as the rights, will and preference of the person.

Our good practice guidance on ARBO highlights five stages of treatment for people with this diagnosis and for most of the people we visited they were inthe final stage of this continuum – long term maintenance and relapse prevention. In this phase, building positive social relationships and developing structure and routine are important to improve outcomes and we expected the care plans to reflect this.

Our good practice guidance notes that successfully preventing alcohol consumption may not only avoid further harm for the person,but may also create potential for the improvement of functioning, and the maximising of opportunities to gain social capital and develop new interests and relationships (4). Consequently we would expect to see care plans which detail how access to and consumption of alcohol is managed and for any care plans which include restrictions inthese areas to be appropriately authorised by a specific power contained within the welfare guardianship order.

As stated previously, ARBO presents complex ethical issues around human rights and respecting autonomy while keeping people safe. Our guidance therefore highlights the importance of multi-disciplinary planning to ensure holistic, personal outcomes are promoted. During this visiting programme we expected to see multi-disciplinary involvement, including advocacy, where appropriate, to ensure the availability of informed advice, guidance and specialist support and to contribute to complex ethical decisions which may be required.

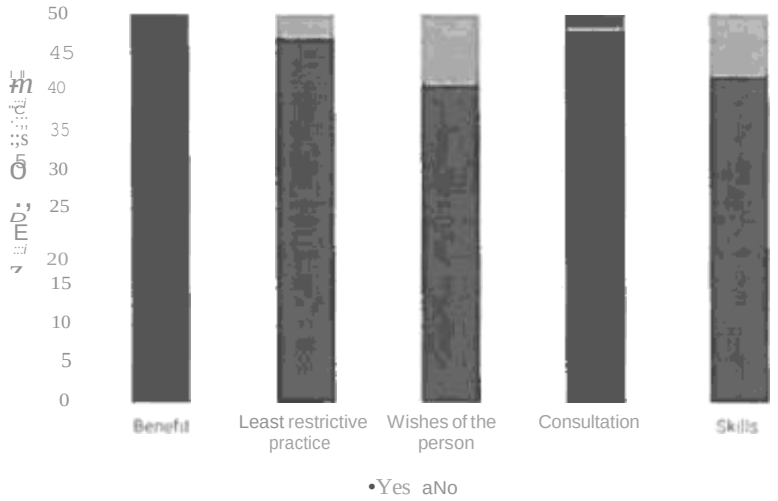
Meaningful activity is an important element of contributing to a good life and for some whose lives have been dominated by using alcohol,opportunities to participate in positive,rewarding activity may have been reduced over long periods of their lives. Finding alternatives to this lifestyle can be a challenge and it is important for anyone who is supporting an adult with ARBO that they understand this and support them to find activities which can enrich their quality of life wherever possible.

We made contact with a number of people who were living in environments which were registered for older people – in some instances we saw people living in care homes where they were 30 years younger than other residents. We expected to find bespoke activities in these instances which recognised the age and preferences of the individual,took account of the person's past and present wishes and also encouraged use of skills (as required by the principles of the AWi Act).

What we found

We looked at whether the key principles of the AWi Act (benefit, least restrictive practice, considering the wishes of the person.consultation with significant others, and exercising and developing skills in relation to relevant decisions) were taken into account. We found that the benefit principle was considered for all.however we found that the wishes of the person were not taken into account for nine people, skills for eight people,least restrictive practice for three and consultation for one (Figure 2).

Figure 2.Application of principles



The aim of the AWi Act is to both protect people who lack capacity to make particular decisions and to maximise their involvement in making decisions about their own lives as far as they are able to do so. We wouldtherefore expect to see all principles fulfilled for all people.

The principles of AWi law are important safeguards. We mention earlier about the dilemmas faced where some parties may determine 'benefit' as a person with ARBO living in a care home with support, with no independent access out with the care setting and no opportunity to buy alcohol. The person themselves may hold the opposite view. There may be a conflict of interest or undue pressure. Failure to take the other four principles into account could render the 'safe' placement as a breach of the person's human rights.

To find nine cases where there was no evidence of the person's wishes being taken into account was a significant concern for us and reinforced the need to ensure advocacy support is available to people receiving continuing care arrangements. Advocacy is one ofthe critically important safeguards to ensure respect for the rights, will and preferences of the person, on an equal basis with others,and not what is considered by others to be in that person's best interests.

There was evidence of care plans in place for all those we made contact with who lived in or received support from a registered care setting (46 people).The degree to which the care plans were person centred varied. In the main,all the care plans we saw covered basic individual needs relating to physical health and personal care. Others included more specific plans around social, recreational, spiritual and financial needs, all of which have a bearing on the person's recovery.

The extent to which alcohol use was addressed also varied. In the 45 care plans we saw, 27 did not include how alcohol was managed. For a number of these, we heard that alcohol misuse was no longer relevant for the person as they had been abstinent for some time whilst for others we heard that alcohol use was prohibited, although there was no care plan which detailed how this was managed or legally authorised.

This picture was complicated because for some of the people whose alcohol use was reported as no longer an issue, this was due to their current living environment which limited or prevented access to alcohol e.g. a hospital or a care home setting.

Of the 16 people for whom there was a care plan which restricted/prohibited alcohol use, 11 of these had an appropriate power contained within the welfare guardianship order. For the remaining five people, this restriction was not legally authorised.

A had been in hospital for almost two years and was preparing to *move to community supported accommodation. Prior to hospital admission, A had a lengthy alcohol dependence and involvement from* a *range of specialist alcohol/addiction services. A had been* assessed *as lacking capacity to make a range of decisions in relation* to *their welfare and the transition to a community setting* was *being authorised by* a *welfare guardianship order with powers to decide where they lived and to return them there in the event that they absconded. There were no powers contained within the order to manage access to and* use *of alcohol, on the basis that this had not been an issue for the duration of their lengthy hospital* stay. *This* was *discussed at length during our visit and highlighted the balance between the least restrictive intervention and ensuring sufficiently robust powers were in place in anticipation of* a *change in living arrangements where risks were historically evidenced.*

For nine of the people we visited, alcohol consumption continued to feature in their day to day lives although for most this was minimal, not deemed to be problematic and was included in a care plan. For a small number, however, this ongoing alcohol use was impacting significantly on their ability to remain safely in their current setting and plans were progressing for a move to a more structured environment with further restrictions on the use of alcohol. For one person, we advised that a review of current welfare guardianship powers should be undertaken to ensure that any additional restrictions would be appropriately authorised.

We visited people who received specialist ARBO services (registered as such with the Care Inspectorate) and the care plans we saw in these instances were more specific to the needs of this group. In one service we saw examples of the use of the Outcome Star care planning model.

This care planning process can cover some or all of the following areas of an adult's life:

- Motivation and taking responsibility
- Self care and living skills
- Managing money and personal administration
- Social networks and relationships
- Drug and alcohol misuse
- Physical health
- Emotional and mental health
- Meaningful use of time
- Managing tenancy and accommodation
- Offending

For each of these areas there is a detailed ladder to help the person work out where they are in that area of their life and what their next step will be. Effective outcomes focussed care planning such as this, maximising independence and achieving outcomes important to the person is the standard we would hope to see consistently for all people with ARBO.

Activities are an integral part of being alive. Thirty-four of the people we saw reported positively on the evident structured, meaningful activities in which they were routinely engaged. We saw a range of activities tailored to individual preferences including swimming, attending local football games, walking groups, cooking and equine therapy. These were often supplemented by activities within care settings (usually organised by activities coordinators) and involvement with family activities. There was a recognition that for some, activities had been significantly curtailed due to Covid-19 restrictions but there was evidence that these were slowly resuming as restrictions began to lift.

In B's case, activities were organised to achieve the outcome he said he wished to achieve:

> *B was accommodated in specialist ARBO supported* accommodation – *after spending* a *significant time in hospital and the preceding period using alcohol excessively whilst living on the* streets, *their goal* was *to* secure *their own tenancy and* to *be self-sufficient. They had said that their life was dominated by using alcohol over* a *number of years and they were unsure how they would find alternative interests which would divert them from resuming their previous lifestyle.*
>
> *Consequently their careplan and meaningful activities were focussed on these outcomes and included self-care, household management, budgeting and exploring activities which could offer* a *more meaningful and positive use of time. This was* a *very practical care plan aimed at realising their personal goal* of *independent living and as* a *result they demonstrated* a strong *commitment and engagement in the* process.

Six people told us that they were unhappy with the level and nature of activity they had. These related mainly to younger adults who were accommodated in care homes primarily catering for older people. There was no evidence of bespoke arrangements in place for them.

Our ARBD:gujdance-hjg blights the-jmpartence of--consicfering-a-cai:e bome-placeme:Rt"aga st= the principles of the AWi Act and the requirement under the United Nations Convention of the Rights of People with Disabilities to respect the "rights, will and preference" of disabled persons. In considering ongoing compulsion under the AWi Act, it is important to consider whether the placement is breaching the person's human rights by imposing a way of life which is unacceptable to them.The answer is to develop more appropriate services.

Advice was given in these instances that the current placements and care plans should be reviewed as a matter of urgency.We will follow this up.

For 22 of the people we made contact with, there was evidence of multi-disciplinary involvement, and for three of these people this included support from a specialist community ARBO service.

The composition of this multi-disciplinary support varied depending on the needs and agreed outcomes of the individual but predominantly comprised of psychiatry, community psychiatric nurses, social workers, mental health officers and third sector providers. In addition, we heard that referrals could be made for additional supports and that links were established with other services to aid ease of access when required. During our visit programme we noted the absence of advocacy support and speech and language therapy in some cases and suggested referrals on the person's behalf which were agreed.

Our good practice guidance highlights the importance of a multidisciplinary approach at various stages of the ARBO pathway. For the majority of the people we visited, their circumstances were indicative of longer term care and relapse prevention and so our findings in relation to the prevalence of the multidisciplinary approach would seem, in the main,to be appropriate.

We heard in some instances that there had previously been involvement from a multidisciplinary team but that the need for this involvement on an ongoing basis was no longer evident. We accept that this is, in some instances, appropriate but would advocate for re-referral if support staff, family/carers witness any material change in the person's presentation which could be indicative of an impact on their capacity so that this can be reassessed.

Abstinence from alcohol, a healthy diet and compliance with prescribed medication can all contribute to an improvement in a person's cognition and functional abilities, as well as their capacity to make informed decisions about their welfare. In these instances, multidisciplinary input can ensure that these changes are recognised and accounted for both in terms of a reviewed care plan and the consideration of the need for ongoing guardianship powers.

Where we saw the involvement of an ARBO service, either community based outreach teams or indeed specialist ARBO providers, there was more evidence of positive outcomes for the person on the basis of enhanced knowledge of the presenting symptoms and a more tailored response to these.

Guardianship supervision

What we expected to find

We expected to find welfare guardianship orders which were supervised in line with AWi codes of practice.

In relation to private guardians, Section 10(1) of the AWi Act states that a local authority must "supervise a guardian appointed with functions relating to the personal welfare of an adult in the exercise of those functionsH.

We expected that the private guardians we met would have an allocated supervising officer from the local authority in which the person subject to the order lived. The supervising officer holds a very important role to support, advise and guide the welfare guardian to fulfil their responsibilities according to the principles of the AWi Act. It is expected that the supervisor would visit the guardian and the person subject to the guardianship order (at an agreed timescale) to monitor the use of and recording of powers and to ensure that the powers are making a positive difference to the person's welfare.

Where the CSWO of the local authority has been appointed as guardian, the duties can be delegated. Section 64(9) of the AWi Act allows the CSWO seven working days, after appointment by the sheriff, to notify the person and the Commission (where incapacity is related to mental disorder) of the name of the person nominated to act on behalf of the CSWO as guardian.

The person nominated to act on behalf of the CSWO is known as the delegated officer and should receive support and supervision to assist them to fulfil this key role. We expected that, for all people we met with a local authority guardianship order in place, a named delegated officer would be in place. The delegated officer's role includes:

- Ensuring they can be contacted by relevant parties
- Ensuring the delivery of the care plan
- Holding regular review meetings
- Monitoring the adult's personal welfare
- Proactive exercise of the powers to promote personal welfare.

We expected to see robust, dynamic review processes which considered the existing care plan, whether t remained appropriate and was meeting the person's outcomes, whether the powers contained within the order continued to be relevant and were being used in line with the principles of the AWi Act. In addition, we expected to find that where care and support was being provided by someone other than the guardian that relevant powers had been duly delegated to the care provider and that there was a record of this delegation. This ensures clarity for providers on the scope and limitations of their use of formal powers to deliver a care plan, particularly where this includes a degree of restrictive practice.

What we found

The 20 private guardianship orders within our sample all had an allocated supervising officer, albeit two were allocated after contact from the Commission as part of this visiting programme. It was noted that although face to face visits had been curtailed during Covid-19 restrictions and that some contacts had been made by telephone, 14 people had been visited in the last 12 months. The remaining six had not been visited for a number of reasons ranging from a proactive decision that ongoing supervision was not required as per The Adults with Incapacity (Supervision of Welfare Guardians etc. by Local Authorities) (Scotland) Amendment Regulations 2014, to no perceived need, Covid-19 restrictions and workload pressures for the supervising officer. One guardianship order appointed a joint private guardian and the CSWO. While a Delegated Officer had been appointed to work alongside the private guardian, there was no Supervising Officer in place. Advice was given to seek the allocation of a Supervising Officer as *we* felt that there could be a potential conflict of interests for this role to be fulfilled simultaneously by the Delegated Officer.

The Adults with Incapacity (Supervision of Welfare Guardians etc. by Local Authorities) (Scotland) Amendment Regulations 2014{6] revised the requirements for the supervision of private guardians. These amendments enabled discussion between guardians and the local authority about the need or not for supervision and the regularity with which this supervision was conducted. In a number of cases, we heard that there are local policies in place which dispense with the need to allocate a Supervising Officer to support a private guardian. We felt that this blanket approach did not take individual circumstances into account and we suggested that the 2014 regulations should be applied to reflect the need for ongoing supervision and to agree an appropriate timeframe for formal supervision to occur.

Where supervision of the welfare guardian has ceased or been varied, practitioners are reminded that they should notify the Commission of the revised arrangements.

Where there was a lack of review, there was reliance on the private guardian or the care provider to raise any welfare concerns with the supervising officer. For an adult with a diagnosis of ARBO, living in a supported placement relieves carers and relatives of some of the issues and stresses they may have had to deal with when the adult was living independently. The placement, however, while offering this protection may not provide a quality of life that is acceptable to the person themselves and the need for an objective assessment of the suitability of the placement and the use of formal powers to authorise it should be seen as a role for the supervising officer. A further protective factor is the involvement of advocacy support; we found little evidence of active advocacy support in the cases we reviewed.

We made contact with 29 people who were subject to local authority orders, all but three of whom had a named delegated officer. We heard that in one area, a delegated officer is not routinely appointed but that in the event that social work intervention is required, a referral to duty social work is the pathway for this. We do not consider this to be in line with the spirit of the legislation. Where a decision has been taken by the local authority to intervene in a person's life on a statutory basis, there should be a lead professional overseeing this intervention to ensure continuity and to ensure that the order is meeting the person's outcomes in line with the principles of the AWI Act.

Similarly, we heard that for some CSWO orders the delegated officer role lies with a review team, not with a named professional. This review team formally review a placement on an annual basis. As we have discussed throughout this report, ARBO is a complex condition which impacts significantly on an adult's cognitive abilities, comprehension, capacity and communication. These complexities may be difficult to take into account where the reviewer is unfamiliar with the person's presentation and conversely where the person does not know the reviewer. It is difficult to understand how a 'one off' annual review meeting can fully assess the effectiveness of an order and the need for the powers on an ongoing basis. The delegated officer role should be an active participant in the assessment process rather than a passive recipient of information received from others.

C is 60 years old and became subject to a CSWO Welfare Guardianship in 2010. The order was granted on an indefinite basis. C is accommodated within a care home. The care home does not have a copy of the guardianship order and there is no evidence that there has been any discussion in relation to the delegation of powers to the care home. C does not have a named delegated officer from the local authority. During the visit we saw care plans which were basic, lacked detail despite the complexities of C's needs and were overdue for review. There was no reference to the powers within the guardianship order within any of the care plans, despite this being a locked door facility and C being unable to leave the premises without support and supervision. C is supported to access money by staff from the care home but this has proved difficult over covid-19 /ockdown as they have been unable to get to the bank. C has substantial savings which they have been unable to access or use creatively over this period. We made recommendations to the local authority to address these observations urgently.

Where we saw the best outcomes for the person with ARBO was when the delegated officer knew the person well, was in regular contact with them and the care provider and was fully familiar with the powers in place and their use. Best practice also included care plans which evidenced full discussion between the delegated officer and the provider detailing the responsibilities and authority of the provider regarding the day to day powers.

In July 2020, the Commission updated the good practice guide *Working with the Adults with Incapacity Act,* aimed at people working in adult care settings. Our expectation is that a record of delegated powers should be retained within records. Within this guidance above, practitioners can find (p.14) a guardianship and power of attorney checklist which will assist in conducting and recording the discussions between the guardian and the provider to ensure clarity of roles and responsibilities [7].

Medical care and treatment

What we expected to find

Part 5 of the AWi Act gives a general authority to treat a person who does not have the capacity to consent to that treatment. Under section 47(4) of the AWi Act, "medical treatment" includes any procedure or treatment designed to safeguard or promote physical or mental health.

The appropriate healthcare practitioner is required to issue a certificate of incapacity for the treatment in question (section 47(1)) and, in doing so, must take full account of the principles of the AWi Act. If the health care practitioner issuing the certificate is aware that a welfare proxy exists, the practitioner, where it is 'reasonable and practicable to do so', should obtain the consent of that proxy section 50(2).

For adults requiring mutiple or complex healthcare interventions, we would expect to see a detailed treatment plan attached to the certificate of incapacity and held in the person's case record. We would also expect to see recording of who had been consulted as part of the process.

We are often asked if a 'section 47 certificate' is required if there is a proxy decision maker with the power to consent or withhold consent to medical treatment. Our guidance is clear that a section 47 certificate of incapacity is still required, as well as the consent of the proxy decision maker.

If the person does not have capacity to be consulted in relation to a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) certificate, we would expect that any DNACPR certificates in place evidenced due consultation with proxy decision makers and took account of the principles of the AWi Act, specifically benefit to the individual, past and present wishes of the individual and consultation with relevant others. The decision regarding DNACPR is however a clinical one.

What we found

With the exception of four people, there were medical powers included in the guardianship order. Where we were told that a section 47 certificate was required to authorise routine care and treatment (38 people), we could see that certificates were in place for 32 people. We followed up on the remaining six. Two people were subsequently deemed to have capacity to consent to routine care and treatment and in the case of four others, advice was given to discuss the need for section 47 certificates with the relevant medical practitioner. It is important to state that if a section 47 certificate is not in place when it should be, the treatment given is unlawful.

Where we saw section 47 certificates (in 32 instances), 24 of these had accompanying treatment plans. For the other eight, we were unable to ascertain if this was because the treatment provided was not regarded as sufficiently complex to warrant a treatment plan or if there was a conscious decision taken that this was not required.

Where section 47 certificates were in place, only half of these evidenced consultation with the welfare guardian. This is a concern. Section 50(2) of the AWi Act determines that a section

47 certificate does not confer authority to treat if there is a known welfare proxy who can be contacted and who does not agree with the proposed treatment. Healthcare practitioners are reminded that this process of consultation with proxy decision makers is a vital component of the authority to treat (the exception being where there is evidence that it would not be reasonable or practicable to do so).

In terms of DNACPR certificates,these were evident in the casefiles of 13 of the people we visited with consultation with proxy decision makers recorded Jn 12 of these. We asked the provider to review this certificate with the medical practitioner to consider if this decision remained appropriate and to ensure that any decision relating to the DNACPR certificate is informed by consultation with relevant parties.

Financial=situation

What we expected to find

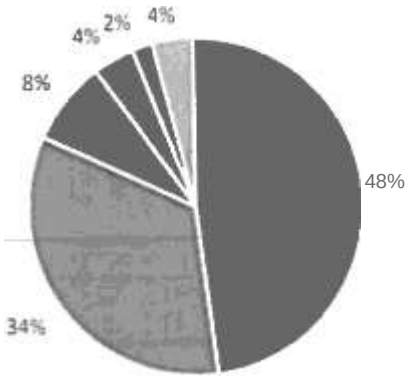
Every person should make their own decisions with regard to financial and property matters. as far as possible, but if someone lacks capacity to make certain decisions and these need to be made by others,this must be done in line with the law and its principles.Our good practice guidance *Money Matters* provides a useful overview for a range of practitioners tasked with safeguarding the welfare and finances of adults who lack capacity [8].

There are legal and ethical issues about how to balance the rights of individuals with the need for intervention where the person may be at risk, including risk of exploitation. For example, those with financial powers may take action to prevent a person with ARBD from having sufficient money to drink alcohol. In such circumstances,we would expect to see evidence of the role of independent advocacy to ensure that people feel empowered to play an integral part in the critical decision making process and to ensure adherence to legislative principles.

What we found

We looked at how the person's finances were managed. About half were managed by a Department for Work and Pension (DWP) appointee and about a third by a financial guardian. In fewer cases the adult themselves, with or without support, a continuing attorney or Part 4 of the AWi Act were the main support systems for the person's finances (Figure 3).

Figure 3.Responsibility of the adult's finances



Although our inquiries suggested that financial arrangements were in place and individuals had appropriate funds available to them, this view was not always shared by the person themselves.

D was *frustrated by the DWP appointeeship in place. They told* us *that they shopped* for *their own food, clothes and bought a pet but did so with staff support. D told* us *that they had no intention to buy alcohol and wanted the freedom to have direct* access to *their own monies. The specialist ARBD team were fully aware of D's wishes, the principles of the Act and the importance of an updated capacity* assessment *involving occupational therapy and psychology* to *inform* a *decision regarding recall or otherwise of the order*.

It was good to see evidence of D at the centre of decision making; whilst they had been offered advocacy support and previously had this, D no longer felt this necessary as they were confident in their ability to express their own views and be listened to.

Family/Carers

What we expected to find

The impact of ARBO on families/carers often results in strained and fractured relationships, with many people becoming estranged from their families. This impact should not be underestimated.

People with ARBO who are still using alcohol may present antisocial behaviour and may be at risk of stigmatisation, exclusion and of being marginalised. This can be difficult for family/carers when seeking support, particularly if they come across the view that the individual is choosing to drink alcohol and therefore making a 'lifestyle choice'. Many relatives/carers often feel that they have nowhere to go for help.

As part of this themed visit we wanted to find out more about family/carers' experience. We spoke with 16 carers who were related to the individuals diagnosed with ARBO. Eleven of those we spoke to had been appointed as the person's welfare guardian.

We wanted to find out more about the circumstances prior to diagnosis and the making of the guardianship order along with the important views of the family/carers post diagnosis and support.

What we found

The majority of those we spoke with told us that they had tried to seek help earlier on in their relative's journey but did not get the help/support that they felt their relative needed at that specific time. They told us that the situation would often end up in a crisis, many times resulting in hospital admissions. Many family members or carers told us that they were shocked by their relative's squalid living conditions, their poor physical health and poor mental health prior to the guardianship order being granted. Below is what we heard from family/carers.

GP was dismissive stating that their drinking was a life choice and relative/carer did not feel that his concerns were listened to or taken seriously.

Family relationships were strained, the family had tried to get support from the GP however had been advised that it was their relative's choice to consume alcohol.

It put a huge strain on family relationships due to the impact alcohol had on her /ife.

It impacted on his whole life with broken relationships with partners and family.

No support for her or her father until diagnosis in 2017.

Seen as a 'problem drinker'.

Spent five, six years trying to get help.

While many of the family/carers who took part in our themed visit reported positively about the care and support that their relative was now receiving, some told us that caring for someone who has ARBO had had devastating and long-lasting effects on the whole family. In terms of relationships, some carers shared with us that roles had been reversed whereby they

were no longer in the role as son/daughter but in fact now parenting their 'parent'. Whilst others told us of the difficulty of being estranged for many years and now being back in their life,their relative sadly now did not always recognise them due to the cognitive impairment.

Eleven of the relatives/carers we spoke with were also the appointed welfare guardians. sometimes making very difficult decisions on behalf of their relatives,at times impacting on their relationships. Hearing these stories evidenced why it is so important that the welfare guardian receives the support they are entitled to in order to fulfil their critical role as guardians but also as son,daughter, sister, brother or whatever important role they fulfil.

We are clear that family/carer involvement should be supported at every level and at every stage as appropriate. Where we found that this had happened we heard about good progress being made and relationships developing and flourishing, for the person and for the family members important to them. Below is some feedback we received from some of the people we spoke with.

