East Lothian
Integration Joint Board

MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD AUDIT & RISK COMMITTEE

TUESDAY 12 SEPTEMBER 2017
COUNCIL CHAMBER, TOWN HOUSE, HADDINGTON

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Members Present:
Mrs M McKay (Chair)
Councillor S Currie
Councillor F O'Donnell

Council/NHS Lothian Officers Present:
Mr S Allan
Ms M Garden
Mr D King
Mr D Small

Others Present:
Ms E Scoburgh, Audit Scotland
Ms G Woolman, Audit Scotland

Clerk:
Ms F Currie

Apologies:
Ms F Ireland
Mr A Joyce

Declarations of Interest:
None

1. INDEPENDENT AUDITORS' REVIEW OF THE IJB ANNUAL ACCOUNTS 2016/17

A report was submitted by the Chief Finance Officer presenting the Independent Auditors' review of the IJB's annual accounts for 2016/17.

David King provided a brief background to the report reminding members that the IJB was required by statute to produce annual accounts and that these must be reviewed by independent auditors. The draft accounts were presented to the IJB in June 2017 and subsequently reviewed by the auditors. Following dialogue with officers, the auditors produced their report which included a series recommendations and responses from the Chief Officer and Chief Finance Officer. Mr King explained that the Independent Auditors now required to present their opinion to the Committee and that the Committee would wish to discuss the accounts and the report before they were presented to the IJB for final approval.

Gillian Woolman, the appointed auditor for the IJB, presented the report. She outlined the contents of Audit Scotland's letter of 12 September 2017 and the accompanying report and confirmed that they would be issuing an unqualified audit opinion. She drew members' attention to main conclusions of the audit report as they related to the areas of financial management and sustainability, governance and transparency and value for money. Ms Woolman concluded by highlighting the recommendations and management responses set out in the action plan.

The Chair noted that the general tenor of the auditors' report was positive. There was a discussion around the issue of risk sharing and Mr King explained that although there was no formal risk sharing agreement in place, a detailed financial assurance process had been undertaken with the Partners and the IJB had been kept informed of progress. Regarding financial pressures and recovery plans, he said that he had already (in 17/18) invoked the IJB's Integration Scheme and had asked NHS Lothian for details of their recovery plans.

Councillor Stuart Currie welcomed the report and the action plan. He remained concerned about how the Partners intended to deliver the necessary efficiency savings and the IJB's ability to recover in-year should these plans fall behind target. He supported the need for multi-year budget planning despite the obvious challenges this may pose. He cited providing assurances for ongoing funding of third sector organisations as just one benefit to this process. He was also pleased that the report recognised the importance of the Committee meeting in public. He concluded that the key factor would be how to measure performance consistently to ensure that targets were met and that sustainability of services was maintained.

David Small advised that NHS Lothian was now working on a five year financial plan and that the IJB would be would undertake its financial planning based on that and the Council's three year plan.

Ms Woolman pointed out that the audits carried out for the other IJBs would provide an overview of how things were working across the country and may also offer examples of good practice for them to consider.

Councillor Fiona O'Donnell asked for clarification on figures in the accounts relating to drug and alcohol funding and the adult wellbeing budget. She sought further information about what was included in the Set Aside allocation and observed that the timing of budget-setting was a major issue as NHS Lothian set its budgets much later than the Council.

Mr King gave further detail on the accounts and agreed to circulate additional information to members. He also explained that this year NHS Lothian had provided an indicative budget in March 2017, with only marginal change between it and the final budget in June 2017. The same arrangement would be in place next year and Mr King said he would use these figures to prepare a three year indicative plan.

Councillor O'Donnell also sought assurances that, despite a decrease in this year's budget, the IJB would be equipped to manage future challenges such as the introduction of the living wage for sleepovers. She noted that while the Scottish Government may make some money available for this change, it would expect the IJB to fund the remaining cost.

The Chair agreed, stating that this would increase funding pressures considerably in the current year and may impact on the ability to deliver existing care packages.

Mr Small indicated that a structure was in place to review night-time support packages but that this would not necessarily mean that care packages would change significantly.

Councillor Currie remarked that many of his constituents had expressed concern about the impact on care packages. He said that one of the key risks was the inability to recruit and retain staff and the living wage was only one part of the solution. He also referred to the transfer of funds from acute services and the importance of showing how this money had been invested elsewhere and the impact this had had on services.

Mr King said that officers were working to understand exactly how each budget within set aside services was used and where resources could be released to increase services elsewhere.

The Chair observed that the transfer of resources was not always about prevention. It could be about packages of care and investing in these and other services to achieve a reduction in demand in the future.

Mala Garden commented that many of the areas in the external auditors' report were consistent with the report she had submitted to the IJB in June 2017 and the recommendations were reflected in the Audit Plan for 2017/18.

Esther Scoburgh concluded that 2016/17 had been the first year of Audit Scotland's role as external auditors and they had developed a good relationship with staff and looked forward to working with them over the next four years.

The Chair raised a technical point regarding the accounts; asking if a reference to criminal justice services could be included. Mr Small confirmed that this would be done. She also asked that the auditors' comments be reflected back to the staff involved in the audit work.

Decision

The Committee agreed to:

(i) Note the Independent Auditors' review of the IJB's annual accounts.

(ii) Support the Auditors' recommendations.

(iii) Recommend the annual accounts to the IJB.

2. DATE OF NEXT MEETING

Mr King advised members that an additional meeting of the Committee had been scheduled for 2pm on Thursday 24 October 2017 to deal with the business not included on today's agenda.

Signed .....

Mrs Margaret McKay
Chair of the East Lothian IJB Audit & Risk Committee

East Lothian
Integration Joint Board

REPORT TO: East Lothian IJB – Audit and Risk Committee

MEETING DATE: 24 October 2017

BY: Chief Finance Officer

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SUBJECT: Audit and Risk Information Sharing Principles

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1 PURPOSE

This paper lays out the proposed information sharing principles between the Audit and Risk Committees of NHS Lothian and the four IJBs in the Lothian area.

2 RECOMMENDATIONS

2.1 The Committee is asked to agree the information sharing principles per the attached paper.

3. BACKGROUND

3.1 In 2015, NHS Lothian and its four Council partners set up Integration Joint Boards in each Council area. Each of these IJBs set up its own Audit and Risk Committee.

3.2 Given that each Council also has its own Audit and Risk committee there is clearly the potential for the IJB's Audit and Risk committees either not being aware of information already available to the partners or other IJBs or undertaking reviews which had already been addressed in other organisations.

3.3 NHS Lothian set up a meeting of IJB A&R chairs which was attended by the CFO on behalf of the East Lothian Audit and Risk Committee. This meeting agreed an overall set of principles to ensure a clear working relationship between the Audit and Risk Committees which, in essence, was an agreement to share all the reports and papers in all the Lothian A&Rs and to ensure that the chairs had the opportunity to share any information they thought fit to share.

3.4 The attached document now formally lays out these principles and NHS Lothian have asked that the IJB A&R committees endorse this position.

4 POLICY IMPLICATIONS

4.1 This paper is covered within the policies already agreed by the IJB.

5 INTEGRATED IMPACT ASSESSMENT

5.1 The are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

6 RESOURCE IMPLICATIONS

6.1 Financial – there are none.

6.2 Personnel – there are none.

7 BACKGROUND PAPERS

7.1 None

Appendices

1. Proposed Principles for Information sharing amongst Audit and Risk Committees – NHS Lothian, East Lothian IJB, Midlothian IJB, West Lothian IJB and Edinburgh IJBN

AUTHOR'S NAME	David King
DESIGNATION	Chief Finance Officer
CONTACT INFO	David.king@nhslothian.scot.nhs.uk
DATE	6 October 2017

THE PRINCIPLES TO UNDERPIN THE WORKING RELATIONSHIPS BETWEEN THE LOTHIAN NHS BOARD AUDIT & RISK COMMITTEE AND THE INTEGRATION JOINT BOARD AUDIT & RISK COMMITTEES

PRINCIPLE 1: The IJB Audit & Risk Committees and the Lothian NHS Board Audit & Risk Committee have an effective working relationship to take forward matters of common interest.

How will this work in practice?

- ✓ In addition to other specific measures, the chairs of the committees will meet every 6 months.
- ✓ The audit & risk committees, chief internal auditors and management from the IJBs and Lothian NHS Board shall work collaboratively to resolve issues and risks, recognising that for some issues and risks there are interdependencies between the IJBs.
- ✓ The IJB Chief Finance Officers shall lead the work required to maximise and maintain consistency in the IJBs' systems for risk management and risk registers. The aim is to create a reliable holistic view of risk from IJBs which can then inform the design of the NHS Lothian internal audit plan and make the most effective use of internal audit resources.
- ✓ In the event that the Lothian NHS Board Audit & Risk Committee should wish to call the attention of an IJB to a specific matter, the Chair will refer the matter through the established communication channel (see below), flagging the need for the matter to be drawn to the attention of the Chair of the IJB and the IJB Chief Officer. The matter could arise from any aspect of the Committee's business, e.g. audit reports, risks identified from risk management reports.
- ✓ In the event that an IJB Audit & Risk Committee identifies a matter of direct and material relevance to the Lothian NHS Board Audit & Risk Committee, the Chair will refer the matter through the established communication channel (see below), flagging the need for the matter to be drawn to the attention of the Chair of the Lothian NHS Board and the NHS Lothian Chief Executive.
- ✓ The IJB Audit & Risk Committees have the right to require NHS managers to attend their meetings, should they wish to discuss an internal audit report with them. However it is agreed that this right would be exercised after due consideration and would probably be exceptional. In the normal course of events the IJB Audit & Risk Committees will in the first instance rely on the scrutiny and oversight work of Lothian NHS Board Audit & Risk Committee.

3.1 Principles to Underpin Working relationships between ARCs

PRINCIPLE 2 : To support the efficient conduct of business, there is a clear communication process from the IJB Audit & Risk Committee to the Lothian NHS Board Audit & Risk Committee, and vice versa.

How will this work in practice?

- ✓ In the event that an IJB Audit & Risk Committee wishes to raise a matter directly with the NHS Lothian Audit & Risk Committee, the IJB Chief Finance Officer will be tasked with communicating the request.
- ✓ The IJB Chief Finance Officer shall send the request to the secretary of the Lothian NHS Board Audit & Risk Committee (currently Alan Payne, alan.payne@luht.scot.nhs.uk). The secretary shall process the request accordingly.
- ✓ With regard to communication from the Lothian NHS Board Audit & Risk Committee to the IJB audit & risk committees, the secretary of the Lothian NHS Board Audit & Risk Committee shall send the information to the IJB Chief Finance Officer (or an officer that the IJB Chief Finance Officer has identified for that purpose).