He has never been better looked after and he now *has a quality of life he has never had as his sole priority used to be drinking*

He is maintaining his independence and there is a difference in him since he left the care home.

Staff provide the necessary care. support and guidance to ensure he is content and his needs are met.

Since the order was granted and he has stopped drinking alcohol I have seen a huge improvement in his ability to look after himself.

We asked family/carers about any difficulties where their relative was still consuming alcohol. We know that balancing rights, principles of the AWi Act and knowing when to intervene can be difficult for welfare guardians, carers and multidisciplinary staff teams. Most of the relatives/carers told us that their relatives were no longer drinking and they were relieved about that.

Whilst family/carers were relieved that their relatives were generally receiving better care and support now they confirmed our findings that some resources did not provide enough stimulation or fully address the needs of individuals who are younger and more active.

One guardian told us of their #frustration at the lack of resources for people with ARBO". We share this view.

0•1c interventioa

We provided a range of advice and guidance as part of the visiting programme we undertook.

We discussed the contents of our ARBO guidance and shared this with care home staff. We explained the role of the welfare guardian,how this differed to the role of the next of kin and how important engagement and participation is. We explained what is meant by delegating welfare powers to the care home and how this should be recorded. We explained the purpose of section 47 certificates to authorise treatment even where a welfare power existed inrelation to treatment.

Whilst reviewing care plans we found that a number of them contained restrictive practices which were not authorised by the powers within the guardianship order and we asked for this to be reviewed with the private guardians or delegated officers as a matter of urgency.

We advised registered providers to seek a copy of the guardianship order for their records so that they were fully aware of the scope and limitations of the powers and we urged providers to discuss which of the powers contained within an order were being delegated to them on a day to day basis. We have created a document to record this discussion which we hope will be helpful. (9).

We requested that action be taken in relation to section 47 treatment specific certificates where we found that they should have been in place but were not. Where there were gaps in the supervision of guardians we highlighted this and where we thought reviews of capacity or of the placement were necessary we asked that this be progressed. We also asked that an investigation be progressed in relation to finance irregularities. On a number of occasions we asked that consideration be given to referral to advocacy services, noting that advocacy involvement had been in place historically, perhaps in relation to the mental health act, but not now, despite this being necessary for some people we met, in our opinion. We asked that the lack of meaningful activity be addressed for all those who reported to us that this was not acceptable. Where we believed an order not to be safe,we took action to address this.

We will be following up on each individual action discussed as part of this visit programme to ensure that all agreed actions have been completed for the person.

We will also be requesting information from local authorities and health boards about how they have been fulfilling their duties to collaborate to secure availability of independent advocacy services in their area as per the duty imposed under the Mental Health (Care and Treatment)(Scotland) Act 2003. We will continue to report to the Scottish Mental Health Review our view that legislation in relation to incapacity should not simply encourage advocacy use but ensure the person has an express right to this critical support.

We are also keen to better understand the landscape of specialist ARBO services and teams across Scotland and we will work with Health and Social Care Partnerships to map this information and detail. We will also discuss the criteria for care home registration with the Care Inspectorate to both understand this and to support transparency and clarity regarding expectations of service provision.We will complete all actions within six months.

Summary and recommendations

Recommendation 1: Health and Social Care Partnerships should commission suitable, age appropriate and where possible specialist ARBO services.

As described in our good practice ARBO guidance and further evidenced in this programme of visits to people subject to guardianship orders, inappropriate community care home placements can precipitate dependency and isolation for individuals with ARBO. Despite the advent of self-directed support and our guidance we saw limited development of specialist, innovative approaches and services in Scotland to meet the needs of people with a diagnosis of ARBO. Where we did find this, more positive outcomes were clearly evidenced.

Those commissioning services must consider whether they are breaching the person's human rights if the person is compelled to live in a setting which they would never choose.

Recommendation 2: Health and Social Care Partnerships should ensure allocation of the delegated officer role to a named individual to ensure consistency and continuity.

The Chief Social Work Officer delegates the role of guardian to a delegated officer; the Chief Social Work Officer remains accountable however. We found that the critical role of delegated officer was not always held by a named officer who maintained regular contact with the person subject to the restrictions of the guardianship order. We do not consider this to be in line with the spirit of the legislation. Where a decision has been taken by the local authority to intervene in a person's life on a statutory basis, there should be a named delegated officer building a trusting relationship and ensuring that the order is meeting the person's outcomes in line with the principles of the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act').

Recommendation 3: Community care review activity within Health and Social Care Partnerships should be dynamic, coordinated processes which include review of personal outcomes, care plans, placement. the guardianship order and whether all or some of the powers remain relevant.

Multidisciplinary reviews should be dynamic, coordinated processes informed by the principles of the AWI Act, maximising both the contribution of the person and their carers/relatives where appropriate. We found that reviews did not always focus on outcomes, the placement and the powers of the order. It is important to ensure that those involved are not passive recipients of information but have ongoing relationships that allow them to actively contribute to the review process.

Recommendation 4: Health and Social Care Partnerships' strategic advocacy plans should include focus on accessibility of advocacy support at all stages of the care and support continuum.

We have highlighted the challenges of supporting the rights of people with a diagnosis of ARBO to live as they choose balanced with their rights to access support to maximise their quality of life. The offer of advocacy support is an important safeguard to ensure respect for

the rights, will and preferences of the person and not what is considered by other to be that person's best interests. Advocacy support is important prior to the guardianship application stage, post guardianship and throughout the provision of continuing care.

Where recommendations are made to health and social care partnerships, this refers to the joint operational arrangements that exist in a council area between local authority social work services and health care services of the local health board.

Glossary

Advocacy
Advocacy means getting support from another person to help a person express their views and wishes,and to help make sure their voice is heard. Someone who helps an adult in this way is called an advocate

Care Inspectorate
The Care Inspectorate carries out joint inspections with other regulators to check how well different organisations in local areas are working to support adults and children. It helps ensure that social care services, including criminal justice social work, meet high standards. It also publishes inspection reports for every care service in Scotland.

CSWO
Chief Social Work Officer. The Social Work (Scotland) Act 1968 requires local authorities to appoint a single Chief Social Work Officer (CSWO) for the purposes of listed social work functions. The role provides strategic and professional leadership in the delivery of social work services.

HSCP
Health and Social Care Partnership. Whenever the term Health and Sc-cial Care Partnership or HSCP is referenced in the report, this refers to the joint operational arrangements that exist in a council area between the council social work services and the health care services of the bcal health board. All clinical, professional and support staff who work within a HSCP are employed by the health board or the council in the specific geographical area.

MHO
Mental Health Officer.An MHO is a social worker who has been qualified for at least two years before undertaking specialist mental health training which includes mental health law.

PoA
Power of Attorney - someone appointed by a person with capacity to make decisions about their welfare in the event that they lose capacity to do so themselves.

OPG
The Office of the Public Guardian in Scotland was created when the Adults with Incapacity (Scotland) Act 2000 received Royal Assent. It is a single information point about financial provisions contained in the Act.

s.47
Section 47 (AWi) Certificate issued by a doctor where the adult cannot consent to the treatment being given.

Welfare Guardian
A person appointed by the Sheriff Court to make decisions in relation to the welfare of a person who has been assessed as lacking capacity to make these decisions themselves.

References

[1] Cox. S, Anderson I, McCabe L. *A Fuller Life. Report* of *the Expert Group on Alcohol Related Brain Damage,* https://lx.iriss.org.uk/content/fuller-life-report-expert-group-alcohol-related-brain-damage (2004,accessed July 28, 2021).

[2] Mental Welfare Commission for Scotland. *Investigation into the care and treatment* of *Mr H,* https://www.mwcscot.org.uk/node/449 (2006, accessed July 26, 2021).

[3] Mental Welfare Commission for Scotland. *Missed opportunities Findings* from *our visits* to *people with Acquired Brain Injury and Alcohol Related Brain Damage,* https://www.pkc.gov.uk/media/1039/Mental-Welfare-Commission-Missed-Opportunities/pdf/Mental_Welfare_Commission_Missed_Opportunities.pdf?m=636099854250130000 (2010, accessed July 28, 2021).

[4] Mental Welfare Commission for Scotland. *Alcohol-related brain damage (ARBO).* Good *practice guide,* https/www.mwcscot.org.uk/node/225 (2019, accessed July 26, 2021).

(5) Burton JK, Lynch E, Love S, et al. Who lives in Scotland's care homes? Descriptive analysis using routinely collected social care data 2012-16. DOI: 10.4997/JRCPE.2019.103.

(6) The Adults with Incapacity (Supervision of Welfare Guardians etc. by Local Authorities) (Scotland) Amendment Regulations 2014.

[7] Mental Welfare Commission for Scotland. *Working with the Adults with Incapacity Act· for people working in adult care settings. Good practice guide.,* https://www.mwcscot.org.uk/node/1480 (2020, accessed July 26, 2021).

(8) Mental Welfare Commission for Scotland. Money *Matters. Good practice guide,* https://www.mwcscot.org.uk/node/502 (2021, accessed July 28, 2021).

[9] Mental Welfare Commission for Scotland. Guardianship and Power of Attorney Checklist, https//www.mwcscot.org.uk/node/1103 (2017,accessed July 26,2021).

Mental Welfare Commission for Scotland
Thistle House,
91 Haymarket Terrace,
Edinburgh,
EH12 SHE
Tel:0131 313 8777
Fax: 0131 313 8778
Freephone: 0800 389 6809
mwc.enquiries@nhs.scot
www.mwcscot.org.uk

East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 7

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING:	**31st MARCH 2022**
REPORT REFERENCE:	**HSCP/310322/07**
CONTACT OFFICER:	**DAVID AITKEN, INTERIM HEAD OF ADULT SERVICES**
SUBJECT TITLE:	**AUDIT SCOTLAND REPORT – DRUG AND ALCOHOL SERVICES MARCH 2022**

1.1 PURPOSE

1.2 The purpose of this report is to present Audit Scotland's report on Drug and Alcohol Services. The update report was published on the 8th March 2022, and reports on key areas of challenge and areas for improvement in Scotland.

2.1 RECOMMENDATIONS

It is recommended that the Performance, Audit & Risk Committee:

2.2 Consider and note the content of Audit Scotland's report.

CAROLINE SINCLAIR
INTERIM CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.1 BACKGROUND/MAIN ISSUES

3.2 Audit Scotland published the update report 'Drug and Alcohol Services' (**Appendix 1)** on the 8th March 2022. The focus of the report was on progress tackling the high rates of ill health and deaths in Scotland from drug and alcohol related harm. Audit Scotland previously produced a similar report in 2009.

3.3 The report intends to provide a high level briefing and that which provides an update on the key challenges and areas for improvement across Scotland.

3.4 The report's findings are based mainly on analysis of available data, research and following meetings with the Scottish Government, Public Health Scotland and Scottish Drug Forum.

3.5 In 2020 1,339 people died in Scotland from drug related causes which was the highest figure reported. There were also 1,190 deaths due to harmful and problematic alcohol use.

3.6 The report highlights that progress in addressing the challenges have been slow since Audit Scotland first reported in 2009.

3.7 Funding issues within the report and the implications of reduced funding are highlighted. Recent increases in Scottish Government funding from 2021/22 are outlined with a further £20 million being allocated to Alcohol and Drug Partnerships over the next five years.

3.8 The new funding has been provided for new initiatives including drug death taskforce and new evidence based treatment and standards. The report highlights that it is too early to assess the effectiveness of the additional funding, and that it remains difficult to track multiple funding streams, and how this is being distributed nationally and monitored.

3.9 The report advocates greater focus on addressing the causes of alcohol and drug misuse and harm, and a focus upon prevention and tackling inequalities.

3.10 The report also calls on the Scottish Government to develop a clear integrated plan on more transparent financial and other information as to how additional investment can be most effectively used and improve outcomes.

4.1 IMPLICATIONS

The implications for the Board are as undernoted.

4.2 Relevance to HSCP Board Strategic Plan – Relevant to Strategic Priorities one, two three and five. To promote positive health and wellbeing, preventing ill health and building strong communities. Enhance the quality of life and supporting independence for people particularly those with long term conditions. Address inequalities and support people to have more choice and control.

4.3 Frontline Service to Customers – Impact to customers should be reflective of additional investment within East Dunbartonshire and focus upon prevention, recovery and upon tackling equalities.

4.4 **Workforce (including any significant resource implications)** – Additional investment provided by the Scottish Government will require the development and growth or our workforce within alcohol and drug recovery services.

4.5 **Legal Implications** – None

4.6 **Financial Implications** – Elements of additional funding have been made available to East Dunbartonshire Alcohol and Drug Partnership. Funding streams have in the main been ring-fenced to support progress against specific areas of work such as residential rehabilitation. Audit Scotland's report identifies concerns that the provision of additional funding may not be sufficiently coordinated or holistically focussed.

4.7 **Procurement** – East Dunbartonshire HSCP is currently reviewing commissioned services in both Alcohol and Drug and Mental Health Services with a view to developing more integrated and recovery focussed services and the development of a collaborative commissioning based approach.

4.8 **ICT - None**

4.9 **Economic Impact** – None

4.10 **Sustainability** – Additional funding proposed for five years.

4.11 **Equalities Implications** – The report highlights that stigma for those who experience challenges with alcohol and drug misuse remains a significant barrier to accessing treatment and support and our approach locally retains tackling stigma at the heart of it's service delivery and offer of support to our communities.

4.12 **Other** - None

5.1 **MANAGEMENT OF RISK**

The risks and control measures relating to this Report are as follows:-

5.2 The Alcohol and Drug Partnership Strategic Plan, and annual Delivery Plan sets out the key risks for the partnership and action plan which mitigates these risks. A specific Action Plan has been developed to seek to tackle the rise of drug related deaths in East Dunbartonshire.

6.1 **IMPACT**

6.2 **EAST DUNBARTONSHIRE COUNCIL** - None

6.3 **NHS GREATER GLASGOW & CLYDE** - None

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction Required

7.1 **POLICY CHECKLIST**

7.2 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.1 **APPENDICES**

8.2 Appendix 1 – Audit Scotland 'Drug & Alcohol Services – An Update'

Drug and alcohol services

An update

AUDIT SCOTLAND

Prepared by Audit Scotland
March 2022

Key messages

1 In Scotland, 1,339 people died from drug-related causes in 2020 – the highest ever reported and the highest rate in Europe. Although the number of people dying from alcohol had started decreasing in the early 2000s, it began increasing again around ten years ago and there were 1,190 deaths in 2020. Problem alcohol use also causes wider harm from other related health conditions, crime and economic costs. Long-standing inequalities remain, with people living in the most deprived areas most affected by drug and alcohol use.

2 Progress addressing these challenges has been slow since we first reported on drug and alcohol services in 2009, with a lack of drive and leadership by the Scottish Government. Delivery of drug and alcohol services is complex, with many organisations working across different sectors, and clearer accountability across all partners is needed.

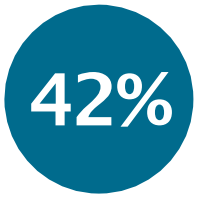
3 Overall funding to alcohol and drug partnerships reduced over several years but by April 2021 it returned to around the level it was six years ago in cash terms, but with no real terms increase in funding. From 2021/22, ADPs will receive a further £20 million each year over five years. The Scottish Government has provided additional investment over the last few years for new initiatives, including a drug deaths taskforce and new evidence-based treatments and standards. However, it is too early to assess their effectiveness and it is still difficult to track spending and how it is being distributed and monitored.

4 Work is under way to evaluate new initiatives and improve data, but there are still gaps. More focus is needed on addressing the root causes of drug and alcohol dependency and breaking the cycle of harm affecting multiple generations across communities. The Scottish Government needs to set out a clear integrated plan on how additional investment can be used most effectively and demonstrate how it is improving outcomes. Good quality, frequent and timely data will be crucial in supporting clear performance measurement and public reporting.

Key facts

Drug-related deaths

- Drug-related death rate highest since 2011 for people aged 35-44 years old (61 per 100,000 population)
- In 93% of all drug-related deaths more than one drug was present in the body
  - 89% opiates/opioids, such as heroin/ morphine and methadone
  - 73% benzodiazepines, such as diazepam and etizolam.



42% of those who recently used drugs reported the use of heroin. The next most frequently reported were:

- cocaine/crack cocaine (36%)
- diazepam (29%) and cannabis (29%).

9.4 litres of pure alcohol sold per adult in Scotland (18 units per adult per week)

- lowest level recorded since 1994
- 6% higher than in England & Wales.

People in the most deprived areas were 18 times as likely to have a drug-related death as those in the least deprived areas, and 8 times more likely to have an alcohol-related death or hospital stay

15% of concerns raised at child protection case conferences related to parental substance misuse (1,135 of 7,315)

Note all figures are for 2020.

Drug-related deaths include all deaths with an underlying cause of drug poisoning or drug abuse where substances involved are controlled in the UK (subject to high levels of regulation because they are addictive or harmful). This means that deaths from other drugs such as aspirin or paracetamol are not included (there were a further 122 drug poisoning deaths excluded from the drug-related deaths count).

Introduction

1. In 2019, we provided an update on progress in tackling the high rates of ill health and deaths in Scotland from drug and alcohol-related problems since our last report in 2009. We highlighted that deaths and morbidity remained high in Scotland compared to the rest of UK and Europe and problem drug and alcohol use was still very much linked to deprivation. These issues remain and the First Minister has described the rising drugs deaths in Scotland as an emergency and a national disgrace.

2. This high-level briefing provides a further update on the key challenges and areas for improvement, which we plan to follow up with more detailed work. Our findings are based mainly on analysis of publicly available data, desktop research and meetings with the Scottish Government, Public Health Scotland and the Scottish Drug Forum.

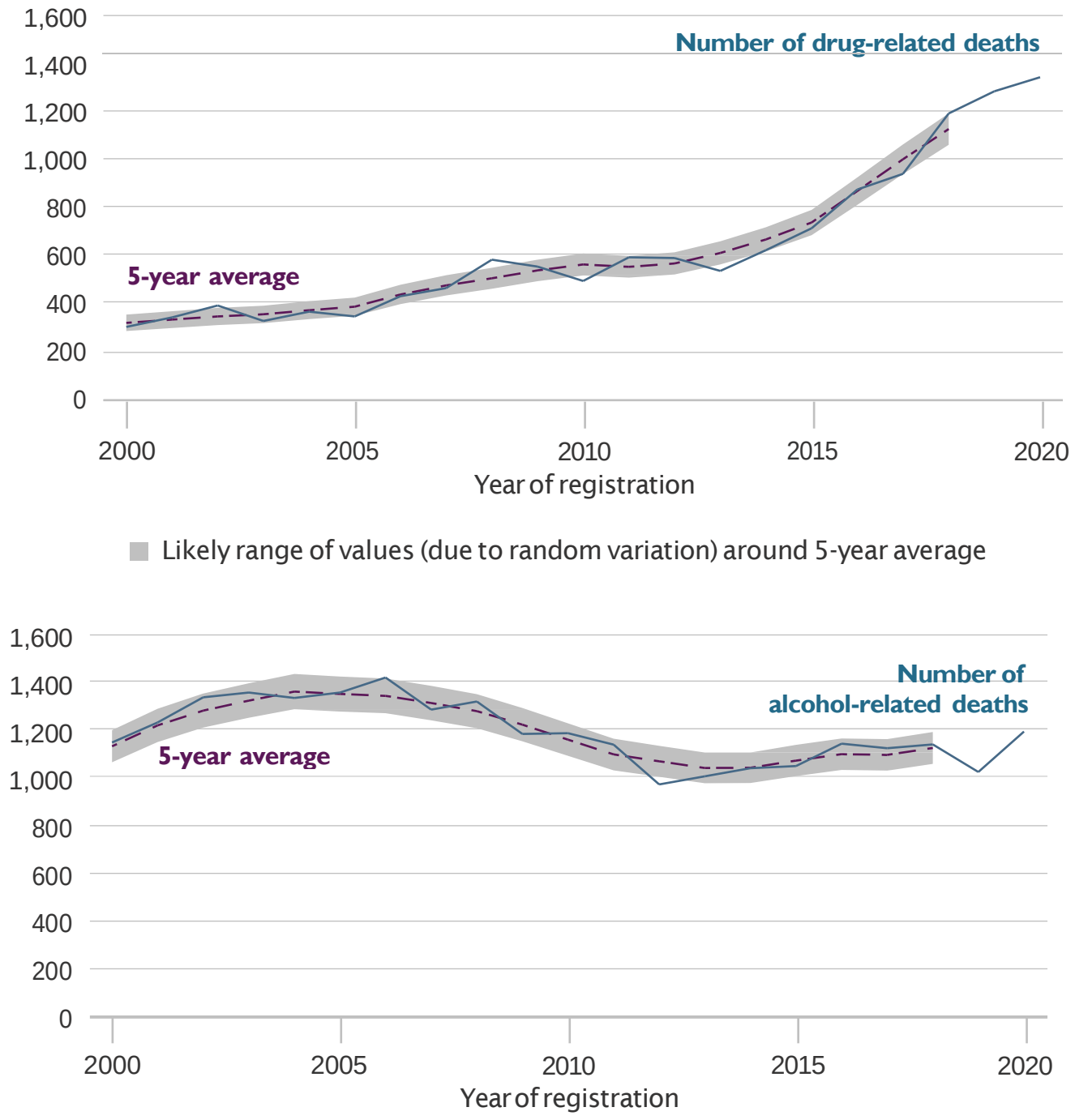
Drug and alcohol deaths continue to increase and inequalities remain

3. Most drug-related deaths are in people aged 35-54, but this is increasing across all age groups, particularly in people aged 25-34. Alcohol-related deaths reduced and levelled off over the last 15 years but are showing signs of increasing again (Exhibit 1, page 6). Deaths are still predominantly among people living in the most deprived areas. Rates of drug-related hospital stays have increased sharply since 2012/13, from 149 to 284 stays per 100,000 population in 2019/20, with a slight decrease to 270 stays per 100,000 population in 2020/21. Alcohol-related hospital stays have gradually decreased for over ten years but are much higher at 614 stays per 100,000 population in 2020/21. Alcohol is a significant contributor to ill health, including cancer and liver disease, and to crime and family breakdown. This in turn leads to costs to the economy.

Exhibit 1

Trends in drug and alcohol-related deaths in Scotland

Drug-related deaths have increased sharply since 2013 and alcohol-related deaths started increasing around ten years ago after decreasing in previous years.



Source: Drug-related deaths in 2020, published July 2021 and Alcohol-specific deaths in 2020, published August 2021, National Records of Scotland

New initiatives have been introduced over the last few years, but it is too early to assess their effectiveness

4. We noted some successes and innovations in our last update. However, there was a lack of evidence of the impact that services were having on their local communities and stigma remained a significant barrier to treatment and support. Cost effectiveness and value for money of the investment made over the last ten years had not been set out.

5. The Scottish Government published an alcohol and drug treatment strategy, 'Rights, Respect and Recovery', in November 2018. It is founded on a human-rights based, public health approach and sets out the following main challenges:

Image reproduced from Rights, Respect and Recovery: alcohol and drug treatment strategy, Scottish Government, November 2018

6. Over the last 12-18 months the Scottish Government has strengthened its approach with increased resources in a new drug policy division and alcohol treatment team. Recently it has increased support to local alcohol and drug partnerships (ADPs) and has regular regional meetings to discuss issues and share learning. In October 2019, the government set out actions, milestones and timeframes up to March 2021 for implementing its strategy. Over the past three years, key developments include:

- July 2019 – a drug deaths taskforce set up to 'coordinate and drive action to improve the health outcomes for people who use drugs, reducing the risk of harm and death' (paragraph 9, page 10).
- December 2020 – a Drug Policy Minister appointed to lead work on tackling and reducing the harm of drug misuse.
- January 2021 – a national mission to reduce drug-related deaths and harms, supported by an additional £250 million funding (£50 million each year until the end of the parliamentary term in 2026).
- From early 2021 – expansion of distribution of take-home naloxone kits to give to people at high risk of accidental opioid overdoses to prevent deaths, including administration by ambulance crews and carried by police.
- June 2021 – new medication assisted treatment (MAT) standards introduced to improve practice in the use of medication, such as opioids, together with any psychological and social support, in the treatment and care of people who experience problem drug use. These aim to give people access, choice and support through drugs services, and are due to be embedded across Scotland by April 2022.
- December 2021 – a campaign launched to tackle drug and alcohol stigma.

7. Another key area of the government's focus has been drug and alcohol residential rehabilitation services. One of the aims of the national mission is to increase capacity in and use of residential rehabilitation. In June 2020, a residential rehabilitation working group was set up to advise Scottish ministers on a programme of work to improve access to rehabilitation services and it made initial recommendations in December 2020. The Scottish Government has committed significant investment to support this - £100 million of the £250 million investment committed to tackle drug deaths over the current parliamentary term. A report was published in November 2021 to inform where funding can most effectively be directed and to help identify barriers and facilitators to accessing residential rehab for those who need it. The Minister for Drug Policy made a commitment to increase the number of publicly funded placements by more than 300 per cent over five years to at least 1,000 people every year by 2026. Public Health Scotland is monitoring the number of placements being funded by ADPs.

8. It is likely that the Covid-19 pandemic has affected drug and alcohol services, such as increasing waiting times and access to treatment. However, it is too soon to show in the current available datasets because of the time lag and periodic reporting of drug and alcohol outcomes data. More regular reporting of service performance is needed to make timely assessments of the impact of improvement activity. In April 2020, the Scottish Government set out how it was supporting services during the pandemic. It provided £166,000 as small grants to help address the impact of Covid-19 on alcohol and drug services. This included increased capacity for helplines, online support and support for family members, and increased access to naloxone in new settings.

Work is under way to evaluate new initiatives and improve data

9. It is too early to assess the effectiveness of many of these recent developments, but evaluation work is under way:

- Public Health Scotland (PHS) published a monitoring and evaluation framework for Rights, Respect and Recovery in March 2020. It sets out indicators for monitoring progress with improving outcomes. It also identifies gaps in data and areas for evaluation. Work is ongoing to improve the data available to help monitor and evaluate progress. The Scottish Government and PHS are developing a new framework to incorporate work related to the national mission and residential rehabilitation. An interactive dashboard, which is regularly updated, is available to view indicators linked to outcomes set out in the framework, where the data is available. The indicators are grouped under four categories: prevention and early intervention; recovery-oriented care; public health approach to justice; family support; and health and social harms.
- There has been a considerable delay in the implementation of the Drug and Alcohol Information System (DAISy) national database. This was developed to collect drug and alcohol referral, waiting times and outcome information from staff delivering specialist drug and alcohol interventions. DAISy was due to go live in late 2019 but was delayed until April 2021. There have been challenges with the completeness and quality of data submitted by services, for example, for waiting time data. Work is ongoing to improve data gaps, for example on access to rehabilitation services. Information will be published from the database as it develops. National drug and alcohol treatment waiting times for the quarter April to June 2021 due to be published in September 2021 were published in February 2022.

- The drug deaths taskforce has set out funding and timescales for each project it is currently undertaking. It made recommendations to ministers in January 2021 on accelerating the impact of its work and published an interim report in June 2021 with an update on progress.

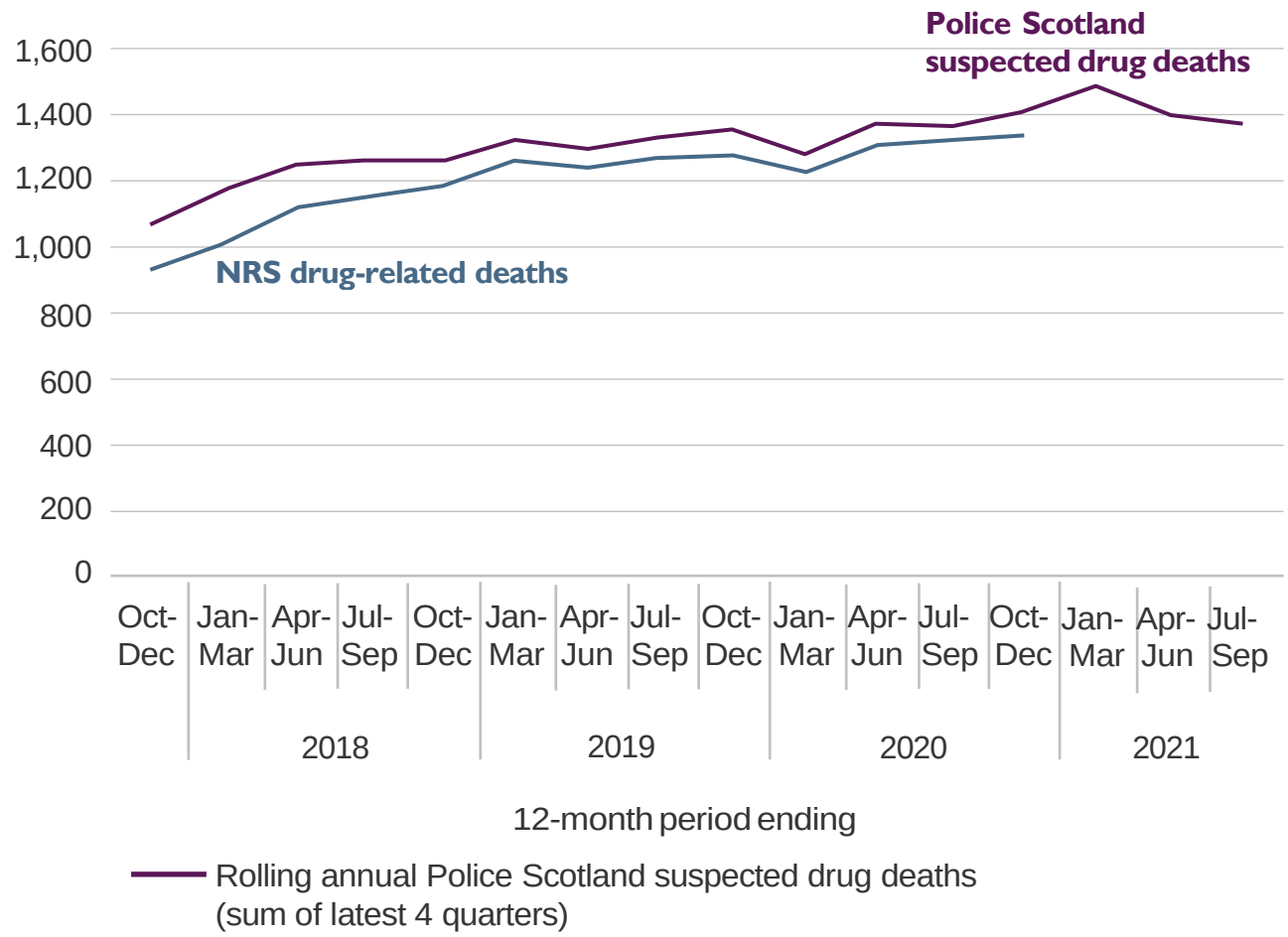
10. Some of this work was paused due to the pandemic or is being refocused to align with the national mission announced by the Drug Policy Minister in January 2021. In late December 2021, the chair and deputy chair of the drug deaths taskforce resigned because they reportedly felt the pace of change being asked by the minister would not allow enough time to implement sustainable change based on evidence. A new taskforce chair and vice chair were announced in January 2022. The minister has asked the taskforce to bring forward its final recommendations planned for December 2022 to the summer.

11. Other planned work in 2022 includes ongoing evaluation of alcohol minimum unit pricing (MUP), evaluation of alcohol brief interventions, developing UK-wide clinical guidelines for alcohol treatment, piloting a managed alcohol programme in Glasgow, and developing new treatment targets for 2022/23 for the numbers of people in treatment. In our 2019 update, we highlighted that it would be helpful to review the appropriateness of the national waiting time target for access to drug and alcohol services within 21 days, which can be too long for people needing treatment. We also highlighted a need to address high 'did not attend' (DNA) rates, especially as it had been shown that a high proportion of people who died of drug-related causes had never had contact with a drug treatment service. This should be considered as part of the work being carried out in 2022.

12. As well as gaps in drug and alcohol data, there is also a considerable time lag in public reporting. As part of its commitment to improve data and surveillance, the Scottish Government began publishing quarterly statistics in September 2021 on suspected drug deaths. These are estimated figures based on information from Police Scotland and supplement the annual statistics published by National Records Scotland on drug-related deaths. The latest update shows 1,007 suspected deaths from January to September 2021, four per cent (40) fewer deaths than during the first nine months of 2020 (Exhibit 2, page 11).

Exhibit 2

Suspected drug deaths in Scotland by quarter, Oct 2017 to Sep 2021



Source: Suspected drug deaths in Scotland: July to September 2021, Scottish Government, December 2021

Funding for tackling problem drug and alcohol use reduced over several years but has recently increased significantly

13. In 2016/17, Scottish Government annual core funding to ADPs reduced by over 20 per cent in cash terms to £53.8 million (in the previous two years ADPs received a total of £69.2 million per year). ADP funding began to increase again from 2018/19 and stood at £76.8 million in 2020/21:

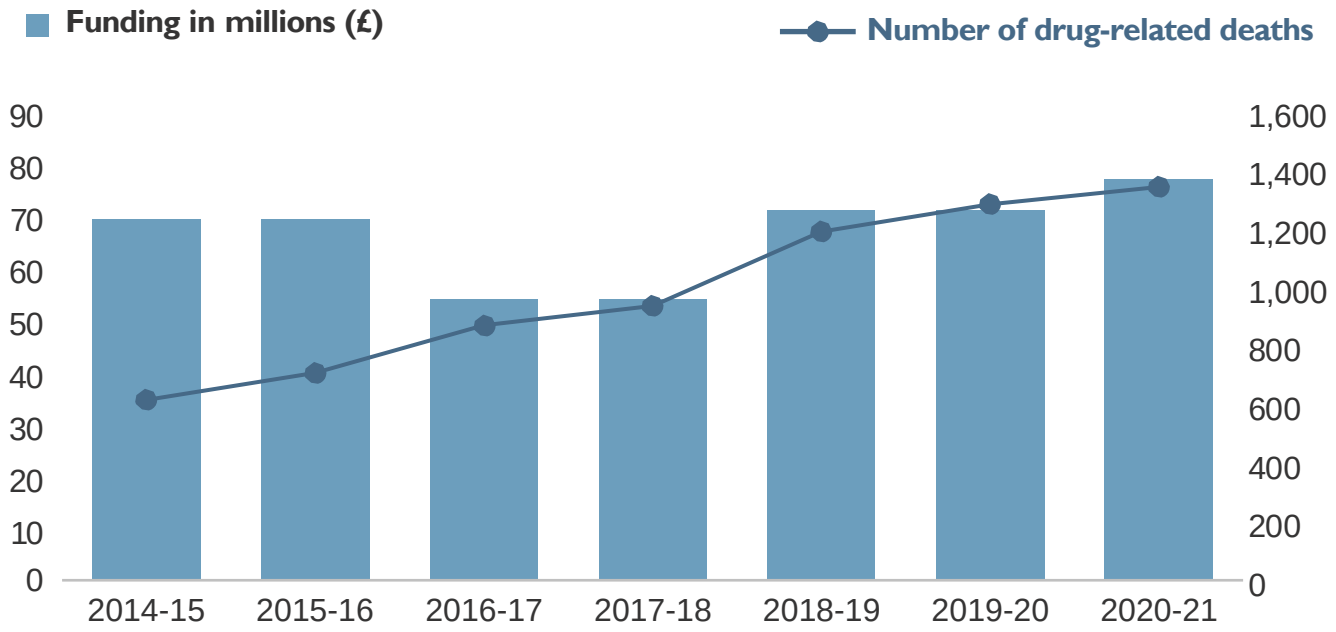
- In the 2017/18 programme for government, an additional £17 million was allocated to ADPs to increase annual funding to £70.8 million from 2018/19 to 2020-21. A further £3 million was made available through a National Development Project Fund which ADPs could apply for awards for projects.
- In 2020/21, an additional £3 million was allocated to ADPs to increase provision of residential drug rehabilitation placements and improve access to treatment and harm reduction activities. Plus, a further £3 million to support the work of the drug deaths taskforce.

14. This means that Scottish Government funding to ADPs returned to similar levels to around six years ago in 2020/21 with no real terms increase in funding. Over this same period drug-related deaths continued to increase year on year (Exhibit 3).

Exhibit 3

Total number of drug-related deaths and funding to ADPs in Scotland, 2014/15 to 2020/21

Funding for ADPs has fluctuated since 2014/15 while the number of drug related deaths has continued to increase.



Source: Alcohol and Drug Partnerships funding allocations, 2014/15-2020/21, and additional funding information provided by the Scottish Government; Drug-related Deaths in Scotland, 2014-2020, National Records of Scotland

Spending on drug and alcohol services is difficult to track and needs to be more transparent

15. In our 2009 report, we highlighted that funding arrangements for drug and alcohol services were complex and fragmented which made strategic planning difficult. It is still difficult to track spending and how it is being distributed and monitored. The Scottish Government does not publish a full breakdown of all funding in one place and information is incomplete, disparate and presented inconsistently. Various funding announcements are published in different places, including the Scottish Government and Parliament websites, and programme for government and budget documents. Funding is not reported in one place and a full breakdown of funding for ADPs is not available. Currently only core funding is published and does not include funding from other streams.

16. In addition to ADP funding, the government has allocated other additional funding since 2018/19 over three years, including £2 million to a challenge fund for preventing homelessness and £1 million to support national and local projects on advocacy services and testing new approaches to recovery. In September 2021, the Programme for government made a commitment to invest an additional £250 million over the term of this Parliament in the national mission to reduce drug deaths – £50 million each year – with £100 million to be spent on residential rehabilitation over the five years. Overall, the government aims to support better outreach, treatment, rehabilitation, and aftercare services in every council. However, a breakdown of the £50 million has not been published with details of how much will be spent on each area or how the funding will be distributed. Between 2014/15 and 2019/20, overall funding for drug and alcohol services decreased by six per cent in real terms (a slight increase in cash terms from £73.4 to £75.3 million). The recent additional funding announcements by the Scottish Government, mean the real terms increases in funding from 2014/15 were a 16 per cent increase in 2020/21 (total funding was £98.2 million) and a 67 per cent increase in 2021/22 (total funding was £140.7 million).

17. More transparency is needed by the Scottish Government on how much is spent overall on drug and alcohol policy and services. This includes more clarity on the different funding streams, which organisations are receiving funding, the purpose of funding and how decisions are made on prioritisation and distribution of funding.

More focus is still needed on prevention and tackling inequalities

18. In our 2019 update, we highlighted that there is strong evidence that public health prevention programmes are cost-effective in drug and alcohol services. However, the Scottish Government had not identified the level of investment in prevention required to achieve maximum benefit. And it was not clear what percentage of spending in this area was targeted on early intervention and prevention. The Scottish Government has still not clearly set this out.

19. Ten years ago, the Christie report recommended a shift towards prevention through partnership working and putting people at the heart of public services. Supported by better planning and performance measurement, this should lead to improved long-term outcomes for individuals and communities. However, as set out by the Auditor General and Accounts Commission, Scotland is still facing multiple inequalities and spending could be more effectively targeted at interventions tackling the root causes of drug addiction in communities. Public services are important to achieving a fair and just society by supporting disadvantaged and vulnerable people but the focus on putting the person at the centre of service delivery is still not the norm.

20. The recent Hard Edges Scotland report showed the nature of severe and multiple disadvantage in Scotland, with 191,000 people having experience across substance dependency, offending or homelessness in a typical year. The report highlights the significance and long-lasting impact of childhood harms, such as poverty, mental illness, and homelessness, leading to problems in adulthood and how some harms experienced by parents go on to affect their children in adulthood. For example, around three per cent of babies born in the UK are affected by foetal alcohol spectrum disorder from alcohol consumption during pregnancy. This means up to 172,000 people could be affected by the disorder in Scotland, which can include brain damage and physical issues, such as poor growth and a smaller head.

21. The Scottish Drugs Forum (SDF) identifies poverty in Scotland as the root cause of the drug deaths crisis, which has not been seen in other comparable European countries. SDF states that wider government policy will have a greater effect than drug policy alone and is needed to break the cycle of intergenerational problem drug use. Childhood harms also have a financial impact, directly from the cost of the wide range of services needed to support people experiencing drug and alcohol problems, and the wider economic impact of reduced life chances. There are similarities to be drawn with care experienced adults. A series of reports produced by the Independent Care Review in February 2020, known as The Promise Scotland, included an economic model on human costs. This showed that care experienced adults are one and a half times more likely to experience severe multiple disadvantage, including substance use, homelessness, mental health issues and offending:

Image reproduced from Follow the money, The Promise, Independent Care Review, February 2020

Delivery of drug and alcohol services is complex and clearer accountability is needed

22. There are 31 ADPs in Scotland which bring together local partners including NHS boards, councils, police and voluntary agencies. ADPs are responsible for commissioning and developing local strategies for tackling problem alcohol and drug use and promoting recovery, based on an assessment of local needs. There are many organisations and structures involved in delivering services, and governance is

complicated and difficult to navigate. There is a role for ADPs, integration authorities and community planning partnerships (CPPs) but accountability is not always clear.

23. In 2019, the Dundee Drugs Commission found a lack of leadership across all services to facilitate the changes required to effectively reduce increasing drugs deaths in Dundee. The absence of a clear governance structure meant that change was not being monitored and implemented effectively. There was a lack of accountability and of clarity of roles and influence across the ADP, integration joint board (IJB) and CPP. Services were outdated, fragmented and unable to effectively share information.

24. We highlighted difficulties around governance, accountability, collaboration and sharing data in our 2018 health and social care integration report. We reported in our 2019 update that ADPs need to improve partnership working with wider services, for example children and families and community justice, on more preventative and early intervention approaches. The Scottish Government and COSLA agreed eight recommendations to improve the governance and accountability of alcohol and drug services. They have been developed to implement the Partnership Delivery Framework for Alcohol and Drug Partnerships published in July 2019. One of the main aims of the national mission is a focus on prevention and a more joined-up approach across policies to address underlying issues.

Issues with drug misuse in the criminal justice system

25. In January 2022, a report by the Criminal Justice Committee identified several issues in relation to the misuse of drugs and the criminal justice system. These included:

- A lack of access to treatment – only 35 per cent of the 60,000 people with drug problems in Scotland are in treatment, compared to 60 per cent in England (although data recording and measurement differs).
- Problems providing alternatives to prosecution or custody where community-based support and referral to drug services would be more beneficial to people charged with drug offences.
- A lack of support for people with drug problems before, during and after their prison sentences.
- The need for more training of police officers and others working in the justice system to become 'trauma informed', so they understand health issues and the underlying causes of drug use. This would facilitate a more appropriate and compassionate response.

26. Many of the committee's findings and recommendations overlap or complement those already made by the drug deaths taskforce. However, the committee believes there is a gap between policy and practice, and it would like to see much faster progress being made on implementing the recommendations of the taskforce. The committee makes several recommendations on increasing access to various treatments, increased support for prisoners, and more emphasis on preventative measures and addressing the health and societal disadvantages.

27. Members from the Criminal Justice Committee, Health, Social Care and Sport Committee and the Social Justice and Social Security Committee held two joint, public meetings in February 2022. Evidence on reducing drug deaths in Scotland and tackling problem drug use was taken from the Minister of State for Crime, Policing and Probation, UK Government and the Chair of the Scottish Drug Deaths Taskforce and Minister for Drug Policy, Scottish Government. In both sessions there was a lot of discussion about the viability of safe consumption rooms in Scotland, a model the Scottish Government is keen to introduce. These have been operating in many European countries since the 1990s. However, legislation on the misuse of drugs is a reserved UK matter and the UK government is not in favour of making changes to the current legislation that would facilitate lawful use of illicit drugs. The Drug Policy Minister said the Scottish Government is doing all it can to find a solution to this.

Implications of a new National Care Service

28. The Scottish Government's consultation on a new National Care Service (NCS) identifies the challenges facing people with drug and alcohol problems who often have multiple and complex needs, including the lack of joined-up services. It can be difficult to create individual care plans for people across health and care systems to provide joined-up care and many people face stigma which can prevent them seeking help or progressing towards recovery.

29. The consultation document poses questions about ADPs as to whether changes can be made to make them more effective and whether they should become part of the NCS nationally or part of proposed local Community Health and Social Care Boards (new bodies proposed to replace IJBs for local delivery of community health and social care in Scotland). It also asks whether specialist provision, such as residential rehabilitation services, should be commissioned by the NCS and whether other services might be organised on a national level.

30. In February 2022, the Scottish Government published an analysis of responses to the consultation. In relation to drug and alcohol services, the main findings were:

- A majority agreed that if included in the remit of an NCS, ADPs would have the benefits of providing greater coordination of drug and alcohol Services (81 per cent) and better outcomes for people accessing care and (75 per cent).
- Confused leadership and accountability was viewed as the main drawback of ADPs and three quarters agreed that they should be integrated into Community Health and Social Care Boards.
- Eight in ten agreed that residential rehabilitation services could be better delivered through national commissioning.

A clear integrated plan is needed to show how investment is improving outcomes

31. The Scottish Government and partners have increased their focus and efforts to tackle drug and alcohol misuse since our last update in 2019. This includes increased funding and focus on key areas for improvement. However, it is too soon to assess impact and more could be done to join up the various strands of work and funding streams to show how they are collectively improving outcomes. To increase transparency and demonstrate value for money, the Scottish Government should implement the following:

- An overarching plan showing how the aims and actions of the Rights, Recovery, and Respect strategy, the national mission and drug deaths taskforce link together and report annually on progress.
- An overall plan showing how evaluation activities link to actions and inform prioritisation of funding to evidence-based approaches.
- Set out in one place the overall funding for drug and alcohol services and support, with a breakdown of the main funding streams and how much is going to ADPs and other agencies. Report spending against budgets annually, including any underspending and redirection of funding.
- Use the information set out above, along with the existing monitoring and evaluation framework and national database, to assess the cost-effectiveness of funding in drug and alcohol services and the level of investment in prevention needed to achieve maximum benefit.

- Demonstrate what impact drug and alcohol policy and investment is having on improving outcomes using clear measures and public reporting. Current data gaps and time lags in reporting will need to be addressed to achieve this.

32. The Auditor General and Accounts Commission have an ongoing interest in how drug and alcohol services are being delivered and the impact this has on people and their families needing support. We plan to carry out more detailed work in this area in the next 12-18 months. Other related work includes a review of adult mental health services and a social care audit. You can find more information on our dynamic work programme on our website.

Drug and alcohol services:
An update

Audit Scotland's published material is available for download on the website in a number of formats. For information on our accessibility principles, please visit:
www.audit-scotland.gov.uk/accessibility

For the latest news follow us on social media or **subscribe to our email alerts**.

AUDIT SCOTLAND

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

ISBN 978 1 913287 72 6 AGS/2022/4

East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 8

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING:	**31st MARCH 2022**
REPORT REFERENCE:	**HSCP/310322/08**
CONTACT OFFICER:	**JEAN CAMPBELL, CHIEF FINANCE & RESOURCES OFFICER (07583902000)**
SUBJECT TITLE:	**AUDIT SCOTLAND – SOCIAL CARE BRIEFING**

1.1 PURPOSE

1.2 The purpose of this report is to present the Audit Scotland Briefing on Social Care.

2.1 RECOMMENDATIONS

It is recommended that the Performance, Audit & Risk Committee:

2.2 Note the contents of the Audit Scotland Briefing on Social Care.

CAROLINE SINCLAIR
INTERIM CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.1 BACKGROUND/MAIN ISSUES

3.2 The briefing summarises the key challenges and recent progress in social care in Scotland. While this briefing acknowledges the work planned by the Scottish Government and stakeholders, it notes that work in many of these areas cannot await the creation of a new organisation. The associated changes to governance and management structures will require legislation and several years to implement.

3.3 The key messages from the report are set out below:

- There are huge challenges facing the sustainability of social care, and the integration of health and social care more widely. There are good examples of improved service delivery, but despite efforts made by the Scottish Government, Integration Authorities, NHS, local government, and their partners in recent years, the pace of change has been slow. At the same time, the pressures from increasing demand and demographic changes are growing. Although a lot of public money is spent on social care (£5.3 billion in 2019/20), progress in moving to more preventative approaches to delivering social care has been limited. This has led to tighter eligibility criteria being applied for accessing care and increasing levels of unmet need.

- Service users and carers do not always have a say or choice about what support works best for them. Bringing together their views, knowledge and experience is critical if the Scottish Government is to deliver its long-standing ambitions for social care. There are around 700,000 unpaid carers who provide most of the social care support in Scotland. Many carers are forced to give up work because of their caring responsibilities and most are not aware of their rights under the Carers (Scotland) Act 2016.

- The 209,690 people working in social care are under immense pressure, and the sector faces ongoing challenges with recruitment and retention. Staff are not adequately valued, engaged, or rewarded for their vitally important role. The workforce is predominantly female and poor terms and conditions for staff contribute to recruitment difficulties, rising sickness absence and high vacancy levels. This puts the capacity, sustainability, and quality of care services at a considerable risk.