PRINCIPLE 3: The reports from the Lothian NHS Board internal audit function shall be readily available to the IJB audit & risk committees. The reports from the IJB internal audit functions shall be readily available to the Lothian NHS Board audit & risk committee.

How will this work in practice?

- ✓ The Lothian NHS Board Audit & Risk Committee has agreed to refer reports by instructing management to publish internal audit reports once the Committee has reviewed and accepted them. The NHS Lothian Chief Internal Auditor routinely publishes internal audit reports on the Board's website once they have been reviewed and accepted by the Committee.

  www.nhslothian.scot.nhs.uk / Our Organisation / Key Documents / Audits

- ✓ Once the reports have been placed on the website, the NHS Lothian Chief Internal Auditor shall email the IJB Chief Internal Auditors and Chief Finance Officers to make them aware of this. This email shall also advise whether any of the reports are relevant to integration functions.

- ✓ The IJB Audit & Risk Committees shall refer any relevant IJB internal audit reports to the Lothian NHS Board Audit & Risk Committee, and reflect that referral in their minutes. The IJB Chief Internal Auditor shall send the reports to the NHS Lothian Director of Finance and the secretary of the Lothian NHS Board Audit & Risk Committee.

3.1 Principles to Underpin Working relationships between ARCs

PRINCIPLE 4: The minutes of the IJB audit & risk committees and Lothian NHS Board audit & risk committee shall be accessible.
How will this work in practice? ✓ The Lothian NHS Board Audit & Risk Committee minutes will be available within the Board papers on its website, and the secretary of the committee will advise the IJB Chief Finance Officers when they are available. ✓ The IJB Audit & Risk Committee minutes will be available on the website of the relevant local authority, and the IJB Chief Finance Officers will advise the secretary of the Lothian NHS Board Audit & Risk Committee when they are available.

PRINCIPLE 5: The NHS Lothian internal audit plan shall take into account the requirements of the IJB internal audit plans.
How will this work in practice? ✓ The IJB Chief Internal Auditors shall liaise with the NHS Lothian Chief Internal Auditor when developing the IJB internal audit plan. The NHS Lothian Chief Internal Auditor shall set aside time to accommodate IJB work. ✓ The NHS Lothian internal audit plan shall be developed in the spirit of collaboration and co-ordination, to ensure that the NHS Lothian internal audit resource deployed to support IJB internal audit plans is being used effectively and with due regard to residual risk. ✓ The IJB Audit & Risk Committee shall approve the IJB internal audit plan. ✓ The Lothian NHS Board shall require assurance from the NHS Lothian Chief Internal Auditor that the NHS Lothian internal audit plan is compatible with the requirements of the IJB internal audit plans.

East Lothian
Health & Social Care Partnership

REPORT TO: East Lothian IJB – Audit and Risk Committee

MEETING DATE: 24 October 2017

BY: Chief Internal Auditor

SUBJECT: Internal Audit Plan 2017/18

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1 PURPOSE

1.1 To inform the Audit and Risk Committee of Internal Audit's operational plan for 2017/18.

2 RECOMMENDATION

2.1 That the Audit and Risk Committee approve the Audit Plan for 2017/18.

3 BACKGROUND

3.1 The annual audit plan has been prepared in accordance with Public Sector Internal Audit Standards (PSIAS).

3.2 In preparing the annual audit plan a range of factors have been taken into account, including:

- The Public Bodies (Joint Working) (Scotland) Act 2014, which sets out the framework for integrated adult health and social care services
- The Integration Scheme
- The IJB Strategic Plan
- The IJB risk register in place
- Changes in service delivery

3.3 Internal Audit will evaluate the adequacy and effectiveness of controls in responding to risks within the Integrated Joint Board's (IJB's) governance, operations and information systems, regarding the:

- Achievement of the IJB's strategic objectives.

- Reliability and integrity of financial and operational information.
- Effectiveness and efficiency of operations and programmes.
- Safeguarding of assets.
- Compliance with laws, regulations, policies, procedures and contracts.

3.4 The provision of the Internal Audit service is on an in-house basis by East Lothian Council's Internal Audit Unit, which is comprised of the Chief Internal Auditor, three Senior Auditors and one Senior Audit Assistant. In addition to the work undertaken by the in-house team, work is also undertaken by the NHS Lothian Internal Audit team – the 2017/18 Audit Plan includes one audit to be undertaken by the NHS Lothian Internal Audit team.

3.5 Internal Audit will adopt a risk based approach to audit assignments as the principal means of providing assurance on the adequacy, reliability and effectiveness of internal controls. Testing of controls will be carried out on a sample basis.

3.6 For each individual audit, a detailed audit report will be prepared for the IJB Chief Officer and copies of the audit report will be provided to External Audit and to members of the IJB Audit and Risk Committee.

3.7 All audit reports will highlight areas where expected controls have been met and areas where there is scope for improvement. A detailed action plan will be attached to each report listing all recommendations made and recording management responses to the recommendations.

3.8 Follow-up audits will be carried out to review the implementation of the recommendations made.

3.9 The Chief Internal Auditor will provide an annual report at the end of the financial year, outlining:

- A statement of the level of conformance with the Public Sector Internal Audit Standards and Local Government Application Note and the results of the Assurance and Improvement Programme that support the statement.
- An opinion on the overall adequacy and effectiveness of the IJB's framework of governance, risk management and control together with a summary of the work supporting the opinion.

3.10 The detailed Audit Plan for 2017/18 is attached.

4 POLICY IMPLICATIONS

4.1 None.

5 INTEGRATED IMPACT ASSESSMENT

5.1 The subject of this report does not affect the wellbeing of the community or have a significant impact on equality, the environment or economy.

6 RESOURCE IMPLICATIONS

6.1 Financial - None

6.2 Personnel - None

6.3 Other - None

7 BACKGROUND PAPERS

7.1 None

AUTHOR'S NAME	Mala Garden
DESIGNATION	Chief Internal Auditor
CONTACT INFO	01620 827326
DATE	13 October 2017

AUDIT PLAN 2017/18

AUDITABLE AREAS	SCOPE OF THE AUDIT	INTERNAL AUDIT ASSESSED RISK	WEEKS
Delayed Discharge (provisional – tbc)	The NHS Lothian Internal Audit team will review the key controls in respect of the delayed discharge process.	High	–
Strategic Plan	We will examine the arrangements in place for the reviewing, monitoring and updating of the East Lothian IJB Strategic Plan.	Medium	6
Risk Management	We will evaluate the effectiveness of the IJB's risk management processes in place including risk appetite, risk identification and the mitigation of risks.	Medium	6
Performance Management – Follow up	We will provide a progress report on the Performance Management arrangements within the IJB.	Medium	6
Other Audit Work	Time has been allocated for other audit work including the preparation of the audit plan, annual report, self-assessment against the Public Sector Internal Audit Standards (PSIAS) and follow up work on previously issued audit reports.	Low	6

East Lothian
Integration Joint Board

REPORT TO: East Lothian IJB – Audit and Risk Committee

MEETING DATE: 24 October 2017

BY: Chief Finance Officer

SUBJECT: Risk Register

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1 PURPOSE

This paper lays out the IJB's risk register.

2 RECOMMENDATIONS

The Committee is asked to:

2.1 Note the current risk register; and

2.2 Consider if any further risks should be added to the register

3. BACKGROUND

3.1 As a key part of its governance process the IJB maintains a risk register. This risk register examines the risks that impact on the business of the IJB itself and not the operational risks that the IJB's partners manage unless those risks are considered so significant that they could impact on the business of the IJB – that is impact on the ability of the IJB to deliver its strategic plan.

3.2 The current version of the risk register is attached. Members are asked to consider if there are additional risks that require to be added to the register and consider if the management actions identified against these current risks provide assurance that these risks are being appropriately managed.

4 POLICY IMPLICATIONS

4.1 This paper is covered within the policies already agreed by the IJB.

5 INTEGRATED IMPACT ASSESSMENT

5.1 The are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

6 RESOURCE IMPLICATIONS

6.1 Financial – there are none.

6.2 Personnel – there are none.

7 BACKGROUND PAPERS

7.1 None

Appendices

1. Risk Register
2. Risk Register action plan

AUTHOR'S NAME	David King
DESIGNATION	Chief Finance Officer
CONTACT INFO	David.king@nhslothian.scot.nhs.uk
DATE	6 October 2017

East Lothian IJB Risk Register with Action Plan

ID	Title	Description	Controls in place	Adequacy of controls	Risk level (current)	Rating (current)	Risk level (Target)	Rating (Target)	Action Plan in Place	Risk Owner	Handler	Date Opened	Last Reviewed
3924	Financial resources may be insufficient to sustain the Strategic Plan	There is a risk that the financial challenges faced by the NHS and East Lothian Council will result in allocations to the IJB that do not allow the Strategic Plan to be delivered leading to the failure to achieve outcomes and targets. (NOTE: In 2016/17 the financial plans were set before the commencement of the IJB therefore this risk is inherited. In 2017/18 and beyond, the IJB will lead the financial planning process and therefore this risk will be managed by the IJB)	1. Financial assurance process carried out by IJB 2. Engagement of IJB Officers and members in NHS and Council budget setting processes 3. Regular performance monitoring reports to IJB 4. Scheme of Integration risk sharing and dispute resolution processes 5. IJB Chief Finance Officer in post 6. Strategic Planning Group in place 7. Strategic Plan Programme Board established and meeting regularly to deliver Strategic Plan within the financial resources available 8. Detailed efficiency and recovery plans are in place for operational teams to 'break even' in 2017/18 9. There is a programme of meetings and discussion between IJB, Council and Health Board leading to an IJB financial planniing process being approved by the IJB and supported by Council and Health Board	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	**High**	**16**	**Medium**	**9**	Y	Small, David A	King, David	26/02/2016	30/03/2017
4018	Impact of Partners' Decisions	There is a risk that Partners reach decisions on priorities and services (including service reviews) that impact negatively on the IJB leading to an inability to deliver the Strategic Plan	1. Involvement of IJB membership in the Partners' decision making process including voting menbers and Officers 2. Involvement in Partners' service reviews 3. Good working relationships and regular formal /informal meetings e.g Acute IJB Interface Group, meetings with Chief Executives and Chairs	Adequate but partially effective; control is properly designed but not being implemented properly	**High**	**16**	**Medium**	**9**	Y	Small, David A	King, David	17/06/2016	30/03/2017