- Other challenges identified through this and past audit work include:

    - Commissioning tends to focus on cost rather than quality or outcomes. Current commissioning and procurement procedures have led to competition between providers at the expense of collaboration and quality.
    - A high turnover of senior staff in councils, the NHS and Integration Authorities, increasing short-term posts and an ageing workforce are affecting leadership capacity. Cultural differences between partner organisations are a barrier to collaborative working.
    - An inability or unwillingness to share information, along with a lack of relevant data, means that there are major gaps in the information needed to inform improvements in social care.

- The Scottish Government is planning significant changes in social care over the next five years. This includes the introduction of a new National Care Service (NCS) which will need legislation to implement it. Work is under way, but there is much to do, including establishing the true costs of reform. Stakeholders have raised concerns

about the scale of reform and the time it will take to implement it. They told us about services in near-crisis, and that a lack of action now presents serious risks to the delivery of care services for individuals.

- Regardless of what happens with reform, some things cannot wait. A clear plan is needed now to address the significant challenges facing social care in Scotland based on what can be taken forward without legislation, which could provide strong foundations for an NCS. The Scottish Government should develop this quickly, with clear timescales, to remove any uncertainty about the future direction of social care, building on lessons learned from previous reform.

3.4 The Audit Scotland report is included as **Appendix 1**.

4.1 **IMPLICATIONS**

The implications for the Committee are as undernoted.

4.2 Relevance to HSCP Board Strategic Plan – 1. Promote positive health and wellbeing, preventing ill-health, and building strong communities / 2. Enhance the quality of life and supporting independence for people, particularly those with long-term conditions / 3. Keep people out of hospital when care can be delivered closer to home / 4. Address inequalities and support people to have more choice and control / 5. People have a positive experience of health and social care 7. Improve support for Carers enabling them to continue in their caring role.

4.3 Frontline Service to Customers – None

4.4 Workforce (including any significant resource implications) – None

4.5 Legal Implications – None

4.6 Financial Implications – None

4.7 Procurement – None

4.8 ICT - None

4.9 Economic Impact – None

4.10 Sustainability – None

4.11 Equalities Implications – None

4.12 Other – None

5.1 **MANAGEMENT OF RISK**

The risks and control measures relating to this Report are as follows:-

5.2 The Audit Scotland reports sets out some of the risks associated with the scale of reform required to address the imminent challenges facing social care.

6.1 IMPACT

6.2 EAST DUNBARTONSHIRE COUNCIL - None

6.3 NHS GREATER GLASGOW & CLYDE - None

6.4 DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH – No Direction Required

7.1 POLICY CHECKLIST

7.2 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.1 APPENDICES

8.2 Appendix 1 – Audit Scotland report 'Social Care Briefing'.

Social care

Briefi g

ACCOUNTS COMMISSION

AUDITOR GENERAL

Briefi g prepared by Audit Scotland
January 2022

Key messages

1 There are huge challenges facing the sustainability of social care, and the integration of health and social care more widely. There are good examples of improved service delivery, but despite efforts made by the Scottish Government, Integration Authorities, NHS, local government, and their partners in recent years, the pace of change has been slow. At the same time, the pressures from increasing demand and demographic changes are growing. Although a lot of public money is spent on social care (£5.3 billion in 2019/20), progress in moving to more preventative approaches to delivering social care has been limited. This has led to tighter eligibility criteria being applied for accessing care and increasing levels of unmet need.

2 Service users and carers do not always have a say or choice about what support works best for them. Bringing together their views, knowledge and experience is critical if the Scottish Government is to deliver its long-standing ambitions for social care. There are around 700,000 unpaid carers who provide most of the social care support in Scotland. Many carers are forced to give up work because of their caring responsibilities and most are not aware of their rights under the Carers (Scotland) Act 2016.

3 The 209,690 people working in social care are under immense pressure, and the sector faces ongoing challenges with recruitment and retention. Staff are not adequately valued, engaged, or rewarded for their vitally important role. The workforce is predominantly female and poor terms and conditions for staff contribute to recruitment difficulties, rising sickness absence and high vacancy levels. This puts the capacity, sustainability, and quality of care services at a considerable risk.

4 Other challenges we have identified through this and past audit work include:

- Commissioning tends to focus on cost rather than quality or outcomes. Current commissioning and procurement procedures have led to competition between providers at the expense of collaboration and quality.
- A high turnover of senior staff in councils, the NHS and Integration Authorities, increasing short-term posts and an ageing workforce are affecting leadership capacity. Cultural differences between partner organisations are a barrier to collaborative working.
- An inability or unwillingness to share information, along with a lack of relevant data, means that there are major gaps in the information needed to inform improvements in social care.

5 The Scottish Government is planning significant changes in social care over the next five years. This includes the introduction of a new National Care Service (NCS) which will need legislation to implement it. Work is under way, but there is much to do, including establishing the true costs of reform. Stakeholders have raised concerns about the scale of reform and the time it will take to implement it. They told us about services in near-crisis, and that a lack of action now presents serious risks to the delivery of care services for individuals.

6 Regardless of what happens with reform, some things cannot wait. A clear plan is needed now to address the significant challenges facing social care in Scotland based on what can be taken forward without legislation, which could provide strong foundations for an NCS. The Scottish Government should develop this quickly, with clear timescales, to remove any uncertainty about the future direction of social care, building on lessons learned from previous reform.

Introduction

1. Our previous reports have highlighted the significant challenges facing social care and the integration of health and social care more widely. Other stakeholders have also recognised these challenges, including the Scottish Government, the NHS and local government. Despite the efforts of these stakeholders and their partners, and some good examples of improvements in service delivery, progress has been slow. There is widespread agreement that the way social care is provided still needs to change significantly.

2. Our previous reports have regularly highlighted the following key themes and challenges in delivering improvements in social care:

- the importance of the service user's perspective and voice
- the fragility of the social care workforce
- tensions between cost and quality in the commissioning of social care
- instability of leadership and leaders failing to work effectively together
- a lack of key data, and ineffective use of existing data, to inform decision-making
- increasing financial challenges and threats to the sustainability of services, including lack of progress in shifting resources to preventative approaches.

3. Since we last prepared a detailed report on health and social care, there have been significant developments in the sector, most notably:

- The Independent Review of Adult Social Care (IRASC) and the Health and Sports Committee's The Future of Social Care and Support in Scotland, both published in February 2021. These reports highlighted many of the same issues we have raised in our work.
- The Scottish Government held an extensive consultation on a new National Care Service between August and November 2021. Our response to the consultation can be viewed on our website.
- The Independent Care Review and its report The Promise published in February 2020, setting out improvements for how partner bodies can work together better to care for vulnerable children and their families.

4. While this briefing acknowledges the work planned by the Scottish Government and stakeholders, it notes that work in many of these areas cannot await the creation of a new organisation. The associated changes to governance and management structures will require legislation and several years to implement.

5. This briefing summarises the key challenges and recent progress in social care in Scotland against each of the themes listed above. We have included quotes from recent publications containing the views of people with experience of social care support and providers of social care. It should help inform Scottish Government and stakeholders' immediate planning for social care alongside longer-term plans for reform. We plan to follow this up with more detailed work on social care in 2022/23.

Social care challenges

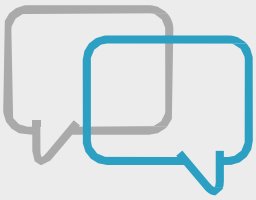
Challenges we have identified through this and past audit work include the service user's perspective and voice, pressures on the workforce, increasing financial challenges and threats to the sustainability of services.

Service users and carers do not always have a say or choice about what support works best for them

6. In our reports, we have consistently highlighted the importance of the user's perspective on what good-quality care looks like. This includes those currently providing unpaid care – family members and friends. Bringing together their views, knowledge and experience will be a critical part of supporting improvements needed for the current pressing challenges facing social care services.

7. We have highlighted in our Principles for community empowerment report that that services can be most effective when delivered in, or by, communities. People contributing to the IRASC, spoke of the need for a flexible approach that takes account of wider supports, such as the support of carers and local services offered by community organisations to enable people to fulfil their potential, goals, and outcomes.

8. Self-directed support (SDS) was introduced jointly by the Scottish Government and Convention of Scottish Local Authorities (COSLA) in 2013. It was designed to give people choice and control over their care, including personalised options for carers to take short breaks from caring. In our Self-directed support progress report, we noted that, despite many examples of positive progress, SDS has not yet been fully implemented. People using social care support who contributed to the IRASC described the hurdles encountered in accessing services and described accessing support as a battle. They summed up the process of accessing social care as notoriously difficult, over-complicated and bureaucratic.

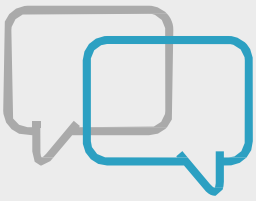


"with SDS I have control. I can choose what option I want (within the rules, of course!). I find this is much more liberating ...Basically, it has been the passport to independence."

Source: 1

Unpaid carers provide a huge amount of support

9. Unpaid carers provide most of the social care support in Scotland. There are an estimated 700,000 unpaid carers, with around 20 per cent of carers aged over 65 and four per cent under the age of 16.[1] Under the Carers (Scotland) Act 2016, carers have a right to support, information and advice. However, a 2019 survey by the Coalition of Carers found that only 16 per cent of carers knew of the Act and what rights it provides; 33 per cent had heard of it but did not know what it was about; and 51 per cent had never heard of it.[2] Women are more likely to work part-time and provide unpaid care. This results in a financial penalty, affecting women more than men and which lasts into retirement.[3] The IRASC highlighted that many carers are forced to give up work because of their caring responsibilities and that access to and options for respite care are limited.



"When unpaid carers are dealing with caring 24/7 it is very difficult for them to have any energy left to 'fight' for social care support."

Source: 4

The social care workforce is under immense pressure

10. The paid social care workforce provides support and care to people with a wide range of different needs in society, including learning disabilities, physical disabilities, and dementia. With around 209,690 people, it accounts for approximately eight per cent of all Scottish employment. There is increasing demand for social care and ongoing challenges with recruitment and retention (Exhibit 1, page 9).

11. In our 2016 Social work in Scotland publication, we reported on the difficulties in recruitment, including low pay, antisocial hours and difficult working conditions, with women making up approximately 85 per cent of the workforce. The IRASC highlighted the gender inequality this creates because the predominantly female workforce is not adequately valued, engaged, or rewarded for its vitally important role. There is too much focus on costs, rather than on high-quality, person-centred care and support. The focus on costs leads to poor terms and conditions for staff and contributes to recruitment difficulties, rising sickness absence and high vacancy levels. This presents a risk to the capacity and quality of care services.

Exhibit 1

Social care workforce

The social care workforce has high vacancy rates with many services facing recruitment problems.

209,690

people working in social care

- 159,260 full-time equivalents (FTE) in 2020
- an increase of 1.6% from 2019

36%

of services reported having vacancies in December 2020

- 3 percentage point decrease from 2019
- > three times higher than across all employers in Scotland (11%)

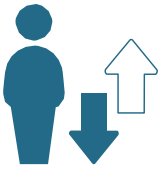
Services with high vacancy rates are:

- housing support services (60%)
- care at home services (59%)
- care homes for older people (55%)
- care homes for adults (48%)

5.1%

FTE vacancy rate for all services at 31 December 2020

- down from 6.2% in 2019
- > more than two and a half times the overall vacancy rate across all establishments in Scotland (1.9%)



20%

are **not** on permanent contracts

11%

are on **zero hours** contracts

13%

of the workforce work over **50 hours a week**

15%

of social care workers work **unpaid overtime**

£9.79

average hourly pay

Source: Scottish Social Services Council (SSSC) workforce survey October 2021, FWC's Fair work in Scotland's social care sector 2019 report, Care Inspectorate and SSSC Staff vacancies in care services 2020 report, Scottish Government's Employer Skills Survey 2020

12. The Fair Work Convention (FWC) has been in place since April 2015 and acts as an independent advisory body to Scottish ministers. Following publication of its Fair Work Framework in 2016, the FWC established a social care inquiry because of concerns raised about the social care workforce during consultation on the framework. The overarching finding was that fair work is not consistently delivered in the social care sector. Despite some good practice and efforts by some employers, the wider funding and commissioning system makes it almost impossible for care providers to offer fair work.

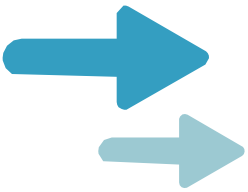
13. The Scottish Government established a Fair Work in Social Care Group, including representation from local government, private sector, third sector, trade unions, and COSLA. Since summer 2020 the group has been discussing improving pay and conditions and improving the staff consultative framework, called Effective Voice.

14. Since 2016, the Scottish Government has provided funding for adult social care staff to be paid the Real Living Wage. However, care providers have expressed concern that this may still not be enough to attract people into the sector. Recent announcements include:

- Funding announced in March 2021 for adult social care workers to receive at least the Real Living Wage of £9.50 an hour. The Real Living Wage increased to £9.90 an hour in November 2021.
- Winter funding announcement in October 2021 included additional funding of up to £48 million this financial year to enable employers to provide an uplift to the hourly rate of pay for staff offering direct care within adult social care to a minimum £10.02 per hour.
- The Scottish budget in December 2021 announced funding for local government to deliver a £10.50 per hour minimum pay settlement for adult social care workers in commissioned services.

15. The Covid-19 pandemic has exacerbated the long-standing challenges facing the social care sector and put the workforce under immense pressure. This has led to increased workloads, staff burnout, and rising sickness levels. Additional pressures on unpaid carers, owing to the closure of day centres and respite services, have resulted in increased feelings of anxiety, depression, and mental exhaustion.[4] Surveys of staff and providers show concerning issues:

- Almost a quarter of staff leave within the first three months of joining an organisation.[5]
- 88 per cent of social care providers said that recruitment and retention was problematic.[6] Ongoing recruitment is a massive cost to the sector as providers are advertising vacancies on a rolling basis.[7]
- 63 per cent of Coalition of Care and Support Providers in Scotland (CCPS) members had to reduce the volume of care provided.[8]
- 7 per cent of CCPS members have returned care packages and 53 per cent have refused/would refuse new care packages.[9]
- 78 per cent of home care workers and 74 per cent of care home workers reported that they frequently did not have enough time with clients to deliver compassionate and dignified care.[10]
- 73 per cent of home care and care home staff reported they frequently had to do training in their own time.[11]



Commissioning focuses on cost at the expense of high-quality, person-centred care and support.

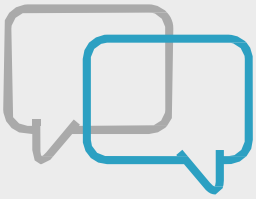
Commissioning tends to focus on cost rather than quality or outcomes

16. We have highlighted the challenging task that councils face responding to financial pressures and managing the market for providing social care services in their local area. There are tensions around making savings while ensuring high-quality services at a fair cost in an environment of increasing demand and financial pressures. However, there is scope for providers to be more involved in commissioning services and at an earlier stage. Our local government financial overview reported that 2019/20 saw a cash increase of £0.5 billion to local government, but reductions over the past seven years are still larger than in other areas of the Scottish Government budget.

17. Current commissioning and procurement procedures have led to competition between providers, at the expense of collaboration. The result is that price is often the main driver for decision-making. The Scottish Government states commissioners could be more flexible in how they procure care and support services, but that it is not being fully used by commissioners.[12] The IRASC highlighted that this focus on cost comes at the expense of high-quality, person-centred care and support. It has led to home care visits being planned on a 15-minute basis, which prioritises social care tasks at the expense of relationships. Short-term approaches to procurement also contribute to poor staff terms and conditions and to providers spending significant time and resources applying and reapplying for contracts.

18. The FWC concluded that low pay in the sector is a symptom of wider structural problems arising from the commissioning system for social care itself. The current method of competitive tendering is based on framework agreements where too often, care provider organisations do not know how many support hours are needed on a day-to-day basis. Employers pass this risk on to staff by giving them contracts that maximise employer flexibility (zero-hours, low-hours, and sessional contracts). This can mean workers having their shifts cancelled if demand falls or being asked to do extra hours at short notice if demand increases, leading to feelings of being always on-call.[13]

19. Voluntary and private sector providers deliver most social care services in Scotland, representing 20 and 57 per cent of registered services respectively.[14] The sustainability of the social care market is key to maintaining Scotland's capacity to address individual care needs. The CCPS 2020 Business Resilience Survey reported that a third of respondents from voluntary services had decided to withdraw from or not to bid for contracts considered unsustainable.[15] Scottish Care reported that half of private care at home services did not apply for local authority contracts in 2017 and 39 per cent handed work back to councils.[16] This was largely because of funding levels for contracts, requirements or penalties in contracts, extent of travel, and a lack of available staff. With the growing financial and workforce pressures facing private and voluntary providers, it is important that Integration Authorities have contingency plans in place and that the financial health of key strategic providers is monitored.



"Everything has a cost, but it is more useful to look at things as a choice rather than a cost, some things are worth the investment."

Source: 4

Capacity and cultural differences are affecting leadership

20. The health and social care sector needs stable and collaborative leadership to address the ongoing challenges, to remobilise services following the pandemic, and to implement significant reform. In recent years, we have highlighted significant challenges for leadership capacity across the public sector. Our Local government in Scotland: Overview 2020 report emphasised the critical need for effective leadership at a time of increasing pressures and change. It highlighted that councils and Integration Authorities are experiencing high turnover of senior staff and are competing not only with each other for the best quality leaders but also with the private and third sectors. Similarly, our NHS in Scotland 2020 report highlighted the continuing lack of stable NHS senior leadership, with high turnover and short-term posts.

21. The current model of governance for Integration Authorities is complicated, with decisions made at Integration Authority, council and health board level. We have found that cultural differences between partner organisations are a barrier to achieving collaborative working. Partner organisations work in very different ways, and this can result in a lack of trust and understanding of each other's working practices and business pressures. There can also be tendency to put the organisation first when alternative actions would benefit partners.

A lack of key data limits informed decision-making

22. The lack of relevant data, or analysis of primary, community and social care data, has been a common theme across a range of our reports. Good data and analysis will be essential for implementing social care reform. For example, in our health and social care integration report, we noted that, despite work to better analyse data, there were still gaps. That report also highlighted that an inability or unwillingness to share information was slowing the pace of health and social care integration. In October 2021, the Scottish Government and COSLA published a revised Digital Health and Care Strategy. The strategy includes a focus on harnessing data for the benefit of citizens and services, with further detail to be published this year on how this will be achieved.

23. Current limitations of social care data include:

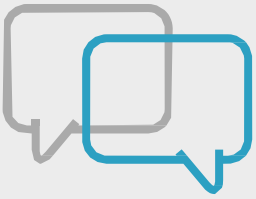
- No individual social care record in the same way that each member of society has an NHS record. This makes it difficult to assess whether social care is meeting people's needs.
- No consistent method for recording unmet need. A person may be assessed as needing social care support but may not meet the eligibility criteria in place. This makes it difficult to assess the level of unmet need and therefore what more is required to deliver a person-centred, human-rights approach to social care.
- No coordinated approach to anticipating future demand for and costs of delivering services. Although some individual health and social care partnerships base their strategic plans on data for the prevalence of conditions in their area, for example heart disease, there is limited evidence of this being used in budget decisions.

Pressure on social care spending is increasing

24. A considerable amount of money is already spent on social care and pressures are growing because of increasing demand and demographic changes. In 2019/20, total social care expenditure was £5.3 billion, most of which was on adult social care – £4.1 billion (77 per cent) (Exhibit 2, page 16).

25. By 2038, forecasts suggest that nearly a quarter of people living in Scotland will be over the age of 65.[17] Scotland's increasingly ageing population means that the demand for social care services will rise, and more resources will be required for social care over the long term. Around a fifth of the population of Scotland define themselves as having a disability and disability is more prevalent in older people. As our older population rises, the number of people with a disability, as a proportion of the population, is expected to increase too. For example, research by Horizon Housing in 2018 projected an 80 per cent increase in the population of wheelchair users by 2024.[18]

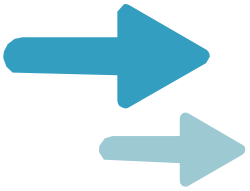
26. The Scottish Government has committed to increasing social care funding by at least 25 per cent in cash terms over the current parliamentary term. This should mean over £800 million of additional funding by 2026/27.[19] Moreover, the UK Government's announced increase in national insurance contributions will provide an estimated additional £1.1 billion to Scotland by 2024/25, some of which will go towards funding social care.[20]



"Consultation has to be honest. You won't be able to deliver on everything people want, but you have to show them how they can be involved in change"

Source: 2

27. In previous reports we have highlighted the importance of public bodies developing medium- and long-term financial plans that take account of forecast demand. The current lack of multi-year budgeting has made managing costs and potential funding shortfalls more difficult in the medium to longer term. We have also commented on the lack of progress in shifting resources from acute to community settings and preventative approaches. A preventative, person-centred approach, as set out by Christie ten years ago, is key for improving outcomes and reducing inequalities.[21] However, we repeatedly reported in our Christie: 10-years on blog that this is not being achieved consistently or at scale. Christie stated that one of the major barriers to preventative action was the extent to which resources are currently tied up in dealing with short-term problems. The report warned that without a shift to preventative action, increasing demand would swamp public services' capacity to achieve outcomes.



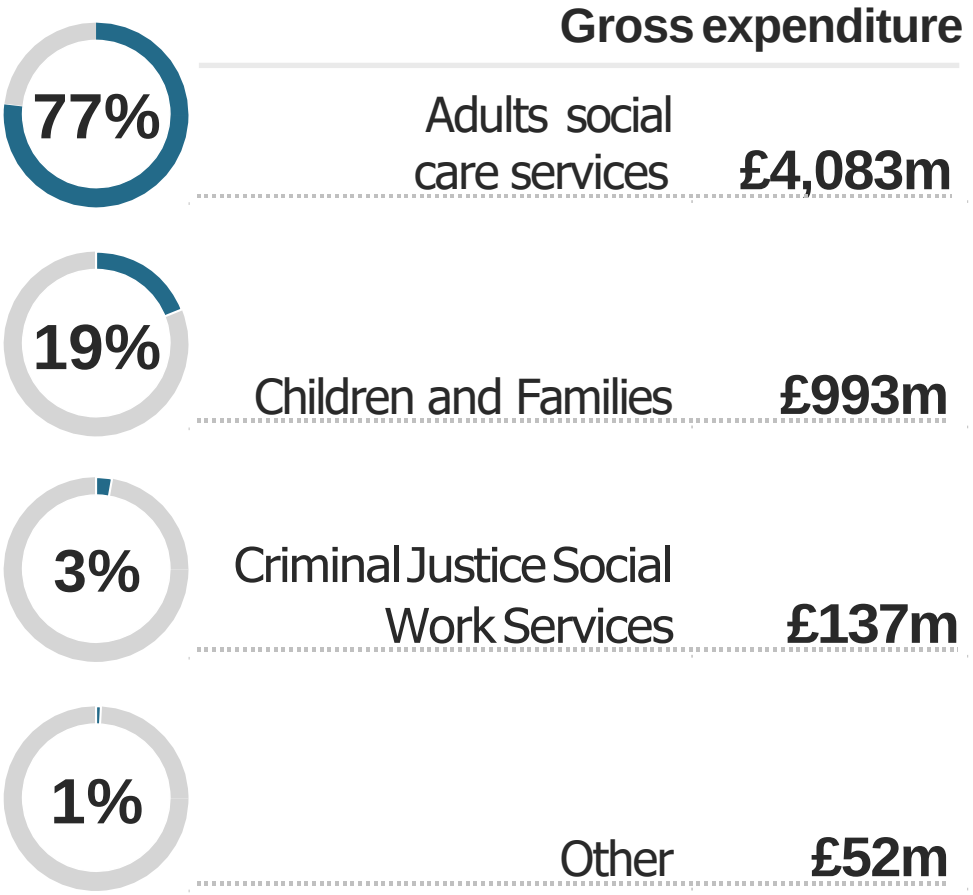
A preventative, person-centred approach, is key for improving outcomes and reducing inequalities.

28. Health and social care partnerships face ongoing challenges, with over two-thirds of Integration Authorities unable to achieve a balanced budget without additional funding from partners in 2018/19. Our report on free personal and nursing care found that abolishing charging led to councils developing eligibility criteria to manage the demand for services. Financial pressures across Scotland are leading to local variations in how those eligibility criteria are being applied to manage access to social care.

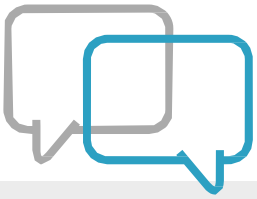
Exhibit 2

Social care expenditure in Scotland, 2019/20

Of the £5.3 billion spent on social care in 2019/20, £4.1 billion (77 per cent) was spent on adult social care.



Source: Scottish Government collated information including Local Finance Returns 2019/20, Independent Living Fund accounts 2019/20, Financial circulars 2019/20.



Quotes from people with experience of social care support and providers of social care.

"There are many, many people who do not speak the language, they will never know who to contact, where to phone, what they get or don't get. Just think about it, their situations, where they're just left, in such a dire situation sometimes." Source: 1

"Disabled people are apprehensive about moving home from one local authority area to another because they know that they will have to go through yet another assessment process. Most of them will have battled with social services for years to get the support that they have currently and are not keen to have to repeat the trauma..." Source: 2

"We are hearing repeatedly from unpaid carers that carers assessments are not being undertaken, that they feel undervalued and their human rights as people are being ignored. Unpaid carers are relentlessly providing care, night and day, with many paying for provision themselves in order to get a break from their caring responsibilities." Source: 4

"I think [we need] recognition that care work is really important and is essential. [...] I think if it was better pay and it was more secure and the hours were better than I wouldn't be so afraid that my personal assistant would leave." Source: 1

"It took 2 years and 6 different social workers to finally get a budget for my daughter." Source: 2

"There is an understanding that eligibility criteria act as a device for local authorities to manage limited resources, however this has resulted in service provision being focused on critical care responses rather than prevention. Social care should be considered an investment and not a cost." Source: 3

Social care next steps

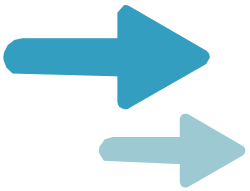
There is much to do to improve social care. Stakeholders have raised concerns about the scale of reform and how a lack of action now presents serious risks.

The Scottish Government is planning significant changes in social care over the next five years

29. On 1 September 2020, the Cabinet Secretary for Health and Sport confirmed the Scottish Government was commissioning a review of adult social care. The cabinet secretary said that the pandemic had 'shone a light on the pressing work we need to do to improve those services and support those who need them and those who work in them'. The key developments and anticipated timescales for social care reform are set out on page 19.

30. The IRASC recommendations were focused on adult social care. The Scottish Government NCS consultation goes further and sets out a vision to create a community health and social care service that supports people of all ages and with a wider range of needs. This includes children's services, community justice, alcohol and drug services, and social work. The proposals are not costed. It states that all proposals will be assessed for value for money as the consultation feedback is considered but there is still much to do to establish the true costs of reform.

31. It is still early days for the Scottish Government's plans for reform. However, stakeholders have raised concerns about the extent of the proposals for reform and the time it will take to implement them. Many of the issues cannot wait for the Scottish Government to implement an NCS. Stakeholders told us of services in near-crisis and explained that a lack of action now presents serious risks to the delivery of care services for individuals. And this in turn will affect the delivery of the Scottish Government's ambitions for social care in Scotland. The social care workforce was frequently described as undervalued, with low wages for the responsibilities of their work, and vacancies hard to fill owing to similar or better wages paid in retail and hospitality sectors.



Stakeholders have raised concerns about the extent of the proposals for reform and the time it will take to implement them.

Timeline for social care reform

2021	3 February	the IRASC advisory panel published its report and made 53 recommendations for improvement
	16 February	the Scottish Government confirmed it accepted the IRASC recommendations
	24 March	the Scottish Government and COSLA issued a joint statement of intent outlining how they would work together to deliver the intentions of the IRASC
	20 July	the Social Care Covenant Group held its first meeting. Chaired by the Minister for Mental Wellbeing and Social Care and including members with first-hand experience, the group was set up to establish a common set of values and beliefs for social care
	9 August to 2 November	the Scottish Government held a wide-ranging consultation on a national care service (NCS) for Scotland
	August and October	the Scottish Government held a series of engagement events at which stakeholders, individuals, and communities came together to share their views on the consultation
	2 September	the Scottish Government awarded a contract to PricewaterhouseCoopers for setting up a programme management structure for an NCS
	2 November	the Scottish Government tendered work on developing an operating model and business case for an NCS
2022	January/ February	the Scottish Government expects to publish the results of the consultation in early 2022
	June	the Scottish Government has committed to begin the legislative process to set up an NCS
2026	May	the Scottish Government expects that an NCS would be fully operational by the end of the current parliamentary term.

Implementing reform will take significant work, but some things cannot wait

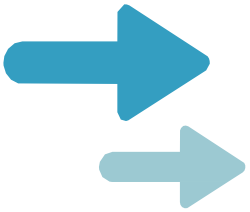
32. The Scottish Government's commitments to an NCS indicates that it recognises the significance of the challenge, but it is at an early stage, with little planning having yet taken place. As we and others have indicated, the need for improvements in social care are now urgent and the government and key stakeholders need to remain focused on making improvements in the areas we have highlighted. The need to address the significant and pressing challenges facing social care in Scotland cannot wait to be solved by a new NCS.

33. The pandemic has exacerbated the long-standing challenges facing the social care sector, highlighting the precarious situation of many vulnerable people who rely on social care or support. The Scottish Human Rights Commission (SHRC) reported on the negative impact Covid-19 had on people requiring support and their rights. The SHRC expressed deep concern about future levels of social care support likely to be available to people whose packages were reduced or withdrawn during the pandemic. It highlighted the need to invest in a social care system, based on human rights, that meets people's needs and improves outcomes.[22]

34. Although there is still uncertainty about what social care reform will look like in terms of scope, the additional funding needed will be significant. It is important that the additional investment set out in paragraph 26 is used effectively to make the changes required in social care and that services do not continue to be funded and delivered in the same way.

Next steps for the Scottish Government

35. Following the end of its consultation, the Scottish Government needs to establish what is included in an NCS and the legislative programme needed to progress it. It should also identify what can be taken forward now without legislation, which could provide a strong foundation for an NCS. Considerable work has already been carried out in some areas on the improvements required, for example on the workforce (Fair Work Commission) and commissioning (CCPS, Healthcare Improvement Scotland).



The Scottish Government should identify where improvement can be made now, drawing on existing work and recommendations and bringing together key stakeholders.

36. It is important the Scottish Government develops a clear scope quickly, with timescales for implementing each workstream, to remove uncertainty about the future direction of social care. The Scottish Government needs to consider the following in developing a plan:

- the functions where there may be value in adopting a national approach to achieve consistency and equity
- areas where improvement can be made now, drawing on existing work and recommendations, by bringing together key stakeholders with a clear remit to deliver the changes required
- developing an understanding of the longer-term costs and funding, including effective exit strategies from current services, identifying double-running costs while setting up new services, and moving more resources into preventative services
- prioritising developing a long-term, integrated workforce plan to address the crisis in the social care workforce and to implement the FWC's recommendations
- developing an understanding of what a preventative and human rights-based approach to social care looks like and a plan for co-producing it. This includes how it will continue to embed the voice of care experienced people in all aspects of developing, planning, and delivering effective social care for people who require support and their carers.

37. The Scottish Government will need to link plans for social care with developments in other policy areas, such as the NHS and housing. This includes the Scottish Government's plans to set up a new care and wellbeing portfolio to focus on reducing inequality, prioritising prevention and early intervention, and improving health and wellbeing outcomes.

38. Lessons also need to be learned from past restructuring and public service reform, for example health and social care integration, police and fire reform, college sector regionalisation, and the development of social security responsibilities in Scotland. Our reports in these sectors have found that reform is challenging and public bodies have experienced difficulties implementing elements of reform – expected benefits are not always clearly defined and, even if they are, reform does not always deliver the expected benefits, particularly in the short term. Any difficulties in implementing social care reform could have a significant negative impact on vulnerable people who rely on care and support. Key learning points include the importance of including:

- realistic costs in financial memorandums accompanying parliamentary bills for legislative change
- a comprehensive business case, clearly setting out the purpose and objectives of reform, timescales, key roles, responsibilities and accountability, risks, and the budget
- evidence to support major changes and being clear about how they will improve outcomes, options appraisal, and economic modelling
- good baseline information and a clear plan for measuring performance and improvement
- governance, accountability, roles and responsibilities in the new structure, and ensuring a shared understanding and agreement among key stakeholders
- strong, consistent strategic leadership from the outset
- an understanding of the time and effort needed to implement major change and complex restructuring, and of the cultural differences between partners.

Endnotes

1 www.gov.scot/publications/scotlands-carers
2 Coalition of Carers in Scotland survey, 2019.
3 State of Caring Survey 2021, Carers UK, October 2021.
4 Health and Sport Committee Social Care Inquiry – Care at Home Survey Results, Scottish Parliament, November 2020.
5 Workforce Recruitment and Retention Survey Findings – Interim report, Scottish Care, September 2021.
6 Workforce Recruitment and Retention Survey Findings – Interim report, Scottish Care, September 2021.
7 Workforce Recruitment and Retention Survey Findings – Interim report, Scottish Care, September 2021.
8 Evidencing the current recruitment picture, CCPS survey, September 2021.
9 Evidencing the current recruitment picture, CCPS survey, September 2021.
10 Show You Care survey, GMB Scotland, August 2020. Survey of 1600 GMB members/social care workers.
11 Show You Care survey, GMB Scotland, August 2020. Survey of 1600 GMB members/social care workers.
12 Procurement of care and support services: Best practice guidance summary, Scottish Government, published March 2016 and updated June 2021.
13 Fair Work in Scotland's Social Care Sector, Fair Work Convention, February 2019.
14 Quarterly statistical summary report (Q2 2021/22), Care Inspectorate, October 2021.
15 Business Resilience Survey 2020, Coalition of Care and Support Providers in Scotland, May 2021.
16 Care at Home Contracts & Sustainability Report, Scottish Care, January 2018.
17 A Scotland for the Future: The opportunities and challenges of Scotland's changing population, Scottish Government, March 2021.
18 Housing to 2040 - The Route Map, Scottish Government, March 2021.
19 A Fairer, Greener Scotland: Programme for Government 2021-22, Scottish Government, September 2021.
20 Build Back Better: Our plan for health and social care, UK Government, September 2021.
21 Christie Commission on the future delivery of public services, Scottish Government June 2011.
22 COVID-19, Social Care and Human Rights: Impact Monitoring Report, Scottish Human Rights Commission, October 2020.

Quote Sources:

Source 1: My Support My Choice, People's Experiences of Self-directed Support and Social Care in Scotland, Self Directed Support Scotland, National Report, October 2020.

Source 2: Social Care Inquiry, Responses from Members of Public, Citizens Space, 2020.

Source 3: Health and Social Care Alliance Scotland, Social Care Review Engagement Activity- Carers People at the Centre September, 2020.

Source 4: Health and Social Care Alliance Scotland, Social Care Review Engagement Activity in partnership with Age Scotland 29 October, 2020.

Social care
Briefi g

Audit Scotland's published material is available for download on the website in a number of formats. For information on our accessibility principles, please visit:
www.audit-scotland.gov.uk/accessibility

For the latest news follow us on social media or **subscribe to our email alerts**.

For further information visit our **Transforming Health and Social Care e-hub**.

Audit team

The core audit team consisted of: Jillian Matthew, Shelagh Stewart, Christopher Lewis and Aileen Campbell under the direction of Mark MacPherson.

AUDIT SCOTLAND

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

ISBN 978 1 913287 69 6

East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
Caroline Sinclair
AGENDA ITEM NO: 9

EAST DUNBARTONSHIRE HEALTH & SOCIAL CARE PARTNERSHIP
PERFORMANCE, AUDIT & RISK COMMITTEE

DATE OF MEETING:	**31st MARCH 2022**
REPORT REFERENCE:	**HSCP/310322/09**
CONTACT OFFICER:	**JEAN CAMPBELL, CHIEF FINANCE & RESOURCES OFFICER (07583902000)**
SUBJECT TITLE:	**AUDIT SCOTLAND – NHS IN SCOTLAND 2021**

1.1 PURPOSE

1.2 The purpose of this report is to present the Audit Scotland report on the NHS in Scotland 2021.

2.1 RECOMMENDATIONS

It is recommended that the Performance, Audit & Risk Committee:

2.2 Note the contents of the Audit Scotland report on the NHS in Scotland 2021.

CAROLINE SINCLAIR
INTERIM CHIEF OFFICER, EAST DUNBARTONSHIRE HSCP

3.1 BACKGROUND/MAIN ISSUES

3.2 The Covid-19 pandemic continues to provide a unique and difficult challenge for the NHS in Scotland. The report builds on Audit Scotland's coverage of the response to the pandemic in the NHS in Scotland 2020 report. The report examines the continued impact of the pandemic on services and people's health in 2021. It also considers the Scottish Government's recovery plans for the NHS and looks at how services might be delivered in the future to better meet changing demand. The report also provides an overview of financial performance across the NHS in Scotland in 2020/21 and considers the financial challenges that lie ahead.

3.3 The Scottish Government and the NHS continue to respond to Covid-19 as the pandemic progresses, while pushing ahead with plans for recovery. Policy and guidance are being updated frequently and the findings reflect the situation at January 2022, using information available before publication. The Scottish Government and the NHS are working in a quickly changing environment, as the emergence of the Omicron variant in late 2021 has shown. A lot of the work covered in the report is at an early stage. It is too early to make judgements on some of these programmes of work.

3.4 The key messages from the report are set out below:

- **The NHS in Scotland is operating on an emergency footing and remains under severe pressure.** The success of the vaccinations programme has reduced deaths but the ongoing impact of responding to variants of Covid-19 has created a growing backlog of patients waiting much longer for treatment. The backlog poses a significant risk to the Scottish Government's recovery plans, which aim to transform how care is delivered. Reform is key to the sustainability of the NHS, and it must remain a focus, building on the innovation seen throughout the pandemic. Crucially, the public must be kept aware of and involved in changes to service provision. But transforming services will be very difficult to deliver against the ongoing competing demands of the pandemic and an increasing number of other policy initiatives, such as plans for a National Care Service.
- **NHS and social care workforce planning has never been more important.** Frontline NHS and social care staff, leaders and civil servants have shouldered a heavy burden over the last two years, and this has affected their wellbeing. The Scottish Government has introduced measures to support staff and is monitoring their effectiveness. But it must also prioritise addressing workforce availability challenges if its recovery plan is to be successful. Its plans to recruit and retrain staff are ambitious and will be challenging to achieve given the NHS's historical struggles to recruit enough people with the right skills.
- **The NHS's ability to plan for recovery from Covid-19 remains hindered by a lack of robust and reliable data across several areas.** This includes workforce data, as well as primary, community, social care and health inequality data. The collection and use of this data must improve to support decision making and to ensure policy decisions are delivering the best outcomes for people.
- **The NHS was not financially sustainable before the pandemic and responding to Covid-19 has increased those pressures.** In 2020/21, the Scottish Government allocated £2.9 billion for pandemic-related costs. It has committed additional funding for health and social care in 2021/22 and beyond but there is uncertainty about future Covid-19 funding levels and the longer-term financial position. The Scottish Government plans to bring financial planning, service planning, workforce planning and capital investment together under a new Care and Wellbeing Portfolio. This has

the potential to help the NHS become sustainable, but it is very early days. The key to financial stability remains a clear focus on the Scottish Government's long-standing commitment to transform how health and social care services are delivered.

3.5 The report sets out a number of recommendation for both the Scottish Government and NHS Boards to mitigate the challenges identified:

The Scottish Government should:

- Address the wellbeing risks affecting staff in the Scottish Government's Health and Social Care directorate as well as the NHS and social care workforce (paragraph 18).

The Scottish Government and NHS boards should:

- work with partners in the social care sector to develop a long-term, sustainable solution for reducing delayed discharges from hospital (paragraph 15)
- publish data on performance against the clinical prioritisation categories, to enable transparency about how NHS boards are managing their waiting lists (paragraph 39)
- work with patients on an ongoing basis to inform the priorities for service delivery, and be clear on how services are developed around patients' needs (paragraph 57)
- take a cohesive approach to tackling health inequalities by working collaboratively with partners across the public sector and third sector, and be transparent on how it will do this (paragraphs 62 and 63)
- improve the availability, quality and use of workforce data to ensure workforce planning is based on accurate projections of need (paragraph 87)
- monitor and manage risks around the impact of additional work outlined in the NHS recovery plan on the NHS workforce, to make sure recovery does not negatively affect staff wellbeing (paragraph 90)
- communicate widely with the public on changes to how services are delivered so that people are aware of how best to access services, and monitor the effectiveness of that communication (paragraph 95)
- prioritise the prevention and early intervention agenda as part of the recovery and redesign of NHS services, to enable the NHS to be sustainable into the future (paragraph 98)
- Improve the availability, quality and use of data on primary, community and social care so that service planning is based on accurate measures of existing provision and demand (paragraph 99).

3.6 The Audit Scotland report is included as **Appendix 1**.

4.1 **IMPLICATIONS**

The implications for the Committee are as undernoted.

4.2 Relevance to HSCP Board Strategic Plan – 1. Promote positive health and wellbeing, preventing ill-health, and building strong communities / 2. Enhance the quality of life and supporting independence for people, particularly those with long-term conditions / 3. Keep people out of hospital when care can be delivered closer to home / 4. Address inequalities and support people to have more choice and control / 5. People have a positive experience of health and social care 7. Improve support for Carers enabling them to continue in their caring role.

4.3 Frontline Service to Customers – None

4.4 Workforce (including any significant resource implications) – None

4.5 Legal Implications – None

4.6 Financial Implications – None

4.7 Procurement – None

4.8 Economic Impact – None

4.9 Sustainability – None

4.10 Equalities Implications – None

4.11 Other - None

5.1 **MANAGEMENT OF RISK**

The risks and control measures relating to this Report are as follows:-

5.2 The Audit Scotland reports sets out some of the risks associated with the scale of reform required to address the imminent challenges facing social care.

6.1 **IMPACT**

6.2 **EAST DUNBARTONSHIRE COUNCIL** - None

6.3 **NHS GREATER GLASGOW & CLYDE** - None

6.4 **DIRECTIONS REQUIRED TO COUNCIL, HEALTH BOARD OR BOTH –** No Direction Required.

7.1 **POLICY CHECKLIST**

7.2 This Report has been assessed against the Policy Development Checklist and has been classified as being an operational report and not a new policy or change to an existing policy document.

8.1 **APPENDICES**

8.2 Appendix 1 – Audit Scotland report ‘NHS in Scotland 2021’.

NHS in Scotland 2021

AUDITOR GENERAL

Prepared by Audit Scotland
February 2022

Contents

Audit team

The core audit team consisted of: Leigh Johnston, Derek Hoy, Eva Thomas-Tudo, Claire Tennyson and Lucy Ross under the direction of Angela Canning.

Key messages

1 **The NHS in Scotland is operating on an emergency footing and remains under severe pressure.**
The success of the vaccinations programme has reduced deaths but the ongoing impact of responding to variants of Covid-19 has created a growing backlog of patients waiting much longer for treatment. The backlog poses a significant risk to the Scottish Government's recovery plans, which aim to transform how care is delivered. Reform is key to the sustainability of the NHS, and it must remain a focus, building on the innovation seen throughout the pandemic. Crucially, the public must be kept aware of and involved in changes to service provision. But transforming services will be very difficult to deliver against the ongoing competing demands of the pandemic and an increasing number of other policy initiatives, such as plans for a National Care Service.

2 **NHS and social care workforce planning has never been more important.**
Frontline NHS and social care staff, leaders and civil servants have shouldered a heavy burden over the last two years, and this has affected their wellbeing. The Scottish Government has introduced measures to support staff and is monitoring their effectiveness. But it must also prioritise addressing workforce availability challenges if its recovery plan is to be successful. Its plans to recruit and retrain staff are ambitious and will be challenging to achieve given the NHS's historical struggles to recruit enough people with the right skills.

3 **The NHS's ability to plan for recovery from Covid-19 remains hindered by a lack of robust and reliable data across several areas.**
This includes workforce data, as well as primary, community, social care and health inequality data. The collection and use of this data must improve to support decision-making and to ensure policy decisions are delivering the best outcomes for people.

4 **The NHS was not financially sustainable before the pandemic and responding to Covid-19 has increased those pressures.**
In 2020/21, the Scottish Government allocated £2.9 billion for pandemic-related costs. It has committed additional funding for health and social care in 2021/22 and beyond but there is uncertainty about future Covid-19 funding levels and the longer-term financial position. The Scottish Government plans to bring financial planning, service planning, workforce planning and capital investment together under a new Care and Wellbeing Portfolio. This has the potential to help the NHS become sustainable, but it is very early days. The key to financial stability remains a clear focus on the Scottish Government's long-standing commitment to transform how health and social care services are delivered.

Recommendations

The Scottish Government should:

- address the wellbeing risks affecting staff in the Scottish Government's Health and Social Care directorate as well as the NHS and social care workforce (paragraph 18).

The Scottish Government and NHS boards should:

- work with partners in the social care sector to develop a long-term, sustainable solution for reducing delayed discharges from hospital (paragraph 15)
- publish data on performance against the clinical prioritisation categories, to enable transparency about how NHS boards are managing their waiting lists (paragraph 39)
- work with patients on an ongoing basis to inform the priorities for service delivery, and be clear on how services are developed around patients' needs (paragraph 57)
- take a cohesive approach to tackling health inequalities by working collaboratively with partners across the public sector and third sector, and be transparent on how it will do this (paragraphs 62 and 63)
- improve the availability, quality and use of workforce data to ensure workforce planning is based on accurate projections of need (paragraph 87)
- monitor and manage risks around the impact of additional work outlined in the NHS recovery plan on the NHS workforce, to make sure recovery does not negatively affect staff wellbeing (paragraph 90)
- communicate widely with the public on changes to how services are delivered so that people are aware of how best to access services, and monitor the effectiveness of that communication (paragraph 95)
- prioritise the prevention and early intervention agenda as part of the recovery and redesign of NHS services, to enable the NHS to be sustainable into the future (paragraph 98)
- improve the availability, quality and use of data on primary, community and social care so that service planning is based on accurate measures of existing provision and demand (paragraph 99).

Introduction

1. The Covid-19 pandemic continues to provide a unique and difficult challenge for the NHS in Scotland. This report builds on our coverage of the response to the pandemic in our NHS in Scotland 2020 report.[1] It also follows our Covid-19 briefings on personal protective equipment and the vaccination programme.[2] [3] The report examines the continued impact of the pandemic on services and people's health in 2021. It also considers the Scottish Government's recovery plans for the NHS and looks at how services might be delivered in the future to better meet changing demand. We also provide an overview of financial performance across the NHS in Scotland in 2020/21 and consider the financial challenges that lie ahead. Our audit approach is set out in the Appendix.

2. The Scottish Government and the NHS continue to respond to Covid-19 as the pandemic progresses, while pushing ahead with plans for recovery. Policy and guidance are being updated frequently and our findings reflect the situation at January 2022, using information available before publication. The Scottish Government and the NHS are working in a quickly changing environment, as the emergence of the Omicron variant in late 2021 has shown. A lot of the work we cover in the report is at an early stage. It is too early for us to make judgements on some of these programmes of work.

3. We would like to acknowledge the support and assistance provided by the Scottish Government and NHS boards that has enabled us to prepare this report.

The ongoing response to the pandemic

The NHS continues to operate under extremely challenging circumstances with an ongoing focus on the response to Covid-19 and providing emergency and urgent care

4. The NHS in Scotland is still operating in extremely challenging circumstances. NHS staff have continued to demonstrate their extraordinary commitment to public service, working under significant pressure for a period longer than anyone could have predicted at the outset.

5. Responding to the Covid-19 pandemic is still putting NHS boards under considerable strain and the Scottish Government has confirmed that the NHS will continue to operate on an emergency footing until at least March 2022. This means that non-urgent care and treatment may continue to be postponed, so that NHS boards can manage the immediate demands of responding to Covid-19 and continue to provide emergency and urgent care.

6. The ongoing need to implement public health measures to prevent and control infection continues to affect NHS capacity and resources. The Scottish Government and the NHS have put in place several programmes of work as part of the ongoing response:

- The Covid-19 vaccination programme. In September 2021, we published a briefing paper on the rollout of the Covid-19 vaccination programme. The NHS has made excellent progress in vaccinating a large proportion of people aged 18 years and over.[4] The programme has since been extended to offer vaccines to children aged five years and over, and to offer third doses for more vulnerable people and booster vaccinations for adults aged over 18 years. Uptake has been very high: at 16 February 2022, 92.2 per cent of those aged 12 years and over have received at least one dose of a Covid-19 vaccine.[5]
- Test and Protect. Scotland's approach to testing and contact tracing has developed as the pandemic has progressed. At 16 February 2022, more than 15.3 million PCR Covid-19 tests had been carried out, and more than 1.1 million of these were positive.[6] [7] In December 2021, the Scottish Government published an evaluation of the asymptomatic testing programme.[8] This found that between 25 November 2020 and 27 June 2021, more than

Covid-19: Vaccination programme
September 2021

7,000 positive cases were identified through this programme. These cases may not have otherwise been detected if they remained asymptomatic or may have been diagnosed later once symptomatic. The evaluation found that there were some barriers to maximising the impact of the programme, including concerns about the perceived reliability of the tests, and the consistency of people self-reporting results.