ID	Title	Description	Controls in place	Adequacy of controls	Risk level (current)	Rating (current)	Risk level (Target)	Rating (Target)	Action Plan in Place	Risk Owner	Handler	Date Opened	Last Reviewed
3925	Operational resources may be insufficient to deliver the Strategic Plan	There is a risk that the IJB fails to achieve its targets due to insufficient access to key services and resources e.g. General Practice, Care at Home, Care Homes, Health Visiting, Housing, acute services etc leading to failure to deliver the Strategic Plan resulting in risk to patients' and clients' safety, external review and reputational damage	1. The Strategic Plan sets out clear priorities 2. IJB directions are clear about actions required by NHS and Council 3. The Partnership Mamnagement Team is focussed on ensuring adequate resources are in place for delegated functions to deliver the Strategic Plan 4. NHS Lothian is focussed on ensuring adequate resources are in place for set-aside and hosted functions to deliver the Strategic Plan 5. NHS Lothian and East Lothian Council are focussed on ensuring adequate resources are in place for non-delegated but related functions (e.g. housing), to deliver the Strategic Plan 6. Quarterly Performance Report to IJB and scrutiny by the Audit and Risk Committee 7. Use of Delayed Discharge Fund to increase capacity and improve terms and conditions	Adequate but partially effective; control is properly designed but not being implemented properly	**High**	**12**	**Medium**	**6**	Y	Small, David A	Small, David A	26/02/2016	30/03/2017
3926	Potential Instability e.g elections / IJB changes	There is a risk that the IJB will be de-stabilised as a consequence of membership change or policy change as a result of elections and Public Sector reform leading to conflicting priorities and/or inability to make decisions	1. Standing orders that control members' behaviour 2. Code of Conduct 3. Scheme of Integtration which icludes a dispute resolution mechanism 4. Ensuring that membership changes are not all planned at the same time e.g. stakeholder member changes are separate from voting member changes, NHS membership changes on a different cycle from the East Lothian Council membership changes	Adequate but partially effective; control is properly designed but not being implemented properly	**Medium**	**9**	**Medium**	**9**	Y	Small, David A	Small, David A	26/02/2016	30/03/2017

ID	Title	Description	Controls in place	Adequacy of controls	Risk level (current)	Rating (current)	Risk level (Target)	Rating (Target)	Action Plan in Place	Risk Owner	Handler	Date Opened	Last Reviewed
3927	Relationship with Partners	There is a risk that East Lothian Council and NHS Lothian do not provide the support services required to enable the IJB to fulfill its functions (e.g. financial planning, I.T. etc)	1. Review of support services in place 2. Clear directions from the IJB to Partners 3. Involvement of IJB membership in Partners' decision making process	Adequate but partially effective; control is properly designed but not being implemented properly	**High**	**12**	**Medium**	**6**	Y	Small, David A	Small, David A	26/02/2016	30/03/2017

East Lothian HSCP IJB Risk Register - Action Plan

Risk ID	Description	Synopsis	Progress	Start date	Due date	Done date
3924	Creation of appropriate financial planning processes	Programme of meetings and discussion between IJB, Council and Health Board leading to a IJB financial planning process being approved by the IJB and supported by Council and Health Board	Action transferred to 'Controls'	17/06/2016	30/09/2016	30/03/2017
	Financial Reporting	Improve financial reporting to the IJB on operational delivery to tie-in with delivery of the Strategic Plan		01/04/2017	31/08/2017	
	IJB and Policy Decisions	The IJB to take a lead role in policy decisions to support the Financial Plan		01/04/2017		
3925	Develop Joint Workforce Plan	Ensure NHS Lothian & East Lothian Council develop a Joint Workforce Plan		01/04/2017	30/03/2018	
	Financial investments in additional capacity	1. Use of Integrated Care Fund to increase capacity and improve terms and conditions 2. Use Primary Care Transformation Fund to improve access in west of county		17/06/2016	31/01/2018	
	Care at Home contracts	New Care at Home contracts are to be implemented		01/04/2017	30/09/2017	
3926	IJB Induction	Ensure there is a robust induction process in place for new Concillors / IJB members		31/05/2017	30/09/2017	
3927	Implementation of outstanding support services issues	Letter from IJB to Partners detailing actions outstanding and requesting report returned to IJB in August 2016		28/04/2016	25/08/2016	
4018	Clarity and monitoring of directions	1. Iterative process of development of directions and performace monitoring 2. Documented process for issuing and management of directions 3. Improved reporting and delivery of directions and performance	Action extended to cover the period April 2017to March 2018	03/04/2017	31/03/2018	

East Lothian
Health & Social Care Partnership

REPORT TO: East Lothian IJB – Audit and Risk Committee

MEETING DATE: 24 October 2017

BY: Chief Internal Auditor

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SUBJECT: Internal Audit Reports – IJB Directions and Performance Targets & Reporting

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1 PURPOSE

1.1 To inform the Audit and Risk Committee of the recently issued audit reports on IJB Directions and Performance Targets & Reporting.

2 RECOMMENDATION

2.1 That the Audit and Risk Committee note the contents of the audit reports.

3 BACKGROUND

3.1 The NHS Lothian Internal Audit team recently carried out reviews of the internal controls surrounding IJB Directions and Performance Targets & Reporting as part of the Audit Plan for 2016/17.

3.2 The main objective of the audits was to ensure that the internal controls in place were operating effectively.

3.3 The main findings from the audit work are outlined in the attached reports.

4 POLICY IMPLICATIONS

4.1 None

5 INTEGRATED IMPACT ASSESSMENT

5.1 The subject of this report does not affect the wellbeing of the community or have a significant impact on equality, the environment or economy.

6 RESOURCE IMPLICATIONS

6.1 Financial - None

6.2 Personnel - None

6.3 Other - None

7 BACKGROUND PAPERS

7.1 None

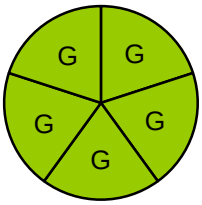
AUTHOR'S NAME	Mala Garden
DESIGNATION	Chief Internal Auditor
CONTACT INFO	01620 827326
DATE	13 October 2017

Internal Audit

IJB Directions – East Lothian

June 2017

Report Assessment



Contents

Introduction

The *Public Bodies (Joint Working) (Scotland) Act 2014* (the Act) places a duty on integration joint boards (IJBs) to develop a strategic plan for functions and budgets under their control. Sections 26 to 28 of the Act set out the method that IJBs should use to implement their strategic plan, which involves each IJB providing their health board and local authority with binding directions. Each IJB should issue directions relating to all of its delegated functions.

The Scottish Government also issued a *Good Practice Note (Directions from Integration Authorities to Health Boards and Local Authorities)* in March 2016. It states that directions should be made in writing and set out clearly how the functions should be delivered, provide detailed information on the related financial resources. In addition, the directions should state whether the health board or local authority are to perform the work individually or jointly.

Scope

This audit reviewed the directions issued by the East Lothian IJB, to ensure that they meet the requirements of the Act, the Good Practice Note, and the IJB's strategic plans. It also reviewed the arrangements in place to manage and report on progress to ensure that the requirements of the directions are applied in practice.

Acknowledgements

We would like to thank all staff consulted during this review for their assistance and cooperation.

Executive Summary

Conclusion

There is good compliance with the *Public Bodies (Joint Working) (Scotland) Act 2014*, and the *Good Practice Note (Directions from Integration Authorities to Health Boards and Local Authorities)* issued by the Scottish Government in March 2016. In addition, the Directions for 2017-18 have been stated using SMART objectives and KPIs where relevant. However, the Directions do not clearly show how they link to the specific objectives stated in the IJB's Strategic Plan. The implementation of this recommendation will provide greater confidence to the IJB Board that the Directions will be implemented effectively.

Summary of Findings

The table below summarises our assessment of the adequacy and effectiveness of the controls in place to meet each of the objectives agreed for this audit. Definitions of the ratings applied to each action are set out in Appendix 1.

No.	Control Objective	Control objective assessment	Number of actions by action rating			
			Critical	Significant	Important	Minor
1	The requirements of the Act have been met.	Green				
2	The directions issued to date comply with the Scottish Government's Good Practice Note.	Green				
3	The priorities stated within the IJB's strategic plan have been reflected within the directions.	Green		1		
4	The directions have been clearly stated using SMART objectives and have, where relevant, related KPIs.	Green				
5	Reporting and monitoring arrangements are clear, have been reflected within commissioning plans, and are implemented in practice.	Green				

Control Objective Ratings

Action Ratings	Definition
Red	Fundamental absence or failure of controls requiring immediate attention (60 points and above)
Amber	Control objective not achieved - controls in place are inadequate or ineffective (21 – 59 points)
Green	Control objective achieved – no major weaknesses in controls but may be scope for improvement (20 points or less)

Main findings

There is good compliance with the *Public Bodies (Joint Working) (Scotland) Act 2014*, and the *Good Practice Note (Directions from Integration Authorities to Health Boards and Local Authorities)* issued by the Scottish Government in March 2016.

The Directions for 2016-17 have already been issued to NHS Lothian and the Council, and the 2017-18 Directions were agreed at the March 2017 meeting of the IJB Board.

SMART objectives are used in plans to help ensure that objectives are specific, measurable, achievable, relevant, and time-bounded. By stating objectives based on these criteria, they are more likely to be effectively implemented. In addition, the use of KPIs allows NHS Lothian and the Council to understand what is expected of them, and also allows the IJB to more effectively measure performance. The IJB's Directions for 2017-18 are stated using SMART objectives and KPIs where relevant.

It is vital that the IJB Board receives accurate information on how effectively NHS Lothian and the Council are implementing the Directions. The IJB has a policy document which sets out the overall process for creating directions and monitoring their implementation.

However, we have identified one significant issue for improvement during the review:

- the IJB's Directions for 2017-18 outline how each direction ties to key Scottish Government targets (such as the National Health & Wellbeing Outcomes indictors), and also the overall objectives of the IJB. However, there is no statement on how the directions link to the specific objectives stated in the Strategic Plan.

Further details of this point are set out in the Management Action Plan.

Management Action Plan

Control objective 1: The requirements of the Act have been met.
We identified no significant issues in relation to this control objective. The *Public Bodies (Joint Working) (Scotland) Act 2014* (the Act) places a duty on IJBs to develop a strategic plan for functions and budgets under their control. Sections 26 to 28 of the Act set out the method that IJBs should use to implement their strategic plan, which involves each IJB providing their health board and local authority with binding directions. Each IJB should issue directions relating to all of its delegated functions. Comparing key elements of the Act with the actions taken by the IJB showed that there is effective compliance with the Act.

Control objective 2: The directions issued to date comply with the Scottish Government's Good Practice Note.
We identified no significant issues in relation to this control objective. The Scottish Government also issued a *Good Practice Note (Directions from Integration Authorities to Health Boards and Local Authorities)* in March 2016. It states that directions should be made in writing and set out clearly how the functions should be delivered, provide detailed information on the related financial resources. In addition, the directions should state whether the health board or local authority are to perform the work individually or jointly. Comparing key elements of the Note with the actions taken by the IJB showed that there is effective compliance with the Note.