- Distribution of personal protective equipment (PPE). PPE has been supplied to the NHS and social care services, free of charge, throughout the pandemic. The Scottish Government has committed to continue this until at least March 2022. This is currently expected to cost £158.9 million in 2021/22. It is not yet clear what arrangements will be in place after March 2022. Our briefing paper on PPE (June 2021) noted that the Scottish Government and NHS National Services Scotland (NHS NSS) have been working with partners to develop a longer-term approach to supplying and distributing PPE.

Covid-19: Personal protective equipment
June 2021

7. NHS boards' ability to implement their remobilisation plans for 2021/22 is highly dependent on how the pandemic progresses. These outlined NHS boards' priorities for increasing activity while maintaining their capacity to treat Covid-19 patients.

8. The assumptions in these plans understandably included a lot of caveats because of the uncertain ongoing impact of the pandemic on the NHS. The Scottish Government reviewed the strength and content of the remobilisation plans and identified several themes, including:

- good coverage of priorities encompassing acute, primary, community and social care
- the importance of looking after the wellbeing of the workforce
- a clear commitment to doing things differently, building on lessons learned and on innovations such as the redesign of urgent care and Near Me
- the importance of working in partnership with the public sector and third sector, with staff and clinical colleagues, and with local communities.

9. The review also highlighted several risks that had been identified by NHS boards and that could considerably affect the scale and pace of remobilisation during 2021/22. These include:

- uncertainty about how the Covid-19 pandemic will develop and the potential impact of future surges on the NHS
- workforce issues, including the need to make sure that staff have time and support to rest and take leave and concerns about sustainability because of retirals, recruitment challenges, redeployment and having the appropriate skills mix

- concerns about the longer-term impact of Covid-19 on the population and the way in which health and social care services will be delivered. Examples include the resources needed to further develop the role of public health services; the ongoing need for enhanced infection prevention and control measures; and the impact of unidentified and unmet healthcare needs on the demand for services.

The Scottish Government and NHS boards took action to prepare for a challenging winter

10. The Scottish Government acknowledged that winter 2021/2022 was likely to be extremely challenging for the NHS and, along with NHS boards, took action to prepare. The usual winter pressures, such as respiratory illnesses and falls, need to be managed along with Covid-19. The NHS has been rolling out its most extensive flu vaccination programme yet to minimise the spread of infection and the impact on services.

11. The Scottish Government asked NHS boards to update their remobilisation plans in Autumn 2021, to help ensure they were well prepared for the winter. In addition, in October 2021, the Scottish Government published a health and social care winter overview, outlining its winter planning preparations.[9] This was based on four principles:

- maximising capacity through investment in staffing, resources and facilities
- caring for staff by ensuring timely access to wellbeing support, so that they can continue to work safely and effectively
- reducing delayed discharge from hospitals and increased access to care in a range of community settings
- improving outcomes by investing in delivering the right care in the right setting.

12. The emergence of the Omicron variant at the start of winter 2021/22 demonstrated how the uncertain path of the pandemic can impact on NHS services. Covid-19 case numbers spiked dramatically throughout December and into early January followed by a spike in hospital admissions and moderate increases in deaths and ICU stays. This added to the pressure on the NHS during an already difficult winter season. This was further exacerbated by staff absences owing to Covid-19 while case numbers grew and isolation guidelines were tightened.

13. The Covid-19 vaccine booster programme was accelerated in line with updated clinical guidance following the emergence of the Omicron variant. While this was expected to reduce the health impact of the virus it added to the pressure on vaccination teams.

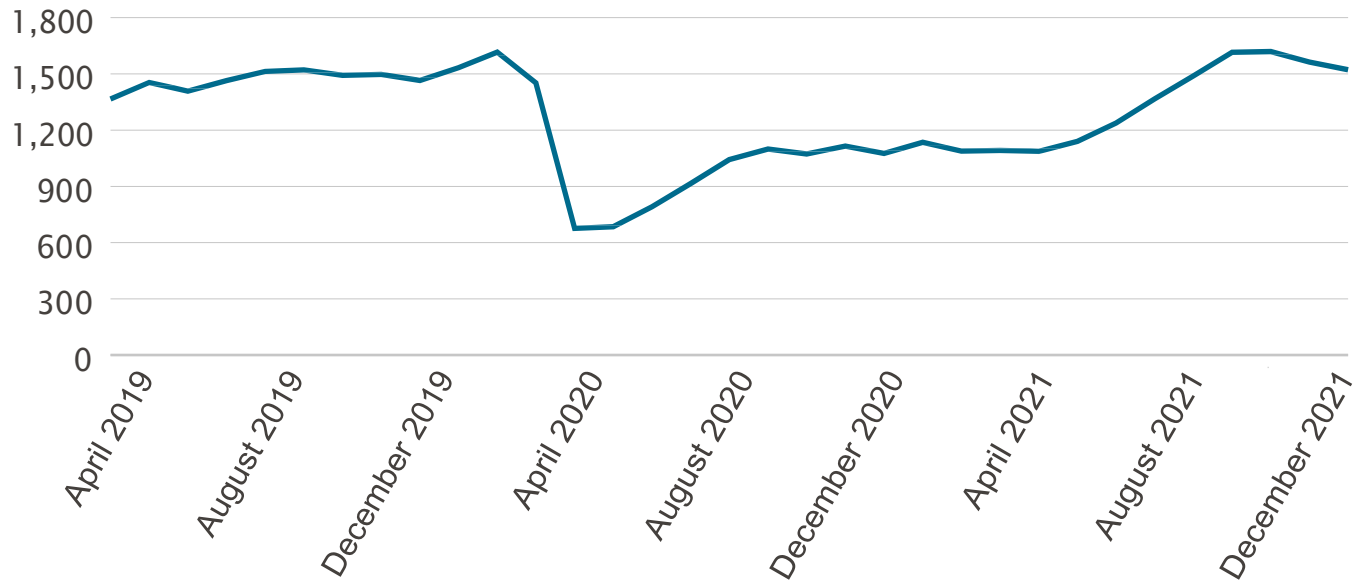
14. At the start of the Covid-19 pandemic, the Scottish Government introduced a rapid discharge strategy aiming to increase capacity in acute hospitals. This was effective, resulting in a substantial drop in delayed discharges between March and April 2020 (Exhibit 1). Delayed discharges gradually increased after April 2020 and had reached pre-pandemic levels by September 2021, putting additional pressure on NHS hospitals. The Scottish Government has said that this is because there have been increasing numbers of people admitted to hospital requiring care packages on discharge.

15. In its health and social care winter overview, the Scottish Government committed to providing £62 million, to increase the capacity for providing care at home, and funding of £40 million, to move people delayed in hospital into care homes on a short-term basis. This aimed to free up capacity in hospitals over the winter. By December 2021 there had been a small decrease in the average daily bed days occupied by delayed discharges (Exhibit 1). The measures to reduce delayed discharges, particularly during the first wave of the pandemic, were effective in the short term but a longer-term, more sustainable solution is needed.

Exhibit 1.

Average daily bed days occupied by patients whose discharge from hospital was delayed – April 2019 to December 2021

There was a substantial decrease in delayed discharges at the start of the Covid-19 pandemic, but they have since returned to pre-pandemic levels.



Source: Public Health Scotland

The unprecedented pressures of the pandemic continue to limit the capacity of the NHS workforce

16. Scottish Government and NHS staff have been working relentlessly to support the ongoing response to the pandemic and deliver services. Staff absences attributable to Covid-19 continue to limit capacity (Exhibit 2, page 11).[10] Vacancy rates for nursing and midwifery, and allied health professionals, such as physiotherapists, were higher in September 2021 than in any of the previous four years.[11]

17. The Scottish Government recognises that the risks relating to workforce capacity and wellbeing are significant. This has been reflected throughout the year in the Scottish Government's Health and Social Care Risk Register. The Scottish Government has introduced a range of controls to mitigate the risks. For example, it developed a recruitment plan to address winter pressures and winter disease. It also set up a Sustainable Vaccination Workforce Group to ensure that delivering the vaccination programme did not put further pressure on the wider healthcare system. It is too early to tell how effective these measures have been.

18. The workforce risks included in the Health and Social Care Risk Register refer only to health and social care staff. The Scottish Government should also consider risks affecting staff in the Scottish Government's Health and Social Care directorate.

19. Our NHS in Scotland 2020 report highlighted the negative impact of the pandemic on NHS staff wellbeing. This impact persists almost two years into the pandemic. Staff surveys carried out by trade unions and regulators continue to show a high number of staff saying their physical and mental wellbeing has been negatively affected. The results of the annual iMatter staff experience survey are currently being analysed and the Scottish Government intends to publish the report in early 2022.

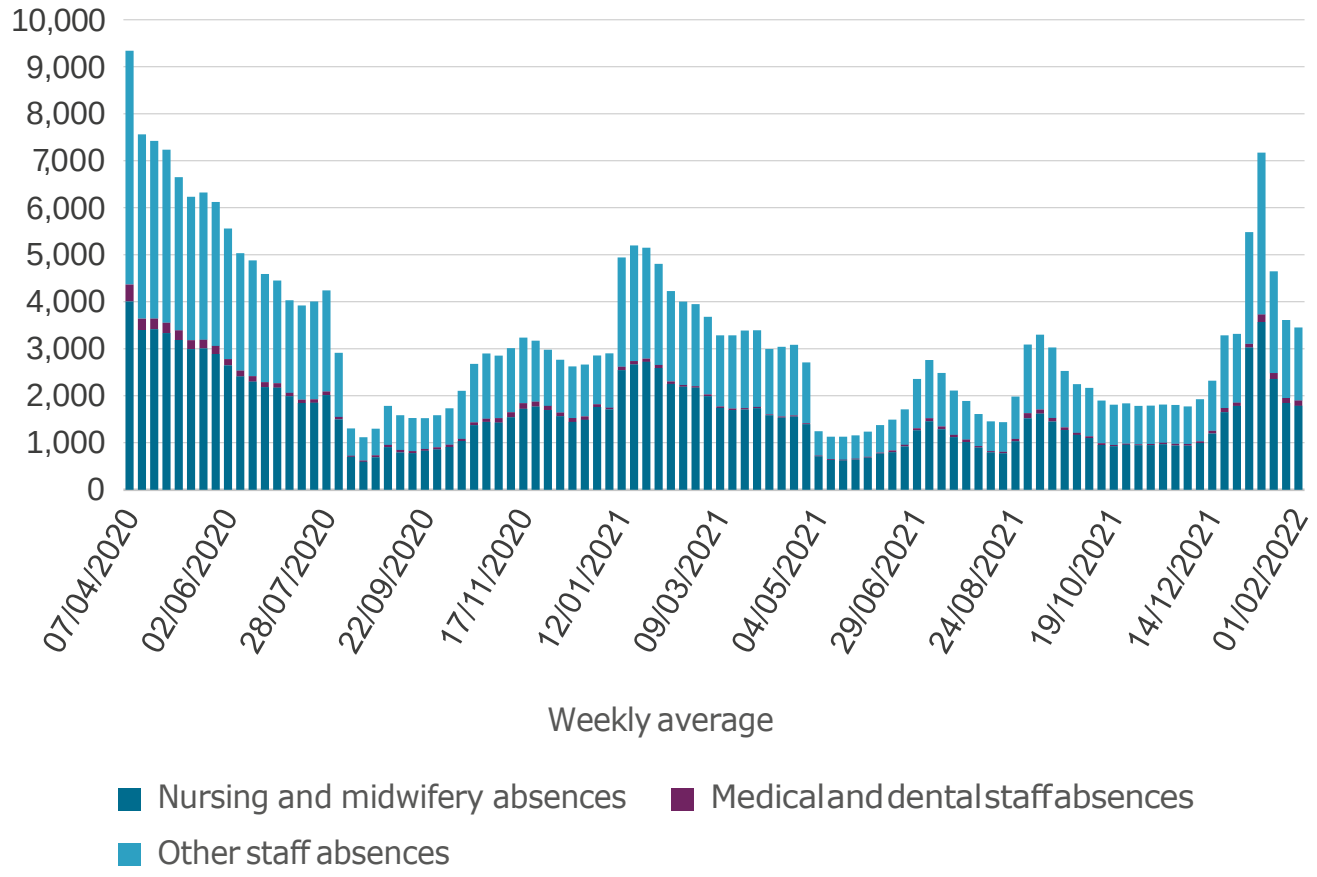
20. The 2021 Royal College of Nursing (RCN) Employment survey found that 40 per cent of nursing staff in Scotland are working beyond their contracted hours on most shifts.[12] Also, 67 per cent said they were too busy to provide the level of care they would like and 72 per cent said they were under too much pressure at work. It also found that 61 per cent are thinking about leaving their current position, with the main reasons being feeling undervalued, feeling under too much pressure, low staff levels and low pay. In comparison, 36 per cent of respondents to the RCN UK-wide Pay and Working Conditions Survey at the start of the pandemic said they were thinking of leaving their current position.[13]

21. The percentage of sickness absence attributable to stress and/or poor mental health increased for most NHS boards in 2020/21, compared with 2019/20. It is not clear whether those increases were caused by work-related stress or poor mental health owing to the pressures of the pandemic. The data also needs to be considered in the context of overall lower rates of non-Covid-19 sickness absence in 2020/21.

Exhibit 2.

The number of NHS staff absent because of Covid-19 – April 2020 to February 2022

Staff absence due to Covid-19 has varied but has been high throughout the pandemic.



Note: This graph shows the weekly average of daily absences.

Source: Scottish Government

The Scottish Government and NHS boards worked quickly to support staff wellbeing, but it is too soon to assess the effectiveness of the measures put in place

22. The Scottish Government and NHS boards worked quickly to increase the support available for the health and social care workforce. In 2020/21, the Scottish Government allocated £8 million for wellbeing support and announced a further £4 million in October 2021 to support wellbeing during the winter pressures.[14] [15] Seven measures have been introduced at a national level to support staff. These include access to support via a National Helpline, an online National Wellbeing Hub and a

Workforce Specialist Service offering specialist support in understanding the mental health needs of health and social care professionals who may be reluctant to seek help or struggle to find confidential care.

23. The measures put in place so far are appropriate, but it is too soon to fully assess their effectiveness. Governance arrangements for the programme of work are in place and include project teams, an oversight group and a programme board. The Scottish Government is monitoring the uptake of the measures and gathering feedback from service users.

24. The Scottish Government has reviewed the first 100 service users of the Workforce Specialist Service, usage of the National Wellbeing Helpline and examined analytics of the National Wellbeing Hub. Feedback has suggested that they have had a positive impact on wellbeing, although the National Wellbeing Helpline has had low call volumes. The Scottish Government will continue to evaluate the staff support measures it has introduced.

25. The scale of need for support is not clear. It is important that the Scottish Government continues to engage with the health and social care workforce and take account of the experiences of different staff groups as this programme of work develops.

26. The Scottish Government established a short life working group, including representatives from the health and social care sector, to provide recommendations to support workforce recovery. These fed into the NHS recovery plan published in August 2021.[16] The Scottish Government is exploring opportunities for a panel of health and social care staff to share their experiences. Our social care briefing, published in January 2022, highlights the immense pressure social care staff are under and the ongoing challenges with recruitment and retention within the sector.[17]

Social care briefi g
January 2022

27. The Scottish Government told us that there is not a culture of seeking help in the health and social care sector. Support needs to be improved, for example by ensuring that wellbeing is part of conversations between staff and their managers. Achieving this will take time and involve managing the tension between the competing demands of staff wellbeing, the pandemic response, and remobilisation.

The Scottish Government and NHS are implementing lessons learned during the pandemic

28. Some changes brought in during the pandemic were specific to the response required and will not be adopted permanently. But other changes can bring ongoing benefits to health services and can aid the recovery effort and improve future service delivery.

29. The Scottish Government and NHS have acted quickly to learn from changes brought in during the pandemic and have started to embed that

learning across NHS services. The Scottish Government commissioned a report, published in August 2021, on lessons identified from the health and social care response to Covid-19 in Scotland during the first six months of the pandemic.[18]

30. The report concluded that a considerable amount of work had gone into identifying what had worked well and what opportunities exist for new ways of working. It identified clear examples of good practice at individual board level and through national programmes. It also recommended clearly defining roles and responsibilities for implementing lessons learned exercises, with the Scottish Government coordinating and overseeing to avoid overlap and duplication.

31. The findings have informed other work, for example, the NHS recovery plan, the Programme for Government, and the development of a Care and Wellbeing Portfolio (paragraph 103). The Scottish Government created an action tracker outlining progress against recommendations and additional commitments. It shows where lessons could inform future pandemic preparedness and the development of policy and reform work. It also outlines how lessons identified are being addressed in the creation of its Care and Wellbeing Portfolio.

32. It is important that new ways of delivering services continue to be evaluated to assess the ongoing appropriateness and effectiveness of the changes, and to avoid exacerbating or creating health inequalities.

Scottish ministers are setting up a public inquiry to investigate the handling of the Covid-19 pandemic in Scotland

33. In December 2021, the Deputy First Minister announced terms of reference and the appointment of a chair for a public inquiry into the handling of Covid-19 in Scotland.[19] The inquiry will look at the strategic response to the pandemic and cover 12 areas of investigation, to identify lessons to be learned and recommendations. It will look across pandemic preparedness, the direct and indirect health impacts, education and financial support. The inquiry will cover the period from 1 January 2020 to 31 December 2022 but will also include pandemic planning undertaken before then. The terms of reference for the inquiry were set by the Scottish Government and informed by public engagement.

The continuing health impact of Covid-19

The pandemic continues to have an impact on the health of people in Scotland, but fewer people are dying from Covid-19

34. By the end of January 2022 Covid-19 had caused or contributed to more than 12,900 deaths in Scotland. The number of people dying from Covid-19 has been significantly lower since the rollout of the vaccination programme from late 2020, despite higher numbers of positive cases (Exhibit 3, page 15).

35. From September 2021, there has been another increase in people with Covid-19 being admitted to hospital. This is putting considerable pressure on hospitals at a time when they are already under enormous strain. There is also the risk that if new variants of the virus continue to emerge, the vaccines may become less effective.

36. On average there has been a higher number of deaths from other causes during the pandemic. From the week beginning 24 May 2021, deaths were above average levels for 32 consecutive weeks. For 2021 as a whole, excess deaths were ten per cent above the average for the five-year period 2015 to 2019.[20] The Scottish Parliament has launched an inquiry to investigate what factors have led to this increase.

The Covid-19 pandemic has led to a considerable backlog of people waiting for NHS diagnosis and treatment

37. Responding to the Covid-19 pandemic has severely affected the ability of NHS boards to continue to see and treat people with other healthcare needs. The Scottish Government directed NHS boards to pause non-urgent treatment and screening programmes during the first wave of the pandemic. The NHS has been working to resume the full range of healthcare services but capacity in hospitals continues to be limited. This has led to increasing numbers of people waiting much longer for diagnosis and treatment (Exhibit 4, page 16).

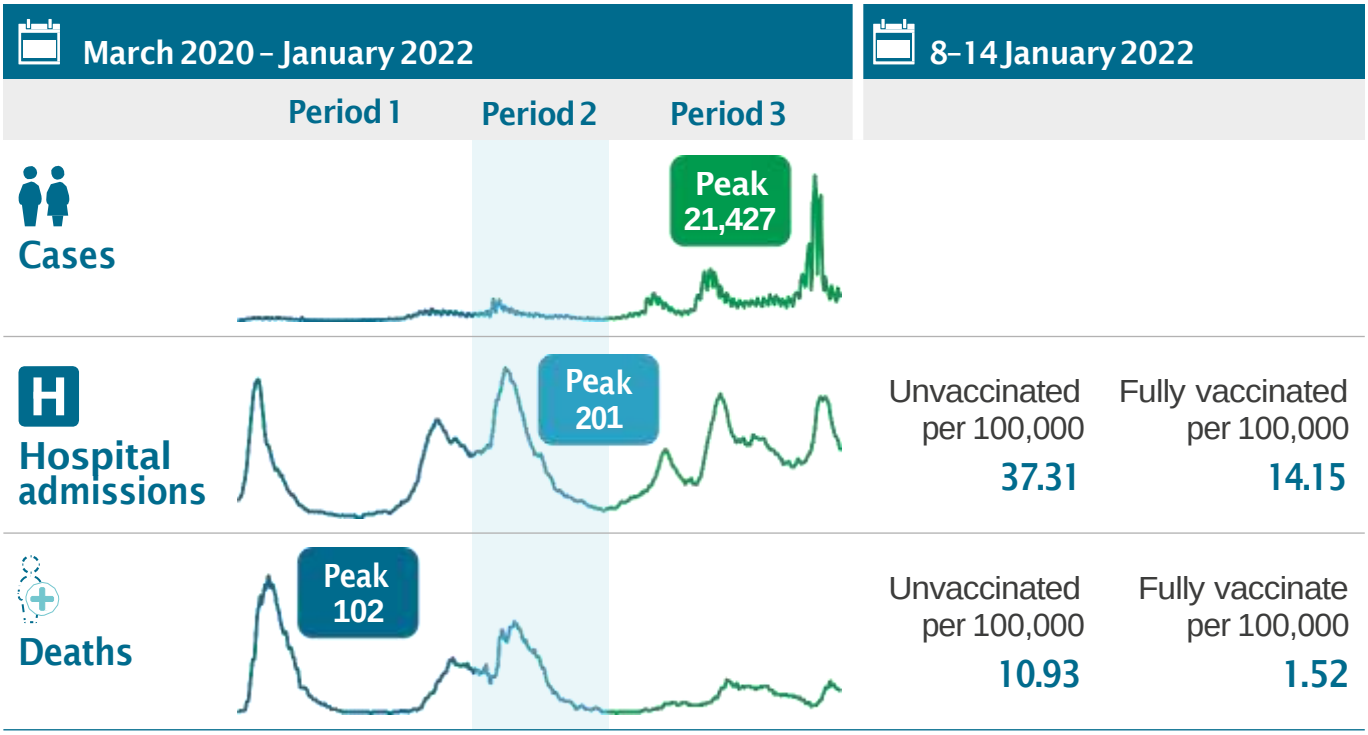
38. In November 2020, the Scottish Government published a clinical prioritisation framework outlining how NHS boards should prioritise patients for treatment during the Covid-19 pandemic.[21] This approach means that patients in most urgent need should be seen first and those of lower clinical priority will need to wait longer. Patients are categorised in priority levels as follows:

- Level 1a emergency – operation needed within 24 hours
- Level 1b urgent – operation needed within 72 hours
- Level 2 surgery – scheduled within four weeks
- Level 3 surgery – scheduled within 12 weeks
- Level 4 surgery – may be safely scheduled after 12 weeks.

Exhibit 3.

Covid-19 cases, deaths and hospital admissions – March 2020 to January 2022

The Covid-19 vaccination programme has helped to reduce the number of people needing hospital treatment or dying from Covid-19.



Period 1 – Before the vaccination programme
Period 2 – 8 December 2020: Vaccination programme began
Period 3 – 7 May 2021: 98% of priority groups 1–9 had received their first dose of a Covid-19 vaccine

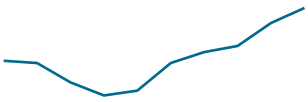
Notes:
1. The data for Covid-19 deaths and hospital admissions are based on the average number of registered deaths and the average number of people admitted to hospital over the previous seven days.
2. People who are fully vaccinated are defined as having a third dose or booster shot.
3. The hospitalisation and mortality rates per 100,000 are age-standardised per 100,000 people per week, standardised to the 2013 European Standard Population.

Source: Public Health Scotland

Exhibit 4.

National trends in demand for hospital services and activity April 2019 – September/December 2021

Hospital activity is increasing but remains lower than pre-pandemic levels. Demand for services and the numbers waiting considerably longer for tests and treatment have increased.