Control objective 3: The priorities stated within the IJB's strategic plan have been reflected within the directions.	
3.1: Not all strategic plan objectives are stated in the directions	**Significant**
Observation and Risk: An IJB's integration scheme sets out those functions which are to be delegated to the IJB from the health board and the relevant local authority. The integration scheme should be used to inform the creation of the IJB's strategic plan, which is in turn should be used as part of the process of creating the IJB's directions. East Lothian IJB's Directions for 2017-18 outline how each direction ties to key Scottish Government targets (such as the National Health & Wellbeing Outcomes indictors), and also the overall objectives of the IJB. However, there is no statement on how the directions link to the specific objectives stated in the IJB's Strategic Plan. There is a risk that the strategic plan is not implemented as directions may not be suitably aligned with strategic planning possibly resulting in conflicting directions, a lack of directions in some areas, or even of there being too many directions.	
Recommendation: All Strategic Plan objectives should be mapped to the Directions. Where there is no direction in place for a particular strategic plan objective (perhaps because it is scheduled for a future year), the IJB Board should be informed when the related direction will be made to NHS Lothian and the Council.	
Management Response: It is accepted that the link between the strategic plan and the directions could be made clearer in some cases. We used the agreed template to lay out the directions which we considered captured the various elements in the regulations well and paragraph 5 (Purpose and Strategic Intent) is designed to capture this link. **Management Action:** A clearer link between the strategic plan and the directions will be developed for the 2018/19 directions and any further directions the IJB may issue for 2017/18.	
Responsibility: IJB Chief Officer	**Target date:** 31 March 2018

Control objective 4: The directions have been clearly stated using SMART objectives and have, where relevant, related KPIs.
We identified no significant issues in relation to this control objective. SMART objectives are used in plans to help ensure that objectives are specific, measurable, achievable, relevant, and time-bounded. By stating objectives based on these criteria, they are more likely to be effectively implemented. In addition, the use of KPIs allows NHS Lothian and the Council to understand what is expected of them, and also allows the IJB to more effectively measure performance. The IJB's Directions for 2017-18 are stated using SMART objectives and KPIs where relevant.

Control objective 5: Reporting and monitoring arrangements are clear, have been reflected within commissioning plans, and are implemented in practice.
We identified no significant issues in relation to this control objective. It is vital that the IJB Board receives timely, relevant, complete, and accurate information on how effectively NHS Lothian and the Council are implementing the Directions. The IJB has a policy document which sets out the overall process for creating directions and monitoring their implementation.

Appendix 1 - Definition of Ratings

Management Action Ratings

Action Ratings	Definition
Critical	The issue has a material effect upon the wider organisation – 60 points
Significant	The issue is material for the subject under review – 20 points
Important	The issue is relevant for the subject under review – 10 points
Minor	This issue is a housekeeping point for the subject under review – 5 points

Control Objective Ratings

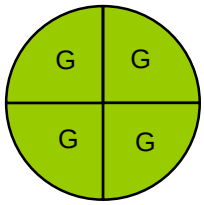
Action Ratings	Definition
Red	Fundamental absence or failure of controls requiring immediate attention (60 points and above)
Amber	Control objective not achieved - controls in place are inadequate or ineffective (21 – 59 points)
Green	Control objective achieved – no major weaknesses in controls but may be scope for improvement (20 points or less)

Internal Audit

Performance Targets & Reporting - IJBs

March 2017

Report Assessment



Contents

Introduction

The Public Bodies (Joint Working) Scotland Act 2014 aims to provide better connected and co-ordinated services for adults through the integration of health and social care services. NHS Lothian participates in four Joint Boards, which are responsible for directing the provision of delegated functions.

The Scottish Government requires that each integration authority publishes an annual performance report, which sets out how effectively they are improving the National Health and Wellbeing Outcomes described within the Strategic Plan. The IJBs issue Directions to NHS Lothian to provide functions to service users and carers in line with the IJBs' strategic plans.

The IJBs must receive regular and accurate information on how effectively functions are being delivered, in particular with regard to the National Health and Wellbeing Outcome measures.

Scope

This audit considered the respective controls in place to ensure the accuracy and completeness of performance reporting information provided by NHS Lothian to the IJBs.

Acknowledgements

We would like to thank all staff consulted during this review for their assistance and cooperation.

Executive Summary

Conclusion

There is effective provision of information to the IJBs by the Local Intelligence Support Teams (LIST), who are employed by the Information Services Division's (ISD). However, not all key high-level plans contain sufficient SMART objectives, and not all state the relevant KPIs. In addition, the IJB boards have not yet formally agreed the KPIs which should be reported to them and with what frequency. The implementation of these recommendations will provide greater confidence that IJB boards are receiving information that will enable them to determine if they are performing effectively.

Summary of Findings

The table below summarises our assessment of the adequacy and effectiveness of the controls in place to meet each of the objectives agreed for this audit. Definitions of the ratings applied to each action are set out in Appendix 1.

No.	Control Objective	Control objective assessment	Number of actions by action rating			
			Critical	Significant	Important	Minor
1	Reporting requirements within individual care commissioning plans meet the requirements of the IJBs' overall strategic plans.	Green		1		
2	NHS Lothian provides all required performance information to the IJBs, including statutory performance measures and compliance with directions, in line with agreed schedules.	Green		1		
3	The controls in place within NHS Lothian ensure that information provided to the IJBs is accurate and complete.	Green				
4	Local arrangements are in place within NHS Lothian to monitor and improve relevant performance targets, including any action plans required.	Green		1		

Control Objective Ratings

Action Ratings	Definition
Red	Fundamental absence or failure of controls requiring immediate attention (60 points and above)
Amber	Control objective not achieved - controls in place are inadequate or ineffective (21 – 59 points)
Green	Control objective achieved – no major weaknesses in controls but may be scope for improvement (20 points or less)

Main findings

The key information source for IJB boards is the Information Services Division (ISD), who collect information from NHS Lothian and other sources before performing data quality checks. Local Intelligence Support Teams (LIST) are ISD staff who have been working within NHS Lothian and the IJBs to provide on-site information provision and analysis. Senior officers from all four IJBs informed us that LIST staff have been very responsive in meeting information requests.

We identified three significant issues for improvement during the review:

- A selection of key high-level plans for the four IJBs were reviewed, namely those related to older people, learning disabilities, physical disabilities, mental health, and alcohol & drug misuse. Some plans were used jointly by one or more IJBs. Many of the plans did not state KPIs or the expected frequency of reporting to committee
- There has been limited reporting of KPIs related to key high-level plans to the IJB boards. However, it should be noted that the four IJB boards have not yet formally agreed the statistics that should be reported to them regularly
- A review of the 16 high-level plans for all four IJBs was performed, and showed that SMART objectives were in place for most plans. However, 5 plans (31%) did not contain SMART objectives for all sections. In addition, 1 plan (6%) contained implementation dates which were all in the past, indicating that these objectives were no longer current.

Further details of these points are set out in the Management Action Plan.

Management Action Plan

Control objective 1: Reporting requirements within individual care commissioning plans meet the requirements of the IJBs' overall strategic plans.	
1.1: High-level plans do not always include KPIs or state the frequency of reporting to committee	**Significant**
Observation and Risk: Each IJB has high-level plans which are designed to guide the effective provision of healthcare to their populations, both now and in the future. A selection of key high-level plans for the four IJBs were reviewed, namely those related to older people, learning disabilities, physical disabilities, mental health, and alcohol & drug misuse. Some plans were used jointly by one or more IJBs. Of the 16 plans reviewed: • 8 (50%) have no KPIs stated • 5 (31%) have either (i) some KPIs in place, (ii) KPIs which do not include numbers or percentages, or (iii) implementation dates which are in the past • 13 (81%) do not state the frequency of reporting of KPIs to committee • 10 (62%) do not state what committees should receive KPIs. If KPIs are not stated and approved for individual high-level plans then there is a risk that the implementation of plans cannot be effectively monitored.	
Recommendation: KPIs should be stated for all objectives contained within the IJBs' key plans, including the plans for older people, learning disabilities, physical disabilities, mental health, and alcohol & drug misuse. These KPIs should then be approved by each IJB board.	
Management Response: Accepted. **Management Action:** KPIs will be stated for all objectives contained within the IJBs' key plans, including the plans for older people, learning disabilities, physical disabilities, mental health, and alcohol & drug misuse. Approval for the use of these KPIs will then be sought from the IJB Board.	
Responsibility: IJB Chief Officer	**Target date:** 30 September 2017

Control objective 2: NHS Lothian provides all required performance information to the IJBs, including statutory performance measures and compliance with directions, in line with agreed schedules.	
2.1: The KPIs to be reported to IJB boards have not yet been agreed	**Significant**

Observation and Risk:

It is the responsibility of each IJB board to determine the information it wishes to receive. This information can come in the form of discussion with key NHS Lothian and local authority officers, and the receipt of statistics covering, for example, national outcome measures and the implementation of strategic plans.

Key statistics relate to performance against the National Health and Wellbeing Outcomes (NHWO) indicators, which are required by the Scottish Government to be provided to IJB boards at least annually. The statistics for the first quarter of 2016-17 have only recently been provided to the HSCPs in January 2017 due to delays by ISD. As such, there has been limited reporting of NHWO statistics to the IJB boards.

In addition, there has been limited reporting of KPIs related to key high-level plans (see Issue 1.1). However, it should be noted that the four IJB boards have not yet formally agreed the statistics that should be reported to them regularly.

If key statistics are not reported to the IJB boards regularly there is an increased risk that high-level plans are not implemented effectively.

Recommendation:

The IJB chief officers should provide their IJB boards with a proposed list of key statistics relating to each high-level plan which they should receive reports on. Once the IJB boards have chosen which statistics they wish to receive, the statistics should be reported to them with the agreed regularity.

Management Response: Accepted.

Management Action: The IJB chief officer will provide the IJB boards with a proposed list of key statistics relating to each high-level plan which they should receive reports on. Once the IJB board has chosen which statistics they wish to receive, the statistics should be reported to them with the agreed regularity.

Responsibility: IJB Chief Officer	**Target date:** 30 September 2017

Control objective 3: The controls in place within NHS Lothian ensure that information provided to the IJBs is accurate and complete.
We identified no significant issues in relation to this control objective. The key information source for IJB boards is the Information Services Division (ISD), who collect information from NHS Lothian and other sources before performing data quality checks. Local Intelligence Support Teams (LIST) are ISD staff who have been working within NHS Lothian and the IJBs to provide on-site information provision and analysis. Senior officers from all four IJBs have stated that LIST staff have been very responsive in meeting information requests.

Control objective 4: Local arrangements are in place within NHS Lothian to monitor and improve relevant performance targets, including any action plans required.	
4.1: High-level plans do not always include all necessary SMART objectives	**Significant**
Observation and Risk: SMART objectives are used in plans to help ensure that objectives are specific, measurable, achievable, relevant, and time-bounded. By stating objectives based on these criteria, they are more likely to aid the effective implementation of plans. A review of the 16 high-level plans for all four IJBs was performed, and showed that SMART objectives were in place for most plans. However, 5 plans (31%) did not contain SMART objectives for all sections. In addition, 1 plan (6%) contained implementation dates which were all in the past, indicating that these objectives were no longer current. If SMART objectives are not stated for all relevant sections of high-level plans there is a reduced likelihood that these plans are achieved.	
Recommendation: The chief officer for each IJB should agree with their respective IJIB board what the key high-level plans are. For each of these plans, the chief officers should ensure that all key actions are phrased as SMART objectives. These objectives should then be approved by the IJB boards.	
Management Response: Accepted. **Management Action:** The IJB chief officer will agree with the IJIB board what the key high-level plans are. For each of these plans, the chief officer will ensure that all key actions are phrased as SMART objectives. These objectives will then be approved by the IJB board.	
Responsibility: IJB Chief Officer	**Target date:** 30 September 2017

Appendix 1 - Definition of Ratings

Management Action Ratings

Action Ratings	Definition
Critical	The issue has a material effect upon the wider organisation – 60 points
Significant	The issue is material for the subject under review – 20 points
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Control Objective Ratings

Action Ratings	Definition
Red	Fundamental absence or failure of controls requiring immediate attention (60 points and above)
Amber	Control objective not achieved - controls in place are inadequate or ineffective (21 – 59 points)
Green	Control objective achieved – no major weaknesses in controls but may be scope for improvement (20 points or less)

East Lothian
Integration Joint Board

REPORT TO: East Lothian IJB – Audit and Risk Committee

MEETING DATE: 24 October 2017 **6**

BY: Chief Finance Officer

SUBJECT: Actions arising from the Annual Accounts process

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1 PURPOSE

This paper lays out the action plan from the Annual Governance Statement within the IJB's 2016/17 annual accounts and the action plan from the Independent Auditors review of the 2016/17 annual accounts.

2 RECOMMENDATIONS

The Committee is asked to:

2.1 Note the action plans; and

2.2 Request further regular updates to ensure that the agreed actions are delivered.

3. BACKGROUND

3.1 As part of the annual accounts process, the CFO prepares an annual governance statement. This statement is reviewed by the Chief Internal Auditor who recommends any actions required to address any governance weaknesses indentified. These actions and a plan to deliver them are then incorporated into the AGS and the annual accounts

3.2 The annual accounts are reviewed by the independent auditor who also draws up a list of matters which require further improvement. This is part of the report of the independent auditors and this report, along with the annual accounts, has been reviewed by this committee and presented to the IJB

3.3 Its important that a review of the actions takes place and that the IJB receives assurance that these are being delivered by the management of the IJB. Both of these actions plans are attached to this report and it is proposed that regular updates on the delivery of the action plan are brought back to this committee in order that it can provide assurance to the IJB that the actions are being delivered and the weaknesses addressed.

4 POLICY IMPLICATIONS

4.1 This paper is covered within the policies already agreed by the IJB.

5 INTEGRATED IMPACT ASSESSMENT

5.1 The are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

6 RESOURCE IMPLICATIONS

6.1 Financial – there are none.

6.2 Personnel – there are none.

7 BACKGROUND PAPERS

7.1 IJB's Annual Accounts and the review of the independent auditors – 2016/17

Appendices

1. Extract from the 2016/17 annual accounts – AGS action plan

2. Extract from the report of the independent auditors – action plan

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DATE	6 October 2017

Appendix 1 - Extract from the 2016/17 annual accounts – AGS action plan

Areas for Improvement identified in 2015/16	Action undertaken 2016/17
Financial Assurance Finalisation of the 2016/17 financial assurance process including a formal offer of financial resources from NHS Lothian	At its March 2016 meeting the IJB accepted the East Lothian Council budgetary offer and an indicative offer from NHS Lothian. NHS Lothian's formal financial allocation offer for 2016/17 was received on 14 June 2016. The final financial assurance for 2016/17 was presented to the IJB at its August meeting. The IJB agreed to the proposed budget.
Three year financial plan The financial plan that underpins the IJB's Strategic Plan should cover a three year period.	Although NHS Lothian have only made an offer for one year, East Lothian Council have made a three year indicative position. The 2017/18 budget is also a one year settlement however this is now being addressed in 2017/18 as part of the future budget setting process.

Financial Risk Sharing Completion of a financial risk sharing agreement between the IJB and its partners.	The 2016/17 financial risk sharing was agreed. NHS Lothian agreed to cover the health elements of the IJB's budget and East Lothian Council made an additional £1.0m available to cover any overspends within the social care element of the IJB's budget.

Areas for Improvement identified in 2015/16	Action undertaken 2016/17
Support to the IJB from the partners Finalisation of the actions requiring to be undertaken by the partners to support the IJB as laid out in the IJB's integration scheme.	A range of matters have been progressed :- • Additional staffing to support for the IJB's planning team • Support from NHS Lothian Internal Audit team to the IJB's CIA • Support for the delivery of performance and activity information from NHS Lothian • Support to prepare an IJB risk register • Redesign of the NHS Strategic Planning group and NHS Finance and performance group to reflect the responsibilities of the IJB • Agreement to an whole Lothian system Internal Audit report sharing mechanism – that is all four councils, NHS Lothian and all four IJBs • Representation of the IJB on NHS Lothian's clinical governance committee.
Performance management Further development of the performance management framework for the IJB.	The IJB is continuing to work with its partners to agree and implement a system of performance management (including financial performance). Detailed reports were presented to the IJB at its meetings in August 2016 and February 2017. Further reports will be presented to the IJB in 2017/18.
Risk management Further developments in the risk management system for the IJB.	A draft proposal and risk register was submitted to the IJB's Audit and Risk Committee on 23 March 2016 with a further report along with an updated risk register which was presented to the Audit and Risk Committee on 21 June 2016. The risk register continues to be developed and has been presented to the Audit and Risk Committee at each of its meeting in 2016/17.

Area for Improvement identified in 2016/17	Actions to be undertaken In 2017/18
Use of the Social Care Fund A lack of a clear audit trail to monitor the actual social care fund (£4.37 million) expenditure incurred to date for certain categories of spends**.**	A range of reports regarding the SCF were made to the IJB in 2016/17 a final report will be made to the IJB meeting of June 2016. This report shows that the expenditure on the SCF was in line with the IJB's agreement with East Lothian Council.
Performance Management The need to ensure that the performance management framework is fully developed and clearly sets out how the IJB will measure performance against the Strategic Plan, identify areas where improvements are required and demonstrate to stakeholders the benefits that are being delivered.	This work continues supported by the IJB's partners and a reporting mechanism has been agreed with further development work in train. Reports were presented to the IJB at its meetings in August 2016 and February 2017.
Risk Register The risk register in place requires review to ensure that it includes all ongoing and emerging risks facing the IJB including these identified as part of the financial assurance process. The register should clearly set out the additional controls and measures to manage the risks identified and meet the desired risk targets.	The IJB's risk register was presented to the meeting of the IJB's Audit and Risk committee in 2016/17. It is being reviewed and updated and work is underway with both NHS Lothian and the other IJBs in the Lothians to ensure that there are all the risk are appropriately covered.
Participation, engagement and the workforce development plan Progress that requires to be made on Participation and Engagement and the Workforce Development and Support Plan, to ensure compliance with the Integration Scheme.	The IJB has continued to engage both its partners and, more importantly the public which its services. Regular updates and briefings are provided on the IJB's website and the IJB has undertaken a second 'big conversation' to engage with the public.

Appendix 1

Action plan 2016/17

2016/17 recommendations for improvement

Para no.	Issue/risk	Recommendation	Agreed management action/timing
28	**1. Budget monitoring** Quarterly budget monitoring reports were not produced during 2016/17 as per the Integration Scheme. **Risk:** The absence of adequate budget monitoring arrangements increases the risk that the IJB will fail to identify and remedy with its partners any projected overspends.	For 2017/18, the IJB needs to finalise its financial plan based on offers from the partners and ensure this is reported quarterly to Members.	The IJB is monitoring the 17/18 position closely and has reported the first quarter position and indicative out-turns to the IJB in August 2017. The financial position will be updated on a quarterly basis and the CO and CFO are progressing any required recovery plans with the partners. Action by the CO and the CFO. Quarterly reports.

30	**2. Risk sharing framework** There is no risk sharing framework in place between the IJB and its partners. NHS Lothian and East Lothian Council were required to provide additional funding in the year in order for the IJB to deliver a break even position. In 2017/18 and future years, in the absence of such funding agreements, the IJB may fail to achieve this break-even position. **Risk:** In the absence of this framework, and given the funding challenges going forward, there is a risk that lines of accountability for overspends are unclear and go unresolved.	The IJB should put in place a risk sharing framework with its partners to ensure that the lines of accountability regarding overspends are clearly set out.	As above, the IJB will follow the actions to manage overspends as laid out in the Integration Scheme. Having reported the potential for an overspend at to the IJB's August 2017 meeting, the CO and the CFO have requested recovery plans from the partners. The CFO will continue to report this position to the IJB . Action – CFO, updated quarterly.
48	**3. Financial Planning** The IJB does not have a medium to long term financial plan in place. Despite the IJB being fully funded by partners	The IJB needs to develop medium to long term financial plans to assist in addressing upcoming and future budget challenges.	The IJB is working with its partners who will provide it with indicative three year allocations. Having considered the resources available to it