Demand				% change
	April 2019 to September 2021			
Number waiting for diagnostic tests	92,239		125,557	↑ 36.1%
	June 2019 to September 2021			
Number waiting for an inpatient or day case admission	75,608		106,496	↑ 40.9%
Number waiting for a new outpatient appointment	323,408		425,242	↑ 31.5%
Activity				**% change**
	April 2019 to December 2021			
Number of scheduled elective operations in theatre system	27,204		17,836	↓ -34.4%
	April 2019 to September 2021			
Number of inpatient and day case admissions	70,691		45,449	↓ -35.7%
Number of new outpatient appointments seen	361,944		286,935	↓ -20.7%
Length of waits				**% change**
	April 2019 to September 2021			
Number waiting longer than 6 weeks for diagnostic tests	16,446		53,023	↑ 222.4%
	June 2019 to September 2021			
Number waiting longer than 12 weeks for an inpatient or day case admission	23,930		66,602	↑ 178.3%
Number waiting longer than 12 weeks for a new outpatient appointment	86,450		220,888	↑ 155.5%

Source: Public Health Scotland

39. We recommended in our NHS in Scotland 2020 report that data on waiting times based on the categories in the clinical prioritisation framework should be published. This will enable transparency and scrutiny of how NHS boards are managing their waiting lists. Public Health Scotland and NHS boards continue to progress this recommendation and the Scottish Government should work with them to publish this information as soon as possible.

NHS in Scotland 2020
February 2021

40. Referrals are increasing but the impact of delayed or missed diagnosis is a big risk. There is evidence that some people avoided accessing health services, particularly during the first months of the pandemic. This creates the risk that health conditions will go undetected for longer, leading to potentially worse outcomes for people.

41. The first port of call for most people with medical concerns is their GP, who can refer them to specialist services where required. Data on the number of GP appointments carried out is not available, so the extent to which people avoided seeing their GPs during the Covid-19 pandemic is based on survey information and referrals to hospital services.

42. A survey by YouGov has been carried out since the start of the pandemic, to monitor public opinion in Scotland. In December 2021, it found that 25 per cent of respondents would avoid contacting a GP for immediate medical concerns unrelated to Covid-19. This has improved since April 2020 (when it was 45 per cent), but it indicates the significant unknown need that is present.[22]

43. Referrals for outpatient appointments, cancer treatment and psychological therapies decreased significantly between April and June 2020. This is concerning, as it is unlikely to be because of a reduced occurrence of illness. There are longer-term risks associated with delayed or missed diagnosis, such as people becoming more acutely unwell and requiring more intensive treatment.

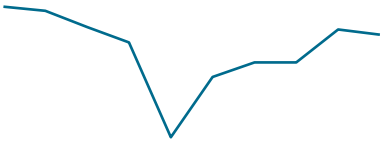
44. Referrals increased throughout 2021, indicating that more people are now seeking help for medical concerns than at the start of the pandemic (Exhibit 5, page 18). Referrals for psychological therapies have now exceeded pre-pandemic levels, and similar trends may be seen in other specialties in future.

45. Clearly the pandemic is having an impact on people's health beyond the direct effects of Covid-19. The scale of delayed diagnosis and treatment and what this means for NHS services and patients is not yet known. The Scottish Government does not yet have an overall strategy for monitoring the wider health impact of Covid-19. Public Health Scotland is monitoring some specific areas, such as the number of undiagnosed cancer cases. But a cohesive strategy is needed to better understand what the wider health impact of Covid-19 will be on NHS services and inform future service provision.

Exhibit 5.

Trend in referrals – April 2019 to September 2021

There were significantly fewer referrals for outpatient appointments, cancer and psychological therapies at the start of the pandemic, but levels have been increasing steadily since.

	April 2019 to September 2021			% change
Number of additions to the outpatient waiting list	464,691		403,770	↓ -13.1%
Referrals to start cancer treatment within 31 days of decision to treat	6,582		6,329	↓ -3.8%
Referrals to start cancer treatment within 62 days of referral	3,907		4,011	↑ 2.7%
Referrals for psychological therapies	38,314		40,528	↑ 5.8%

Source: Public Health Scotland

Demand for urgent and emergency care is putting significant pressure on hospitals

46. During the first few months of the pandemic, the number of people attending accident and emergency departments (A&E) fell significantly, and there were fewer emergency hospital admissions. These have both now increased and are similar to pre-pandemic levels.

47. Additional measures to prevent the spread of Covid-19, such as enhanced infection prevention and control measures, impact on productivity and flow in A&E.[23] This means that it is much more challenging to see and treat people within the four-hour target. For example, between 27 December 2021 and 23 January 2022, 72.9 per cent of unplanned attendances at A&E were seen within four hours, compared with 84 per cent between 30 December 2019 and 26 January 2020.[24]

48. The Scottish Ambulance Service (SAS) has also been under significant pressure. The need for additional PPE has increased the length of time that ambulance crews are spending with patients at the scene, and ambulances are also waiting outside hospitals for considerably longer. This is limiting the ability of ambulance crews to respond to other calls and leading to longer wait times for people who need an ambulance. SAS has required military support to supplement ambulance drivers and staff mobile testing centres. In September 2021, 225 military personnel were drafted in to support SAS.

49. SAS is working to improve the situation. It has accelerated plans to establish a navigation hub to direct paramedics to the most appropriate care for their patients. It is also in the process of recruiting GPs to assess the needs of patients waiting for an ambulance to prioritise their urgency more effectively.

Referrals for mental health services are now exceeding pre-pandemic levels, reflecting the impact of Covid-19 on people's mental health

50. The pandemic has had a considerable impact on mental health. It has been a difficult period for everyone, and lockdowns and physical distancing meant that some people were isolated from friends and family for months. There was, however, a considerable decrease in referrals for both adult and children's mental health services in 2020/21.[25] This is likely to reflect the impact of school closures and limited access to GPs and other services from which referrals are often made, rather than a reduction in demand.

51. In October 2020, the Scottish Government published its mental health transition and recovery plan, to respond to the mental health impacts of the pandemic.[26] The plan contains more than 100 actions, and the Scottish Government has committed £120 million in 2021/22 to take this work forward.[27] Referrals to mental health services and the number of appointments offered have now returned to pre-pandemic levels. In 2022, we plan to carry out further performance audit work on mental health services.

The Scottish Government has started to plan for Long Covid rehabilitation, but the extent of this condition is still unknown

52. Long Covid consists of prolonged symptoms, following a Covid-19 infection, that continue for more than four weeks and are not explained by an alternative diagnosis. In January 2022, an estimated 1.9 per cent of people in Scotland[28] were experiencing Long Covid symptoms.[29] The prevalence of Long Covid in Scotland is based on self-reported data, so this figure may not accurately represent the number of people with the condition. The figure only covers people living in individual

households and does not cover those in communal places of residence, such as care homes.

53. The Scottish Government has funded nine studies to develop the clinical knowledge base for Long Covid and its impact on people's health, which will also inform planning for the expected demand on NHS services.

54. In September 2021, the Scottish Government announced a £10 million Long Covid Support Fund and published its approach to supporting those affected. The approach is based on four key elements: self-management, primary care and community-based support, rehabilitation support, and secondary care services.[30] Many people are able to recover from Covid-19 at home, and the Scottish Government plans to promote self-management where possible. Self-management will also reduce any additional pressure being placed on NHS services. Several pieces of work are under way, including a self-management marketing campaign launched in October 2021.

The Scottish Government aimed to make public health measures inclusive, but some people were disproportionately affected

55. The Scottish Government and NHS Scotland took action to make attempts to control the virus as inclusive as possible. The Scottish Government carried out equality impact assessments (EQIAs) of several measures introduced to respond to the pandemic, such as the expansion of the Near Me video consulting programme. Other measures taken to support an inclusive approach included the following:

- Covid-19 vaccination programme – the Scottish Government and NHS boards worked with partners to increase vaccination uptake and reduce vaccine hesitancy through methods such as improving the accessibility of information, tailoring messages to specific communities and outreach work targeting groups that may be less likely to come forward for vaccinations.
- Test and Protect – working with partners to reach under-represented groups, for example by improving access to testing in targeted settings such as places of worship, making contact tracing scripts more accessible for non-native English speakers and people with other needs, and providing financial support for those self-isolating.

56. The Health and Social Care Alliance Scotland was invited by the Scottish Government to lead engagement work on people's experience of changes to health and social care during the pandemic.[31] The findings of this work included variation in access to services, such as GP services and specialist services. For some, such as those with chronic pain, the reduced access to support resulted in concerns about managing their health. Disability Equality Scotland also reported that disabled people

were anxious about the impact of cancelled or postponed appointments on their health.[32]

57. The Scottish Government and NHS boards should work with patients on an ongoing basis to inform the priorities for service delivery and be clear on how services are developed around patients' needs.

A collaborative approach is required to tackle long-standing health inequalities

58. Our NHS in Scotland 2020 report highlighted that some people have been more adversely affected by the pandemic than others. Those from the most deprived areas and from some ethnic minority backgrounds were more likely to die from Covid-19. Further data has shown that disabled people were more likely to have died from Covid-19.[33] Adults with learning disabilities were also at a greater risk of being hospitalised or dying from Covid-19.[34]

NHS in Scotland 2020
February 2021

59. The pandemic has exacerbated long-standing health inequalities. Life expectancy in Scotland had not changed since 2012–14, and the number of years that people live in good health has started to decrease. The trends in healthy life expectancy show that people living in more deprived areas could expect to live more than 20 fewer years in good health than those living in less deprived areas.[35]

60. Health inequalities continue to be a significant problem in Scotland since we last reported on this topic.[36] The disproportionate impact of Covid-19 on certain groups has led to the Scottish Government increasing its focus on tackling health inequalities, but there is no overarching strategy. Several programmes of work are under way targeting specific areas, for example on improving women's health and mental health, and improving race equality.

61. In September 2021, the Scottish Government published its Race Equality: Immediate Priorities Plan.[37] This aims to ensure a fair and equal recovery from Covid-19 for minority ethnic communities. It sets out the work taking place on race equality across government, as well as the actions being taken to implement the recommendations from the Expert Reference Group for Covid-19 and Ethnicity.

62. While it is positive that these programmes of work are taking place, it only targets some of the groups experiencing health inequalities. For instance, there are no separate plans for people with disabilities or those experiencing homelessness. The Scottish Government should develop an overarching strategy for tackling health inequalities and develop work programmes for all target groups.

63. Improving health and reducing health inequalities require holistic action across the Scottish Government and its partners. Public sector partners can play an important role in changing behaviours. As well as

providing health services, it is necessary to create the conditions that lead to good health, such as employment, education and good quality housing. Better health will also have wider benefits to society and the economy.

64. In December 2020, the Scottish Government established the new Health Inequalities Unit (HIU) within its Population Health Directorate. The HIU aims to embed equity and human rights in the response to the pandemic and across wider healthcare services.

65. The HIU is developing a single health equity vision. This aims to provide NHS boards with clear priorities, but this work is at a very early stage. The HIU includes a fair health team that focuses on the social and economic drivers of health inequality, such as low income, inadequate housing and poverty. The team will work with other government departments including education, social justice and housing, to bring a cross-government approach.

66. The work of the HIU will be crucial to building a sustained approach to reducing health inequalities. Such work should focus on cross-government initiatives and emphasise tackling the wider factors contributing to inequality. The fair health team will have a role in driving this work forward.

Public Health Scotland has had an important role in responding to the pandemic, and work on its wider priorities is now under way

67. Public Health Scotland (PHS) became operational in April 2020, at the start of the pandemic. PHS was established to enable and support local and national bodies to work together to improve health and wellbeing in communities. It has a key role in working with its partners to reduce health inequalities.

68. Since PHS was established, its focus has largely been on responding to the pandemic. This has included developing the Covid-19 daily dashboard, providing public health advice and supporting the Covid-19 vaccination programme. As a newly established body, PHS has also been developing its leadership and organisational structures.

69. PHS has identified priorities as part of its strategic plan 2020–23 and delivery plan 2021–23.[38] [39] These are Covid-19; mental wellbeing; communities and place; and poverty and children. These are complex challenges that will need collective action from PHS and partners across government and the public sector and third sector. Despite the pandemic being a core focus for PHS so far, several pieces of work are now under way, including:

- working with Police Scotland to produce real-time data on suicide and drug-related deaths to allow preventative action

- working with partners to support communities and local planning partners to better consider how climate change will affect their local area and on health and wellbeing
- working with children to develop mental health indicators that capture the key issues for children and young people
- providing guidance to local government on housing and homelessness.

More robust data is needed to understand and respond to long-standing health inequalities

70. Data on health inequalities is often confined to focusing on deprivation and sex, and less data is available on characteristics such as disability and ethnicity. The Scottish Government recognises this and has initiated programmes of work to improve the availability of data that can help inform decision-making. For instance, data is now being collected on Covid-19 vaccination uptake by ethnicity. This provides a better understanding of any inequity in the uptake of the Covid-19 vaccines, which will also allow appropriate action to be taken to increase uptake where it is lower in specific minority ethnic groups.

71. The Scottish Government is developing the Equality Data Improvement Programme. This aims to better understand what equality data is available and the barriers to collecting it, and to promote good practice in collecting better evidence. Some pieces of work have progressed quickly, for example the Scottish Government's chief statistician is leading a programme of work to improve data collation and analysis, by linking healthcare data with other datasets such as census and university data. This aims to improve the analysis of equality characteristics and to enable more preventative work to take place when tackling health inequalities (Case Study 1).

Drug- and alcohol-related deaths remain a serious concern

72. Despite Covid-19 being at the centre of government activity, other significant public health challenges remain. Drug and alcohol-related deaths have increased year on year, with 1,339 drug-related deaths and 1,190 alcohol-specific deaths registered in 2020. Deaths are higher among those living in deprived areas. Scotland's drug related death rates are the worst in Europe, and alcohol specific deaths rates are one of the worst in the United Kingdom.[40] [41]

73. A cross-government approach will be fundamental to providing holistic support for people at risk of drug and alcohol misuse. In the 2020/21 Programme for Government, the Scottish Government committed to investing an additional £250 million over this Parliament's term specifically to tackle the drug death emergency.[42] This will focus on community based support, quick access to treatment and expanding residential rehabilitation.

Case Study 1.
Data linkage to identify the risk factors to homelessness

Linking health data with data on homelessness has illustrated the impact that data can have on outcomes for vulnerable people.

Work led by the Scottish Government's chief statistician has connected these datasets to identify what happened to people before they became homeless. For example, people often go to see their GP about alcohol or drug use, and this information can be linked to other issues such as domestic abuse or involvement in the justice system. Using data in this systematic way helps to predict who is at risk of losing their homes, so that they can receive support to prevent them from becoming homeless in the first place. The use of data in this way supports a multi-agency and preventative approach to homelessness.

Source: Scottish Government

74. The Scottish Government has also committed to publishing quarterly data on drug-related deaths, to enable enhanced monitoring. Data from January to September 2021 shows a four per cent improvement compared to the same period in 2020.[43] But suspected drug deaths remain at a high level and there continues to be an upward trend over the period for which data is available. It is likely that results from new initiatives will take longer to show.

75. We published a drug and alcohol briefing in 2019 and plan to publish a further update in March 2022.[44] This will summarise the ongoing challenges for drug and alcohol services and the improvements needed.

Drug and alcohol services: An update
May 2019

NHS recovery and remobilisation

The Scottish Government's plans for the recovery and redesign of NHS services are ambitious but will be challenging and take a long time to realise

76. The Scottish Government and NHS Scotland are having to balance the immediate priorities of responding to Covid-19 and tackling the ever-increasing backlog of patients waiting to be seen. At the same time, they are planning for how healthcare services can be delivered more sustainably in the future. There is a long road ahead, and it will be challenging to make sufficient progress while dealing with the substantial pressures already in the system, which have been exacerbated by the pandemic.

77. The Scottish Government recognises that innovation and service redesign will be essential for the recovery of NHS services. It has published its NHS recovery plan, which aims to address the substantial backlog in planned care while continuing to meet ongoing urgent health and care needs.[45] The NHS intends to achieve this by increasing the capacity of healthcare services and redesigning patient pathways.

78. Key actions will include opening National Treatment Centres (NTCs) across Scotland to help increase inpatient and day case activity to 20 per cent above pre-Covid levels by 2025/26. Within the same timescale, redesigning care pathways is expected to contribute to an increase in outpatient activity to ten per cent above pre-pandemic levels. The Scottish Government has developed a Centre for Sustainable Delivery (CfSD), which aims to support boards to redesign how services are delivered and embed best practice across Scotland.

79. The ambitions in the plan will be stretching and difficult to deliver against the competing demands of the pandemic and an increasing number of other policy initiatives, such as plans for developing a National Care Service (NCS). The recovery plan will involve new ways of delivering services and these will take a lot of work. There is not enough detail in the plan to determine whether ambitions can be achieved in the timescales set out.

80. In our NHS in Scotland 2017 report we noted the growing complexity in how healthcare is planned, with a mix of local, regional and national planning.[46] The NTCs, CfSD and the NCS have the potential to add to this complexity. It is not yet clear how planning across these

NHS in Scotland 2017
October 2017

different levels will work in practice. It is important that roles and responsibilities, and how they link together, are well defined to ensure:

- there is clear accountability
- it is clear how public money is being used
- the public are easily able to access health and social care services that are joined up effectively.

81. We welcome the Scottish Government's commitment to publishing annual updates on the NHS recovery plan to inform the public on the progress being made.

There are several risks associated with the successful recovery and redesign of NHS services

82. Making significant and ambitious changes in how services are delivered inevitably involves risks. The Scottish Government and the NHS must manage these risks carefully if the objectives set out in the recovery plan are to be achieved.

83. The NHS recovery plan and other key strands of recovery, such as the new Care and Wellbeing Portfolio and the new Digital Health and Care Strategy (paragraph 108), show that the Scottish Government and the NHS have plans in place to manage some of the risks. But it remains to be seen how some other risks will be managed. These are set out in the rest of this section.

New Covid-19 variants could derail recovery plans

84. The emergence of the Omicron variant towards the end of 2021 shows that the future course of the Covid-19 pandemic, and the impact on people's health and NHS services, remains uncertain. There is potential for any new variant to spread more easily, to be more resistant to vaccines, or to result in more severe symptoms. These possible outcomes could all potentially divert efforts away from recovery and back towards the immediate pandemic response.

The Scottish Government must prioritise addressing workforce availability challenges if its recovery plan is to be successful

85. The workforce commitments set out in the recovery plan are significant and build on substantial existing commitments from previous plans (Exhibit 6, page 27).

86. The additional numbers of staff needed to meet the plan's ambitions, alongside existing and potential recruitment challenges, mean that the Scottish Government will need to use innovative recruitment methods to fill positions. The recovery plan includes a commitment to invest £11 million over the next five years in new national and international

recruitment campaigns and establish a Centre for Workforce Supply. There are also plans to increase the number of undergraduate places to study medicine by 100 per year.

87. We have highlighted in previous reports that the NHS has struggled to recruit enough people with the right skills to certain positions, and that the UK's departure from the EU could further reduce the pool of workers available in future years.[47] We also highlighted a lack of robust and reliable workforce data in our NHS workforce planning – part 2 report, particularly in relation to primary care.[48] We are yet to see evidence that this has improved, and there is a risk that it inhibits effective workforce planning. It will also make it difficult to monitor progress in achieving workforce objectives.

NHS workforce planning – part 2
August 2019

Exhibit 6.
New and existing workforce commitments

Existing committments from the Integrated National Workforce Plan 2018

- 800 new mental health workers by 2022
- 500 advanced nurse practitioners
- Increase the GP workforce by 800 by 2027
- 225 new advanced musculoskeletal practitioners by 2024/25
- 30 new reporting radiographer training places over the next three years
- 30 new training places in cardiac physiology

Staffing committments – NHS Recovery Plan 2021/26

- 1,500 new clinical and non-clinical staff for National Treatment Centres by 2026
- 1,000 additional staff in primary care mental health
- 100 more undergraduate medical places per annum and more widening access places
- New recruitment campaigns and establish a Centre for Workforce Supply (£11 million)
- Youth employment opportunities through the Young Person's Guarantee
- Additional training opportunities through the NHS Academy

Source: Scottish Government

88. The Scottish Government, in conjunction with the Convention of Scottish Local Authorities (COSLA), aims to publish a new national workforce strategy for health and social care in early 2022. This will include high level objectives, an action plan covering the short, medium and long term, and projections for anticipated workforce growth. It is crucial that this strategy is aligned with the NHS recovery plan and leads to a more integrated approach to workforce, service and financial planning. Recovery ambitions cannot be met if the right people with the right skills are not in place. We plan to carry out further audit work on this in due course.

Meeting ambitious targets must not come at the expense of staff wellbeing

89. There is clear commitment at Scottish Government and NHS board level to support staff wellbeing, and it features prominently in the NHS recovery plan. However, the plan also outlines significant additional demands on NHS staff that could negatively impact their wellbeing. The ambition to significantly increase activity could undermine the desire to improve staff wellbeing.

90. It will be important for the Scottish Government and health and social care bodies to work together to monitor the progress and evaluate the effectiveness of the new staff wellbeing measures (paragraph 22), and to better understand and provide for staff support needs.

Supporting and developing NHS leaders is vital

91. Leaders in the NHS and Scottish Government have been under considerable pressure throughout the pandemic. The planned NCS will see responsibility for social care transfer from local authorities to Scottish ministers. It will require significant reform which will add further pressure, along with the challenges of responding to the pandemic and the recovery and redesign of NHS services. We set out key risks and challenges in developing a NCS in our response to the Scottish Government's consultation.[49]

92. The recovery and reform of health and social care services needs stable, effective and capable leadership. We have previously highlighted issues with high turnover and short tenures in some NHS leadership positions, as well as concerns about a lack of succession planning and support for new leaders.

93. Over three years ago, the Scottish Government introduced Project Lift. This is a leadership development programme designed to create a more person-centred approach to leadership in the health and social care system. The Scottish Government is now developing a National Leadership Development Programme (NLDP), building on the progress made under Project Lift. The NLDP is at an early stage and is initially

focusing on senior and executive leaders. We will continue to monitor the impact of the NLDP in future audit work.

NHS in Scotland 2018
October 2018

94. The NLDP includes a workstream on succession planning, aimed at creating a system to identify and develop talent for senior leadership roles. In our NHS in Scotland 2018 report we found that a similar succession planning programme was under way.[50] It is not clear how the new workstream links to this previous work.

The Scottish Government needs to ensure that new ways of delivering services are clearly communicated

95. The Scottish Government and NHS boards need to continually engage with the public in a meaningful way to shape priorities for recovery and develop sustainable, person-centred ways of delivering health and social care services. The public will have to access services differently, and that will require a culture change. The Scottish Government and NHS need to clearly communicate to the public any changes to how services should be accessed.

96. The Scottish Government commissioned Health and Social Care Alliance Scotland to engage with the public to identify priorities for accessing services. The priorities it identified put people at the centre of decision-making. The Scottish Government and NHS boards should incorporate these priorities into their plans for the recovery and redesign of NHS services.

The Scottish Government and NHS need to prioritise prevention, early intervention and equity in their recovery plans

97. Early intervention and preventative care are fundamental to the long-term sustainability of NHS services and can help reduce health inequalities. The Scottish Government and NHS need to make sure that the importance of prevention is not lost as they continue to respond to the pandemic and transform how care is delivered. In his September 2021 blog, the Auditor General for Scotland discussed the slow progress in making the shift towards prevention and in improving long-term outcomes for individuals and communities set out in the Christie report.[51]

98. The NHS must prioritise this while also dealing with immediate pressures based on clinical priority and urgency. It will have to address the challenge of moving funding into early intervention and preventative care when there are existing pressures in emergency and planned healthcare.

The collection and use of health and social care data must improve to support decision-making and monitor progress in delivering outcomes

99. The lack of, or analysis of, primary, community and social care data has been a common theme in Audit Scotland reports for several years. This data is important for informed decision-making, planning and scrutiny. It is also needed to demonstrate whether, and the extent to which, government policies and initiatives are delivering improved outcomes. There should be stronger data linkages across the NHS and public sector to help deliver better outcomes for people.

100. Data is a prominent theme throughout the refreshed Digital Health and Care Strategy (paragraph 108). It commits the Scottish Government and COSLA to developing a Data Strategy for Health and Social Care. It also acknowledges the impact that poor data sharing and access to health records can have on the delivery of care and continuity between services. Information governance, assurance and cyber-security will be key elements of the data strategy.

Meeting net zero targets could make the recovery process more challenging

101. Like all public bodies in Scotland, NHS boards are required by law to reduce carbon emissions and become net zero by 2045. NHS Scotland aims to bring this forward to 2040 following consultation on its draft NHS Scotland Climate Emergency and Sustainability Strategy.[52]

102. Net zero requirements add to the challenges of the NHS recovery process and will need additional investment. It is vital that the Scottish Government and NHS make the most of the opportunities arising during the pandemic to reduce carbon emissions in the health sector.