Para no.	Issue/risk	Recommendation	Agreed management action/timing
	who only receive annual funding allocations from the Scottish Government, this should not prevent the IJB from preparing medium to long term financial plans based on sensitivity analysis and scenario planning for possible budget changes. **Risk:** Issues relating to financial sustainability and planning in the medium to long term are not identified in a timely matter and this could prevent future delivery of key services.		the IJB will prepare a three year financial plan laying out how it will achieve its Strategic Plan. The partners are committed to supporting the IJB in these actions and the CFO and CO have been discussing and preparing these plans working with both the partners and the IJB's Strategic Planning Group. The proposal is to prepare an outline plan by January 2018. Action CFO
54	**4. Efficiency savings** For 2017/18 the IJB is required to deliver £3.3 million savings with £500,000 yet to be identified. Robust plans need to be in place as it is unlikely that further funds will be made available by partners to fund any further pressures. **Risk:** The IJB may not be able to deliver the targeted savings in 2017/18 and will not break-even.	The IJB needs to identify and agree the remaining 2017/18 savings required in order to break-even.	As above, the IJB has approached the partners regarding their efficiency and recovery plans and this will be reported as part of the quarterly financial reporting. Action CFO, updated quarterly.
65	**5. Risk management** The IJB has not developed its own risk management strategy, and has chosen to rely exclusively on the risk management strategy of its partners in developing its own risk register. **Risk:** The IJB is not in compliance with the requirements of the Integration Scheme with respect to risk management and could consequently be less effective in capturing and monitoring all of the relevant risks for the IJB.	The IJB should develop its own risk management strategy to ensure it is complying with the Integration Scheme. Further work is still to be done to refine the risk management and review processes within the IJB.	Agreed. This will be developed with the IJB's Audit and Risk committee. Action, CO and CFO, to be completed by the end of the financial year.
73	**6. Performance reporting** The annual performance report was not submitted in line with the Act during 2016/17.	The IJB needs to ensure that it produces an annual performance report in line with the requirements of the Act and that it is relevant to the	The Annual performance report was submitted to the IJB for approval at its August 2017 meeting. The report has now been published on the IJB's

Para no.	Issue/risk	Recommendation	Agreed management action/timing
	Risk: There is a risk that the failure to routinely monitor and report in-year performance could lead to the IJB failing to meet some or all of the metrics set out by the Act as well as failure to address issues as they become known.	IJBs operations and presented to members by 31 July each year.	website.

East Lothian
Integration Joint Board

REPORT TO: East Lothian IJB – Audit and Risk Committee

MEETING DATE: 24 October 2017

BY: Chief Finance Officer

SUBJECT: Other Reports of Interest

7

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1 PURPOSE

This paper presents audit and other reports of interest to the Committee.

2 RECOMMENDATIONS

The Committee is asked to:

2.1 Note the reports; and

2.2 Consider if any further actions require to be taken.

3. BACKGROUND

3.1 The IJB has a range of functions delegated to it by its Partners. However the operational delivery of these functions is the responsibility of the partners and the partners, as part of their governance processes, will seek assurance on the adequacy of their operational services through their internal audit plans amongst other controls. These internal audit report are shared with the IJBs and the CFO and CIA will bring any reports that pertain to the IJB's delegated functions or the governance around these functions to the Audit and Risk committee.

3.2 Audit Scotland produce a range of report on Health and Social Care issued and the CIA and CFO will also endeavour to appropriate reports to the committee's attention.

3.3 There are other reports undertaken by public bodies that are of interest to the IJB. The Scottish Government has a Health and Sports committee which considers a range of matters in health and social care

and presents reports to the Scottish Government laying out their concerns and recommendations.

3.4 There are four reports (three of which are attached to this report) which are of interest to the members of the Audit and Risk Committee :-

- NHS Lothian – Internal Audit report on Budget Setting and Financial Management
- Audit Scotland – Report on self directed support
- Health and Sports Committee – public engagement
- East Lothian – Internal Audit report on non residential charging

3.5 NHS Lothian's Audit and Risk Committee have received a report on Budget Setting and Financial Management (Appendix 1). Although no part of the delegated functions per se these systems are a key part of the financial governance of the health budgets of the IJB. This report notes that with the introduction of a new reporting system there are improved financial controls but further work is required to review and update financial operating procedures, including the review of the monitoring process for the large value and high risk financial recovery plans. Key Budget Holders should be reminded of the requirement to return formal agreement via email of their allocated budgets

3.6 Audit Scotland have published a detailed report on progress with Self Directed Support (SDS) – this is attached as Appendix 2. This report notes 'our evidence shows many examples of positive progress in implementing SDS. But there is no evidence that authorities have yet made the transformation required to fully implement the SDS strategy'. The report further notes 'SDS implementation stalled during the integration of health and social care services. Changing organisational structures and the arrangements for setting up, running and scrutinising new integration authorities inevitably diverted senior managers' attentions.' It further recommends that the SDS model continues to be progressed.

3.7 It should be noted that the IJB specifically addressed this in its Directions for 2017/18. The table of Integration Priorities (table E) lays out in item 8 'Continue implementation of Self Directed Support' and this priority is cross referenced to individual directions as appropriate

3.7 The Health and Sports committee (a committee of the Scottish Government) has published as useful review of the Integration Authorities and their engagement with the public (Appendix 3). The IJB is renewing its engagement strategy which will be presented to the IJB's Strategic Planning Group at its October meeting.

3.8 There is also a report on the East Lothian Internal Audit review of non-residential charging (Appendix 4).

4 POLICY IMPLICATIONS

4.1 This paper is covered within the policies already agreed by the IJB.

5 INTEGRATED IMPACT ASSESSMENT

5.1 The are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

6 RESOURCES IMPLICATIONS

6.1 Financial – there are none.

6.2 Personnel – there are none.

BACKGROUND PAPERS

7.1 None

Appendices

1 NHS Lothian Internal Audit report – Budget setting and financial management

2 Scottish Audit – Self Directed Support

3 Health and Sports Committee – Public Engagement

4 Non-residential Charging – ELC Internal Audit

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DATE	6 October 2017

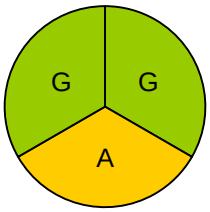
Appendix 1

Internal Audit

Budget Management & Financial Recovery Plan Monitoring

June 2017

Report Assessment



Contents

Introduction

In common with other NHS Boards in Scotland, NHS Lothian faces a significant financial challenge to continue to deliver high quality services within budget, and to achieve the Board's financial targets. At the 2016-17 quarter one financial review, the Board's Finance and Resources Committee expressed concerns about how financial breakeven will be achieved, given the level of savings necessary in the financial plan.

A key element of NHS Lothian's Financial Plan is the recovery actions agreed by budget holders across Directorates to deliver savings. Services have identified a range of potential savings – classified as low, medium or high risk of being achieved.

During 2016-17, NHS Lothian changed the approach to the management of its Local Reinvestment Plans. Budget holders are expected to manage the £12.8m legacy LRP gap where savings have not been recognised on a recurring basis.

In March 2016 Internal Audit reported on the process for financial planning across NHS Lothian. In particular how NHS Lothian agrees detailed savings plans for current and future financial years.

Scope

The audit reviewed the processes in place to monitor and report on recovery actions indentified by budget holders including monitoring progress against budget and further action taken to address over / under spends.

Acknowledgements

We would like to thank all staff consulted during this review, for their assistance and cooperation.

Executive Summary

Conclusion

With the introduction of the Tableau financial performance dashboards, Financial Management have established an effective control framework around the monitoring and reporting of spend in a number of areas. Utilising an electronic system of review has also allowed management to monitor access and use of the dashboards. Appropriate controls are in place for the high-level reporting and review of financial recovery plan performance.

Further work is required to review and update financial operating procedures, including the review of the monitoring process for the large value and high risk financial recovery plans. Key Budget Holders should be reminded of the requirement to return formal agreement via email of their allocated budgets.

Summary of Findings

The table below summarises our assessment of the adequacy and effectiveness of the controls in place to meet each of the objectives agreed for this audit. Definitions of the ratings applied to each action are set out in Appendix 1.

No.	Control Objective	Control objective assessment	Number of actions by action rating			
			Critical	Significant	Important	Minor
1	Budget holders understand the financial plan and their role in delivering current recovery action, and tackling the legacy LRP savings gap.	Green	-	-	2	-
2	Budget holders and the management accounting team has developed and implemented a process for monitoring progress against savings and escalating variations/risks	Amber	-	1	-	1
3	Reporting on efficiency / recovery actions is complete and timely.	Green	-	-	-	-

Control Objective Ratings

Action Ratings	Definition
Red	Fundamental absence or failure of controls requiring immediate attention (60 points and above)
Amber	Control objective not achieved - controls in place are inadequate or ineffective (21 – 59 points)
Green	Control objective achieved – no major weaknesses in controls but may be scope for improvement (20 points or less)

Main findings

The internal audit review of financial planning carried out in early 2016 and reported in March of that year noted that key budget holders are notified of the financial planning process in sufficient time for the start of the planning cycle. Budget holders at all levels within the services have been involved in the identification of cost pressures and in identifying potential service development for the coming year. Any service developments are analysed into local/organisational priorities and categorised as either 'must do' or optional developments. Budget holders are involved in identifying areas where savings could be made and/or efficiencies created.

Managers have been encouraged during 16/17 to realign their budgets to reduce the historic £12.8m negative budget, which represents the balance of the unmet efficiency target carried forward from 15/16. Despite this the cumulative financial position at December 2016 showed an NHS Lothian overspend of £4.8m. This included an £8.9m overspend against budget for University Hospitals Support Services and £2m attributed to East Lothian and Edinburgh Partnerships. Additional reserves of £9.8 million have contributed significantly to the overall position. The current breakeven forecast for 2016/17 is reliant on the delivery of a number of recovery actions from operational and corporate schemes.

A new method of budget reporting has been rolled out during 2016/17 and will replace the current budget reporting methodology from 17 April 2017. Up until now and as part of the financial performance support provided by the Finance Directorate of NHS Lothian, all managers with budgetary responsibility have received routine monthly performance reports.

As part of the ongoing improvement strategy, monthly finance performance information will now be shared with managers online via Tableau dashboards. Tableau dashboards are already used in NHS Lothian to provide performance information and are an interactive application that allows users to explore data rather than just viewing it. In preparation for the official launch in April the Finance Directorate implemented a training strategy which comprised meeting with budget holders to demonstrate use of the Tableau dashboards. Where staff were unable to engage personally with budget holders, written instruction has been emailed.

Finance performance teams meet with managers, either collectively or individually on a regular basis to discuss any issues that may affect the year end forecast. The frequency and format of these meetings vary depending on area.

Financial Recovery Plans established each year across all business units are recorded in a detailed spreadsheet to facilitate review of each plan's performance by Finance Business Partners. Recovery plans are recorded, along with brief monitoring methodology, financial risk, anticipated savings and savings achieved to date. The spreadsheet is updated each month by Business Partners and Assistant Finance Managers, who liaise with business units in identifying savings.

Performance against the Financial Recovery Plans is reported monthly by the Director of Finance to the Board and Finance & Resources Committee as part of the monthly financial report.

We identified one significant and two important issue during this review:

- Measurement and monitoring arrangements are not explicit around how efficiencies are identified, recorded and reported.
- Budget holders are not all signing-off their budget in line with procedures and the Board's Standing Financial Instructions.
- Financial Operating Procedures for Budgetary Control have passed their review date and require updating.

Further details of these points and one minor issue are set out in the Management Action Plan.

Management Action Plan

Control Objective 1: Budget holders understand the Financial Plan and their role in delivering current recovery actions, and tackling the legacy LRP savings gap.	
1.1 Financial Operating Procedures for Budgetary Control have passed their review date and require updating	**Important**
Observation and Risk: In February 2010 the Director of Finance approved for publication the Financial Operating Procedures for Budgetary Control. The Procedures include the processes for: • Budget setting and approval, and • Budgetary control and reporting. However, the Procedures have passed their review date of February 2013 with no review carried out or yet scheduled. While the procedures remain valid for the most part, Finance has this year implemented new budget reporting and monitoring procedures which have made section 4.3 of the Procedures no longer valid. As part of the ongoing improvement strategy, monthly finance performance information will now be shared with managers online via Tableau dashboards. Tableau dashboards are already used in NHS Lothian to provide performance information and are an interactive application that allows users to explore data rather than just viewing it Without up-to-date procedures, there may be a risk that staff may be unclear about the process for setting and approving budgets. Also, current procedures will require to be updated with the new budget monitoring arrangements using Tableau dashboards. To ensure that they remain relevant across all aspects of budget setting and monitoring the current procedures will require to be updated with the new budget monitoring arrangements using Tableau dashboards.	
Recommendation: Financial management should review and update the Financial Operating Procedure for Budgetary Control, including information where necessary on the use of the Tableau financial dashboards.	
Management Response: Agreed. However the update of the procedure will wait for a period of review on the Tableau dashboards in the first quarter. **Management Action:** The Financial Operating procedure will be reviewed and updated following the establishment of tableau dashboards for monthly reporting, following a review at Q1.	
Responsibility: Head of Management Accounting	**Target date:** October 2017

1.2 Budget holders are not signing-off their budget in line with procedures and the Board's Standing Financial Instructions	**Important**

Observation and Risk:

In line with the Financial Operating Procedures the Finance Department formally distribute proposed budget statements to each senior officer based on the outcome of the Financial Planning Process. Senior officers are required to sign-off their annual budget for the forthcoming year by 31 March. This sign-off represents the Budget Holders commitment to provide agreed service levels within the overall budget.

Also, the Board's Standing Financial Instructions records that the Director of Finance shall administer a process to obtain evidence of the acceptance of the opening budgets from budget holders. Processes in place should ensure that the budget holder confirms his or her acceptance of the budget.

On 26 June 2016, budgets were sent out to a number of budget holders almost three months after the 31 March deadline for approval and sign-off by 30 June 2016. This was due to a delay in finalising the 2016/17 NHSLothian Financial Plan, which could not be done until the Scottish Government had signed off on the overall budget for NHS Boards. Of the 22 budget holders requested to formally sign-off their budgets, five budgets had not been formally signed-off:

Also, agreement of the budgets had been received from budget holders on average 21 days after receipt, with three responses received more than 60 days later and eight by the 30 June deadline. While agreement of the budget is recorded by Management Accounting, there is no formal process in place to follow-up delayed responses.

Without timely issue of the budgets and prompt receipt of formal sign-off, management cannot demonstrate that the Financial Operating Procedures and Standing Financial Instructions are being followed. Also, insufficient time may be available to address any concerns with the budgets prior to the start of the financial year.

Recommendation:

Where possible, Management Accounting should endeavour to issue budgets for agreement each year as soon as possible following approval of the Board's Financial Plan. To ensure prompt response from key budget holders, controls should be set up to chase agreement after a number of days and, where necessary, escalate instances where significant delays have occurred.

Management Response:

NHS Lothian can only issue forms for budget sign off once the Financial Plan has been approved by the Board. Thereafter we will always aim to issue the budget sign off forms as early as practicable. Of the 5 forms that were not returned in 2016, 3 of these achieved breakeven against budget at the year end.

Management Action: We will continue to respond to the requirement to issue budget sign off sheets as early as possible. For 2017, a deadline of 26 of May was set and a reminder email were sent out on the 31 May. As at the 12 June, 8 responses are still outstanding and continue to be actively followed up.	
Responsibility: Head of Management Accounting	**Target date:** Ongoing

Control Objective 2: Budget holders and the management accounts team have developed and implemented a process for monitoring progress against savings and escalating variations/risks	
2.1 Measurement and monitoring arrangements are not explicit around how efficiencies are identified, recorded and reported	**Significant**

Observation and Risk:

For the period April to December 2017 local Financial Recovery Plans had delivered savings of £15.9m, with a year end forecast of £27.4m. However, recovery plans for 2016/17 financial year anticipated efficiency savings of £33.3m.

Following the Internal Audit Review of Financial Planning in March 2016 the Head of Management Accounting, along with Business Partners, had agreed to develop clear measurement and monitoring arrangements for large value recovery plans by May 2016. Review and update of the monitoring process is included within the Management Accounting improvement workplan. The workplan also includes the review and update of the Financial Planning and Budget Setting procedure.

Within the consolidated Financial Plan spreadsheet, which is used record all recovery plans, a column has been added by Finance which summarises how each Financial Recovery Plan will be monitored. However this has not be developed where necessary into a more detailed monitoring methodology within the business units. Also, some plans do not have any summary monitoring information recorded within the consolidated Financial Plan.

The development and update of the procedure for measuring and monitoring Financial Recovery Plans remains outstanding and therefore a consistent approach to the measurement and monitoring arrangements for recovery plans across all business units is not yet documented. Subsequently there is no control framework in place to determine whether schemes are functioning as planned, or whether the forecasting is accurate compared to anticipated delivery. Currently, Business Partners and Assistant Finance Managers have agreed independently with business units on the monitoring methodology.

Considering the risks associated with the success of some Financial Recovery Plans, an effective means of monitoring, reporting and, if necessary, escalating recovery plans should be in place and followed by Business Partners and Business Unit key budget holders.

Recommendation:

The methodology for measuring savings achieved by each financial plan should be reviewed to ensure that actual efficiency savings are being identified, recorded and reported for each financial recovery plan taken forward for the 2017/18 financial year.

Management Response:

A methodology and process is already in place for measuring savings, with documentation. Actual efficiency savings are identified, recorded and reported for each plan taken forward on a monthly basis, and outputs on delivery reported through the appropriate monthly

governance committee. **Management Action:** A review of the existing methodology introduced last year will be undertaken to establish opportunities for improvement and areas where good practice can be shared. Any updates will be documented to ensure consistency of understanding.	
Responsibility: Head of Management Accounting	**Target date:** December 2017

2.2 Comments and suggestions on the use of Tableau financial dashboard are not acted upon promptly	**Minor**

Observation and Risk:

Through the Finance Online intranet site budget holders are able to provide comment and suggestions on the use of the Tableau dashboards. Staff are required to complete a form and email this to a finance dashboards email address.

Receipt of each form is recorded into a spreadsheet, along with date received, sender and the comment/suggestion. A separate column is used by finance staff to record whether it has been actioned and the date of any email replies sent.

Of the eight comments received between 12/09/16 and 25/11/16 and requiring response, replies were sent on average 101 days after receipt of the form. Also, comments and suggestions received since 21/12/16 are not recorded as actioned or replied to. Currently, there are no controls to establish a required response time and monitor activity against this. However, comments and suggestions likely to become more important following the April 2017 launch of Tableau

Unless comments and suggestions are acted upon promptly, there is a risk that budget holders are unable to utilise their Tableau dashboards effectively in the monitoring of their budgeted expenditure.

Recommendation:

Finance staff should ensure that all comments and suggestions received in relation to the use of the Tableau financial Performance dashboards are dealt with within 14 days and response issued thereafter.

Management Response:

The finance function had previously agreed that no changes would be made to Tableau dashboards in the short term to allow a period of stability in the presentation of data and allow users to familiarise themselves with the new suite of information. A Finance Dashboard User group (sub-group of the Improvement group) has responsibility for the roll out and update of the Tableau dashboards

Management Action:

The Finance Dashboard User Group will take responsibility for ensuring a process for suggested improvements to dashboards is in place and adhered to.

Responsibility: Chair, Finance Dashboard User Group	**Target date:** October 2017

Control Objective 3: Reporting on efficiency/recovery actions is complete and timely

We identified no significant weaknesses in relation to this control objective.

With the introduction of Tableau dashboards, budget holders now have access to a suite of financial information relevant to their role. Budget holders are granted access to the system according to their hierarchy level and cost centre and can view information on a number of areas, such as:

- Expenditure for the whole year to date;
- In month variances;
- Actual expenditure against budget;
- Pay and non-pay expenditure;
- Payroll staff list; and
- Expenditure on drugs and medicines.

Finance have introduced a number of key performance indicators to monitor the utilisation of the Tableau, which includes:

- Number for views per dashboard (by finance staff/service staff);
- Number of views per business unit; and
- Number of service users accessing the performance dashboards.

Finance staff can also extract data on individual members of staff should any analysis on their use of the dashboards be required.

Finance have developed a Financial Recovery Plan summary spreadsheet to record progress against the various Financial Recovery Plans in place for the financial year. The spreadsheet provides a summary of all financial recovery plans agreed between Business Partners and the various business units and specialities, and include for each plan the financial risk, monitoring methods and anticipated savings. Business Partners and Assistant Finance Managers liaise closely with the business units in updating this spreadsheet when recording the progress to date. The spreadsheet is updated monthly to record the actual savings achieved and any shortfall in financial delivery.

Business Partners meet quarterly with the Director and Deputy Director of Finance to update them on the financial performance of the Business Units, key budget holders are invited to attend where necessary.

The Director of Finance presents a financial performance report each month to the Board and Finance & Resources Committee. This includes an update on the savings realised to date, broken down by Business Unit.