The Scottish Government is developing a Care and Wellbeing Portfolio to improve outcomes and health and social care services

103. The Scottish Government has recognised that a new long-term strategy is needed for health and social care to direct and oversee the recovery and redesign of services. It has set up a Care and Wellbeing Portfolio to set the strategic direction for health and social care in Scotland and to oversee four programmes of work. The programmes and their aims are:

- integrated planned care – to be flexible and adaptable to respond to emerging challenges, embrace rapid change in the delivery of health and care services and be inclusive in the approach to recovery, and promote transformation and innovation to deliver a world class service

- integrated unscheduled care – to take a whole system approach to the redesign of services, with an overarching aim of improving outcomes for people and delivering the right care in the right place
- preventative and proactive care – to proactively keep people well, independent and in the most appropriate care setting for their needs
- place and wellbeing – communities, third sector and public sector organisations working jointly to drive improvement in health and wellbeing and reduce health inequalities of the population within local communities.

104. The Care and Wellbeing Portfolio is at an early stage of development. It has considerable potential and ambitious aims but achieving these will be challenging. The Scottish Government is committed to designing a new coherent and sustainable system, focused on reducing inequality, prioritising prevention and early intervention, and improving health and wellbeing outcomes.

105. Its objectives include developing a decision-making framework that prioritises prevention and early intervention. This is promising, but more detail is needed to determine how it will work in practice.

106. This work will require long-term, dedicated resources and commitment from leaders. It should take a whole-system approach, involving staff across government and other partners across public services and the third sector. The portfolio should embed service redesign, workforce planning, financial planning and capital investment in its approach and governance structure, to ensure that strategies are aligned and are working towards the same goals.

The NHS has implemented a range of new ways of working to improve access to healthcare services

107. Several new ways of working have been introduced throughout the pandemic to enable the NHS to improve access to healthcare services not related to Covid-19. The pandemic has also accelerated improvements that were already under way. The examples shown in Exhibit 7 (page 32) demonstrate the range of and potential for new ways of delivering services emerging from the crisis.

The Scottish Government is committed to embracing digital technologies

108. The Scottish Government is committed to increasing the use of digital technologies as part of the recovery and remobilisation of NHS services. The Scottish Government and COSLA published a revised Digital Health and Social Care Strategy in October 2021.[53] It highlights the progress made during the pandemic, and identifies gaps that need to

Maintaining patient access

The rapid rollout of NHS Near Me and other non-face-to-face consultations helped to maintain some access to healthcare services during the early stages of the pandemic (Exhibit 7).

Exhibit 7.

The NHS has introduced innovative new ways of working throughout the pandemic

There is scope to roll out new ways of delivering services beyond the pandemic with potential benefits to future healthcare provision

Theme	Case study	Benefits
 **Maintaining patient access**	The rapid rollout of NHS Near Me and other non-face-to-face consultations helped to maintain some access to healthcare services during the early stages of the pandemic.	Reduced need for physical attendance at a hospital or GP practice, helping maintain patients at home during the pandemic while reducing the risks associated with delayed diagnosis. There are also timesaving, environmental and travel safety benefits. It helps to reduce the number of missed appointments and cuts back on PPE usage.
 **Technological innovation in treatment, diagnosis and monitoring**	Rollout of faster, simpler alternatives to endoscopic procedures for diagnosing conditions like Barrett's Oesophagus, a known risk factor for oesophageal cancer.	Procedures can be carried out in locations other than traditional hospital environments, like community health centres and GP practices. It frees up senior staff and capacity within endoscopy units and reduces the cost and time needed to diagnose and treat patients.
 **Using data to improve services**	PHS is collaborating with some Scottish universities on the EAVE-II study, which tracks the progress of the Covid-19 pandemic in near real-time across Scotland.	EAVE II shows the difference Covid-19 vaccines make, but it shows that by linking data we can learn about the difference a whole series of interventions can make to Scotland's health. This approach offers opportunity to study other conditions, to describe their risk and the public health benefit of treatments in the future.
 **Introducing new operational models**	The Redesign of Urgent Care (RUC) programme is designed to address the demand issues in urgent and unscheduled care.	The Scottish Government continues to review the new model, but if successful it should reduce A&E waiting times and relieve pressure on A&E staff and ambulance services.
 **Multi-agency and collaborative working**	Local multidisciplinary teams from NHS boards and councils enhanced the oversight of local care homes and wider social care services during the pandemic.	The relationships built up in these multi-disciplinary teams enhanced support for social care services. These relationships will hopefully lay the foundations for further collaborative working and strengthen health and social care integration.

Source: Scottish Government and Audit Scotland

be addressed, particularly digital exclusion. The Accounts Commission's September 2021 blog post on digital exclusion highlights how Covid-19 has exacerbated inequality in this area.

109. The revised strategy aims to improve the care and wellbeing of people in Scotland by making best use of digital technologies and delivery of services. It has three main aims:

- Aim 1 – Citizens have access to, and greater control over, their own health and care data, as well as access to the digital information, tools and services they need to help maintain and improve their health and wellbeing.
- Aim 2 – Health and care services are built on people-centred, safe, secure and ethical digital foundations that allow staff to record, access and share relevant information across the health and care system, and to use digital technology confidently to improve the delivery of care.
- Aim 3 – Health and care planners, researchers and innovators have secure access to the data they need to increase the efficiency of our health and care systems and develop new and improved ways of working.

110. Adopting digital technologies will be crucial to the transformation needed to make sure NHS services are sustainable in the future. But this cannot be done in isolation. It must be part of wider overall service redesign plans that are built around the needs of patients and staff.

NHS finances

The Covid-19 pandemic resulted in significant additional expenditure across the NHS in 2020/21

111. Responding to the Covid-19 pandemic resulted in significant additional costs. In 2020/21, £2.9 billion of funding was allocated across health and social care for Covid-19-related costs.[54] Of this, £1.7 billion was allocated to NHS boards and integration authorities (IAs). In 2020/21, NHS boards' total funding allocation was £16.3 billion (Exhibit 8, page 35). This is 19 per cent more in cash terms than in 2019/20 (£13.7 billion).

112. The Scottish Government provided clear direction to NHS boards about how Covid-19 expenditure should be monitored and reported throughout 2020/21. External auditors found that financial management associated with Covid-19 expenditure was appropriate across all NHS boards, with a clear distinction between reporting of Covid-19 and non-Covid-19 expenditure. Our NHS in Scotland 2020 report sets out detail of the monitoring and reporting arrangements in place during 2020/21.

NHS in Scotland 2020
February 2021

Covid-19 had a considerable impact on NHS boards' ability to achieve efficiency savings

113. Responding to the Covid-19 pandemic has had a considerable impact on NHS boards' ability to deliver efficiency savings. In recognition of this, in February 2021, the Scottish Government stated that it would fully fund NHS boards and Health and Social Care Partnerships (HSCPs) to achieve financial balance for 2020/21.[55]

114. Several NHS boards relied on this support from the Scottish Government in 2020/21. In total, the Scottish Government allocated £102 million to 14 NHS boards for this purpose. The shortfall is recurring, and boards will need to achieve the savings in future years, adding to the substantial financial pressures which existed in the NHS before the pandemic.

115. The Scottish Government is providing additional support to six NHS boards facing a particularly challenging financial position. As part of this, since autumn 2021 these NHS boards have been submitting monthly plans to the Scottish Government on how they plan to achieve savings, with the aim of improving their positions by the start of the 2022/23

Exhibit 8.
A breakdown of NHS funding in 2020/21 and key areas of spending

Total Scottish Government health budget including Covid-19 funding

£18bn

£2.9bn

Of which is Covid-19 funding

35%
of total Scottish budget

£1.7bn
Central Spend

NHS Scotland including Covid-19 funding

£16.3bn

£15.8bn	**£480m**
Revenue	**Capital**
£13.7bn Territorial boards	**£391m** Territorial boards
£2.1bn National boards	**£89m** National boards

Examples of key areas of spend

£8.6bn
Staffing costs
£7.6bn in 2019/20

£2.7bn
Drug and medical supplies
£2.4bn in 2019/20

Notes:
1. Staffing costs include medical and dental (£2bn), nursing (£3.3bn), and other (£3.3bn).
2. Drugs and medical supplies includes prescribed drugs secondary care (£818m), prescribed drugs primary care (£1.1bn), PPE and testing kits (£286m), and medical supplies (£492m).
3. Central spending is the amount spent centrally on behalf of NHS boards – this includes initiatives such as non-discretionary payments (Family Health Services), the £500 thank you payments and the nursing bursary.

Source: Scottish Government 2020/21 Spring Budget Revision, Scottish Government 2020/21 consolidated accounts

financial year. These boards are NHS Ayrshire and Arran, NHS Borders, NHS Dumfries and Galloway, NHS Fife, NHS Highland and NHS Orkney.

116. NHS Tayside has been subject to ongoing parliamentary attention in recent years. In December 2020, we presented a sixth consecutive Section 22 report to the Scottish Parliament on NHS Tayside.[56] This found that NHS Tayside was making progress under its new executive leadership team, financial management was stronger and there were some improvements in service performance. However, there were still

The 2019/20 audit of NHS Tayside
December 2020

Case Study 2.
NHS Tayside

The board operated within its revised financial targets for 2020/21 and achieved its planned efficiency savings of £28.1 million. This was after repaying £3 million to the Scottish Government of its outstanding £7 million borrowed and returning £7 million of its allocated funding to the Scottish Government for re-allocation in 2021/22. In common with all NHS boards, the Covid-19 pandemic has had a significant impact on the focus and priorities of NHS Tayside, and the effect of this on the board's longer-term financial position and savings targets is still uncertain.

Improvements are being made in mental health services in Tayside although significant work is still required. NHS Tayside is considering its response to the recent independent inquiry into mental health services in Tayside, Trust and Respect, Progress Report 2021. The Minister for Mental Wellbeing and Social Care has recently appointed an independent group to provide oversight and assurance, and support progress in improving Tayside's mental health services. We will monitor the board's progress in this area in 2021/22.

In June 2021, the Scottish Government de-escalated NHS Tayside from stage 4 on the escalation framework to stage 2, in relation to financial position, governance and leadership, and performance; and to stage 3, in relation to mental health performance. This further reflects the improvements made by the board.

Source: Audit Scotland

matters to be addressed. The 2020/21 annual audit found that NHS Tayside is continuing to make progress (Case Study 2).

NHS boards face an uncertain and challenging financial position in 2021/22 and beyond

117. The NHS was not financially sustainable before the Covid-19 pandemic, with boards relying on additional financial support from government or non-recurring savings to break even. The scale of the financial challenge has been exacerbated by the pandemic. The cost of delivering services has risen and additional spending commitments made by the Scottish Government add to NHS boards' financial pressures.

118. The Programme for Government 2021-22 sets out the Scottish Government's intention to increase funding for frontline healthcare services by at least £2.5 billion by 2026/27.[57] It also commits to increasing primary care funding by 25 per cent, and to reviewing the NHS funding formula to ensure that the funds are distributed equitably. The Scottish Government has not yet set a date for this review to be completed.

119. The Programme for Government also sets out the commitment to invest £10 billion over the next ten years to replace and refurbish healthcare facilities across Scotland. Of this, a considerable amount, £400 million, will be spent on the NTCs. The Scottish Government has also now committed to bringing forward its target date for the NHS estate to achieve net zero emissions from 2045 to 2040. This will require substantial investment and it is not yet clear whether additional capital funding will be needed to achieve this over and above the £10 billion already announced.

120. The Scottish Government required NHS boards to produce one-year financial plans for 2021/22 because of the ongoing uncertainty about the costs and financial impact of Covid-19 and about what funding would be available. In September 2021, NHS boards and HSCPs submitted updated projections of the costs associated with Covid-19 and remobilisation for the 2021/22 financial year. These showed that they expect to spend £1.5 billion, including predicted unachievable savings of £116.6 million. The main areas of expected spending are as follows:

- Covid-19 vaccination programme – £203.7 million
- testing – £184.6 million
- additional PPE – £158.9 million
- additional staff costs – £95.1 million.

121. The Scottish Government has confirmed that all frontline health-related Barnett consequentials received from the UK Government would continue to be passed on to health and social care in Scotland.[58] At

February 2022, the Scottish Government has confirmed £2.5 billion in Covid-19 health-related consequentials in 2021/22.

122. There is uncertainty in the longer term about what Covid-19 related expenditure will be needed and about what funding will be available. NHS boards should return to medium-term financial planning in 2022/23, to help identify the known factors in NHS funding over the next three to five years and ensure a balance between policy ambitions and available resources.

123. The Scottish Government is working with NHS boards to determine which Covid-19 related costs are likely to become recurring. Uncertainty about how the pandemic will progress makes this particularly challenging. Greater certainty about costs would enable the Scottish Government to develop more accurate funding requirements for NHS boards and would enable NHS boards to develop more accurate financial plans.

124. The Scottish Government has committed to revising the health and social care medium-term financial framework. The timing of this will depend on the impact of Covid-19 across health and social care and planned reforms, including the impact of the Care and Wellbeing Portfolio and establishing an NCS.

Endnotes

1 NHS in Scotland 2020, Audit Scotland, February 2021.

2 Covid-19: Vaccination programme, Audit Scotland, September 2021.

3 NHS in Scotland 2020, Audit Scotland, February 2021.

4 Covid-19: Vaccination programme, Audit Scotland, September 2021.

5 Daily Trend of Vaccinations by Age Group and Sex, Public Health Scotland, February 2022.

6 PCR means polymerase chain reaction. These tests are a highly accurate way to diagnose certain infectious diseases, such as Covid-19.

7 Coronavirus (COVID-19): trends in daily data, Scottish Government, February 2022. COVID-19 Daily Dashboard, Public Health Scotland, February 2022.

8 Coronavirus (COVID-19) asymptomatic testing programme: evaluation – November 2020 to June 2021, Scottish Government, December 2021.

9 Health and social care: winter overview 2021 to 2022, Scottish Government, October 2021.

10 Coronavirus (COVID-19) trends in daily data, Scottish Government, February 2022. Numbers of NHS staff reporting as absent for a range of reasons related to Covid-19. Covers hospital and community health services and excludes those working in general practice. Stress-related absence due to Covid-19 is recorded as sick leave and is also excluded.

11 NHS Scotland worforce data, NHS Education for Scotland, September 2021.

12 RCN Employment Survey 2021, Royal College of Nursing, December 2021.

13 Ibid.

14 £8 million package for health and social care workforce wellbeing, Scottish Government, June 2021.

15 Health and social care: winter overview 2021 to 2022, Scottish Government, October 2021.

16 NHS recovery plan 2021–2026, Scottish Government, August 2021.

17 Social care briefing, Audit Scotland, January 2022.

18 Coronavirus (COVID-19) initial health and social care response: lessons identified, Scottish Government, August 2021.

19 COVID-19 Inquiry, Scottish Government, August 2021.

20 Deaths involving Coronavirus (Covid-19) in Scotland, weekly data tables (week 1, 2022), National Records of Scotland, January 2022.

21 Coronavirus (COVID-19): supporting elective care – clinical prioritisation framework, Scottish Government, November 2020.

22 Public attitudes to coronavirus: tracker – data tables, Scottish Government, December 2021.

23 Productivity in UK healthcare during and after the Covid-19 pandemic, The Productivity Institute, February 2021.

24 NHS Performs – weekly update of emergency department activity and waiting time statistics, weekly NHS Scotland data, Public Health Scotland, week ending 9 January 2022.

25 Child and Adolescent Mental Health Services, Audit Scotland, August 2021.

26 Coronavirus (COVID-19): mental health – transition and recovery plan, Scottish Government, October 2020.

27 NHS recovery plan 2021–2026, Scottish Government, August 2021.

28 Long Covid estimates are based on participant responses to the Coronavirus Infection Survey, collected over the four-week period ending 2 January 2022 and are weighted to represent the UK population.

29 Coronavirus (COVID-19) latest insights: infections, Office for National Statistics, January 2022.

30 Coronavirus (COVID-19): Scotland's Long Covid service, Scottish Government, September 2021.

31 Health, Wellbeing and the COVID-19 Pandemic: Scottish Experiences and Priorities for the Future, Health and Social Care Alliance Scotland, September–December 2020.

32 Impact of COVID-19 on Disabled People, Disability Equality Scotland briefing paper, Disability Equality Scotland, March 2020.

33 Deaths involving coronavirus (COVID-19) in Scotland, National Records of Scotland, March 2021.

34 COVID-19 infection and outcomes in a population-based cohort of 17,173 adults with intellectual disabilities compared with the general population, Scottish Learning Disabilities Observatory, February 2021.

35 Scotland's Population 2020: The Registrar General's Annual Review of Demographic Trends, August 2021.

36 Health inequalities in Scotland, Audit Scotland, December 2012.

37 Race equality: immediate priorities plan, Scottish Government, September 2021.

38 Public Health Scotland Strategic Plan 2020–23, Public Health Scotland, September 2020.

39 Public Health Scotland Delivery Plan 2021–24, Public Health Scotland, June 2021.

40 Drug-related Deaths in Scotland in 2020, National Records of Scotland, July 2021.

41 Alcohol-specific deaths, National Records of Scotland, August 2021.

42 A Fairer, Greener Scotland: Programme for Government 2021-22, Scottish Government, September 2021.

43 Suspected drug deaths in Scotland: July to September 2021, Scottish Government, December 2021.

44 Drug and alcohol services: An update, Audit Scotland, May 2019.

45 NHS recovery plan 2021–2026, Scottish Government, August 2021.

46 NHS in Scotland 2017, Audit Scotland, October 2017.

47 NHS in Scotland 2020, Audit Scotland, February 2021. NHS Workforce Planning – Part 2, Audit Scotland, August 2019. NHS Workforce Planning, Audit Scotland, July 2017. Scotland's NHS Workforce, Audit Scotland, February 2017.

48 NHS Workforce Planning – Part 2, Audit Scotland, August 2019.

49 Response to consultation on a National Care Service for Scotland, Audit Scotland, November 2021.

50 NHS in Scotland 2018, Audit Scotland, October 2018.

51 Christie 10-years on, Audit Scotland, September 2021.

52 Consultation draft: NHS Scotland Climate Emergency and Sustainability Strategy 2022-26, NHS Scotland, November 2021.

53 Digital health and care strategy, Scottish Government, October 2021.

54 Covid-19: Tracking the impact of Covid-19 on Scotland's public finances, Audit Scotland, September 2021.

55 Health and Social Care Partnerships were formed to integrate services provided by NHS boards and councils in Scotland.

56 The 2019/20 audit of NHS Tayside, Audit Scotland, December 2020.

57 A Fairer, Greener Scotland: Programme for Government 2021-22, Scottish Government, September 2021.

58 The UK Government uses the Barnett formula to allocate funds to Scotland, Wales and Northern Ireland when additional money is spent in areas that are devolved to the relevant administrations, such as health.

Appendix

Audit methodology

This is our annual report on the NHS in Scotland. Given the continuing challenges of the Covid-19 pandemic in 2021, the report focuses on:

- the ongoing response to the Covid-19 pandemic
- the health impact of the pandemic on the population of Scotland
- the impact of the pandemic on the NHS workforce
- the progress being made towards the recovery and remobilisation of NHS services
- the financial impact of the Covid-19 pandemic on the NHS in Scotland in 2020/21, and challenges for 2021/22 and beyond.

Because of the Covid-19 pandemic, the audit was carried out remotely. Our findings are based on evidence from sources that include:

- strategies, frameworks and plans for responding to Covid-19
- the audited annual accounts and auditors' reports on the 2020/21 audits of NHS boards
- activity and performance data published by Public Health Scotland
- publicly available data and information including results from surveys
- Audit Scotland's national performance audits
- interviews with senior officials in the Scottish Government and some NHS boards.

We reviewed activity and demand information at a national level to present the national picture. We focused on a sample of indicators that cover some of the main activities in the NHS.

NHS in Scotland 2021

Audit Scotland's published material is available for download on the website in a number of formats. For information on our accessibility principles, please visit:
www.audit-scotland.gov.uk/accessibility

For the latest news follow us on social media or **subscribe to our email alerts**.

AUDIT SCOTLAND

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

ISBN 978 1 913287 70 2

Burns, Christina

From: John Gilchrist <jgilchrist@audit-scotland.gov.uk>
Sent: 18 March 2022 10:06
To: Campbell, Jean
Subject: Proposed auditors 2022/23 to 2026/27

18 March 2022

Dear Jean Campbell

Audit Scotland recently conducted an audit tender exercise on behalf of the Auditor General for Scotland (for central government, health and further education bodies) and the Accounts Commission for Scotland (for local government). Following the completion of the tender, the proposed auditor of East Dunbartonshire IJB for the financial years 2022/23 to 2026/27 is KPMG.

I would be grateful if you could let me know of any reason why the proposed appointment would create a conflict of interest that would make the appointment inappropriate. When assessing potential conflicts of interest, we refer to the FRC's Ethical Standard and the Code of Audit Practice. The final decision on the appointment rests with the Auditor General and Accounts Commission.

The Auditor General and Accounts Commission selected six firms of accountants that, alongside Audit Scotland's own audit teams, will undertake public sector audits in Scotland for the financial years 2022/23 to 2026/27. Across all sectors, the successful private firms will undertake 38% of the total audit portfolio. The following firms and Audit Scotland will work in the sectors shown below:

Auditor	Local government	Health	Central government	Further education
Azets Audit Services	✓	✓	✓	✓
Deloitte	✓	✓	✓	✓
Ernst & Young	✓	✓		
Grant Thornton	✓	✓	✓	
KPMG	✓		✓	
Mazars	✓		✓	✓
Audit Scotland	✓	✓	✓	✓

In constructing the provisional allocation of audits, the following criteria were applied:

- Conflicts of interest – auditors were not appointed where they have a conflict of interest, for example through being internal auditors of the body.

- Grouping audits – auditors were appointed to align health boards and at least one of the councils in the health board area, and councils with associated Integrated Joint Boards and Joint Boards/Committees.

- Rotation of auditors – auditors were rotated to minimise reappointing a firm to the same audit.

- Equal portfolio sizes – audit firms were allocated equal sized portfolios to provide certainty of the level of work by bidding firms.

- Balanced portfolios – auditors were allocated at least two principal bodies and a mixture of differently sized bodies.

You will understand that it was not possible to satisfy all these criteria for each appointment.

Please provide any comments by 1 April 2022 so that we can proceed with finalising appointments. Please address any email responses to osmith@audit-scotland.gov.uk and copy to jgilchrist@audit-scotland.gov.uk. If we do not hear from you by this date, we will assume that you are not aware of any impediment to the proposed appointment. If you wish to discuss any aspect of this letter or the proposed appointment, please contact me (on 0131 625 1762) or Owen Smith (on 0131 625 1914).

Please let me know if you are no longer the right person to contact about this so we can update our records.

Yours sincerely

Elaine Boyd
Director – Audit Quality and Appointments

East Dunbartonshire Health & Social Care Partnership

Interim Chief Officer
Caroline Sinclair

East Dunbartonshire HSCP Performance, Audit & Risk (PAR) Committee Agenda Planner

Meetings

September 2021 – September 2022

Updated 21/03/22

Standing items (every meeting)
Minutes of last meeting (JC)
Committee Agenda Planner (JC)
HSCP Annual Delivery Plan Update (JC)
HSCP Committee Agenda Items – October 2021 (re scheduled from Sept 21)
Internal Audit Update (GMcC)
HSCP Corporate Risk Register Update (JC)
Final Audited Annual Accounts 2020/21 (JC)
Audit Scotland Annual Audit Report (PL)
Children's House Project Update (CC)
HSCP Committee Agenda Items – January 22
Internal Audit Update (GMcC)
Interim Internal Audit Follow Up Report (GMcC)
Care Inspectorate Report – Care at Home Service (DP)
HSCP Committee Agenda Items – March 2022
Internal Audit Update (GMcC)
Internal Audit Plan 2022/23 (GMcC)
Annual Audit Plan – Audit Scotland (PL)

Mental Welfare Commission Report – Care & Treatment for People with Alcohol Related Brain Damage in Scotland (2021)
Audit Scotland Reports
HSCP Board Agenda Items – June 2022
Internal Audit Update (GMcC)
Annual Internal Audit Report (GMcC)
HSCP Corporate Risk Register Update (JC)
Final Internal Audit Follow Up Report (GMcC)
Draft Annual Accounts 21/22 (JC)
HSCP Board Agenda Items – September 2022
Internal Audit Update (GMcC)
Final Audited Annual Accounts 2020/21 (JC)
Audit Scotland Annual Audit Report (PL)