Appendix 1 - Definition of Ratings

Management Action Ratings

Action Ratings	Definition
Critical	The issue has a material effect upon the wider organisation – 60 points
Significant	The issue is material for the subject under review – 20 points
Important	The issue is relevant for the subject under review – 10 points
Minor	This issue is a housekeeping point for the subject under review – 5 points

Control Objective Ratings

Action Ratings	Definition
Red	Fundamental absence or failure of controls requiring immediate attention (60 points and above)
Amber	Control objective not achieved - controls in place are inadequate or ineffective (21 – 59 points)
Green	Control objective achieved – no major weaknesses in controls but may be scope for improvement (20 points or less)

Health and social care series

Appendix 2

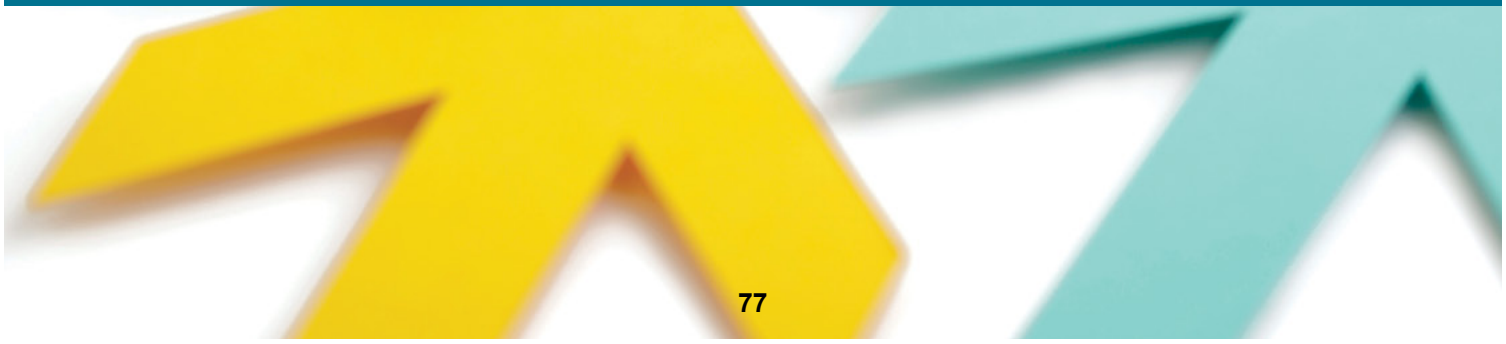
Self-directed support

2017 progress report

ACCOUNTS COMMISSION

AUDITOR GENERAL

Prepared by Audit Scotland
August 2017



The Accounts Commission

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

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

Our work includes:

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

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

Auditor General for Scotland

The Auditor General's role is to:

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

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

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

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

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

Contents

Easy read summary
PDF available to download

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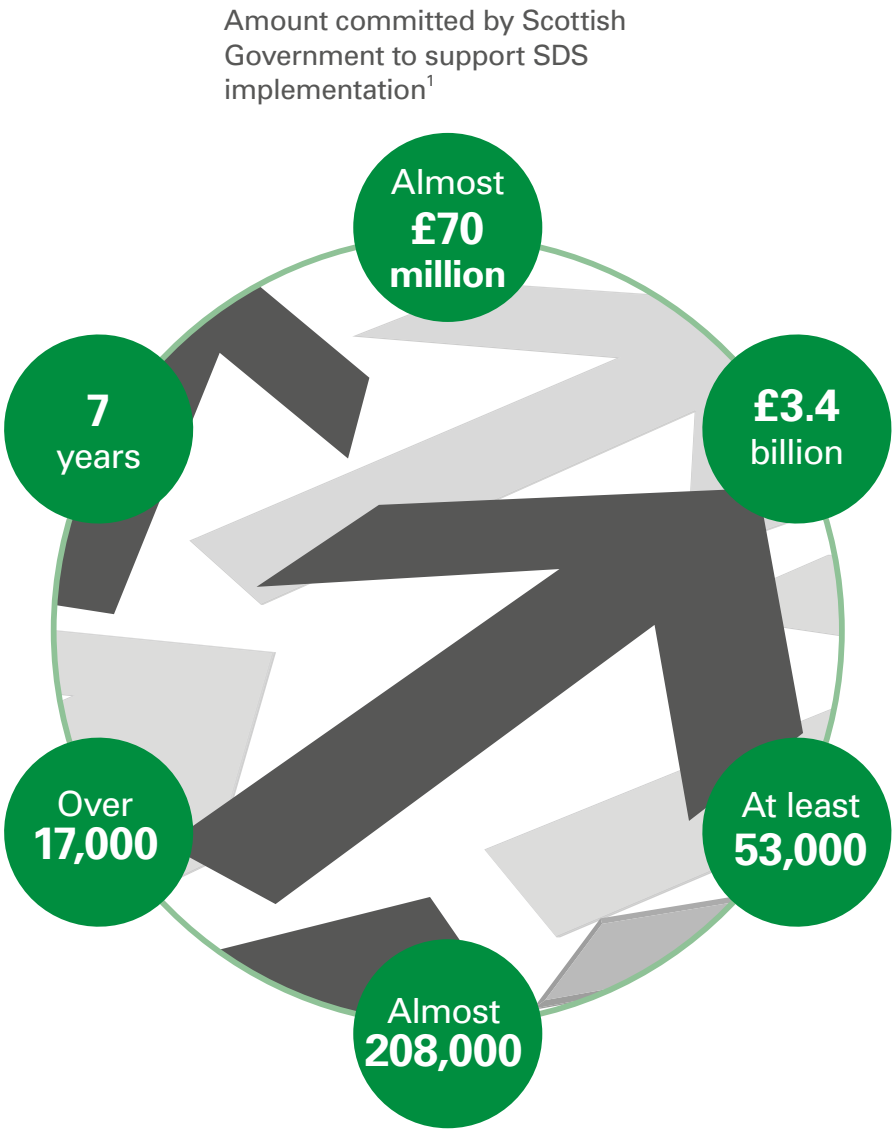
Exhibit data
When viewing this report online, you can access background data by clicking on the graph icon. The data file will open in a new window.

Key facts

In 2015/16:



Notes: 1. Amount committed from 2011/12 to 2017/18 by Scottish Government to support SDS implementation. 2. Councils' audited annual accounts, 2015/16.

Summary

Key messages

1 Our evidence shows many examples of positive progress in implementing SDS. But there is no evidence that authorities have yet made the transformation required to fully implement the SDS strategy. Most people rate their social care services highly and there are many examples of people being supported in new and effective ways through SDS, but not everyone is getting the choice and control envisaged in the SDS strategy. People using social care services and their carers need better information and help to understand SDS and make their choices. More reliable data is needed on the number of people choosing each of the SDS options. Data should have been developed earlier in the life of the strategy in order to measure the progress and impact of the strategy and legislation.

2 Social work staff are positive about the principles of personalisation and SDS but a significant minority lack understanding or confidence about focusing on people's outcomes, or do not feel they have the power to make decisions with people about their support. Front-line staff who feel equipped, trusted and supported are better able to help people choose the best support for them. What makes this possible for staff is effective training, support from team leaders or SDS champions, and permission and encouragement from senior managers to use their professional judgement to be bold and innovative.

despite many examples of positive progress SDS has not yet been fully implemented

3 Authorities are experiencing significant pressures from increasing demand and limited budgets for social care services. Within this context, changes to the types of services available have been slow and authorities' approaches to commissioning can have the effect of restricting how much choice and control people may have. In particular, the choices people have under option 2 are very different from one area to another. Authorities' commissioning plans do not set out clearly how they will make decisions about changing services and re-allocating budgets in response to people's choices.

4 There are tensions for service providers between offering flexible services and making extra demands on their staff. At the same time, there are already challenges in recruiting and retaining social care staff across the country owing to low wages, antisocial hours and difficult working conditions.

5 SDS implementation stalled during the integration of health and social care services. Changing organisational structures and the arrangements for setting up, running and scrutinising new integration

authorities inevitably diverted senior managers' attentions. Some experienced staff are also being lost through early retirement and voluntary severance schemes as the pressures on budgets mount.

Recommendations

Directing your own support

Authorities should:

- work in partnership with service users, carers and providers to design more flexibility and choice into support options
- review their processes for supporting children to transition into adult services.

The Scottish Government, COSLA, partners and authorities should:

- continue working together to develop:
  - the accuracy and consistency of national data on the number of people choosing each SDS option
  - methodologies to understand the impact of SDS on people who need support and their carers.

Assessing needs and planning support

Authorities should:

- provide staff with further training and help on identifying and planning for outcomes
- work with service users and carers to review their assessment and support planning processes to make them simpler and more transparent
- establish clear guidance for staff on discussing the balance between innovation, choice and risks with service users and carers and implementing local policies in practice
- support staff in applying professional judgement when developing innovative solutions to meet individual needs flexibly
- ensure they are providing information on sources of support to those who are accessing SDS
- work with service users, carers and providers to review the information and help they offer to people during assessments, reviews and planning discussions.

Commissioning for SDS

Authorities should:

- develop longer-term commissioning plans that set out clearly how more choice and flexibility will be achieved for local service users and how decisions will be made to re-allocate money from one type of service to another
- work with service users, carers and provider organisations to develop more flexible outcome-focused contractual arrangements
- continue to work with communities to develop alternative services and activities that meet local needs.

Implementing the national SDS strategy

Authorities should:

- develop targeted information and training on SDS for healthcare professionals who have a direct or indirect influence on people's health and social care support
- monitor and report the extent to which people's personal outcomes are being met and use this information to help plan for future processes and services.

The Scottish Government, COSLA and partners should work together to:

- review what independent information, advice and advocacy people will need in future, and how that should be funded after current Scottish Government funding for independent organisations comes to an end in March 2018. This review should fully involve users, carers, providers and authorities, and should conclude in time for appropriate action to be taken
- agree how any future financial support should be allocated, taking into account how authorities' local commissioning strategies will inform future spending priorities
- seek solutions that address the problems of recruitment and retention in the social care workforce
- ensure that the requirement to effectively implement SDS is reflected in policy guidance across all relevant national policies, such as health and social care integration, community empowerment, community planning, housing and benefits
- routinely report publicly on progress against the 2016-2018 SDS implementation plan and the SDS strategy.

The Scottish Government should:

- report publicly on the outcomes it has achieved from the almost £70 million funding it has committed to support implementation of SDS.

Background

1. Social care services provide personal and practical help to improve the quality of people's lives and support them to live as independently as possible. Social care support describes services and other types of help, including giving carers a break to help them continue in their caring role. Support ranges from assistance with everyday tasks such as dressing and preparing meals to helping individuals live fulfilling lives at home, at work and in their families and communities. In 2015/16, councils spent £3.4 billion on social work services, supporting almost 208,000 adults in non-residential care and over 17,000 children and their families.

2. Self-directed support (SDS) aims to improve the lives of people with social care needs by empowering them to be equal partners in decisions about their care and support. Four fundamental principles of SDS are built into legislation – participation and dignity, involvement, informed choice and collaboration.[1] This means social care should be provided in a way that gives people choice and control over their own lives and which respects and promotes their human rights. It requires significant changes to the way social care has been provided in the past. Crucially, authorities should work in partnership with people and communities to design and deliver the services that affect them.

3. The ten-year SDS strategy was introduced jointly by the Scottish Government and COSLA in 2010.[2] It is one of a number of national policies designed to empower people and communities to become more involved in designing and delivering services that affect them. The Social Care (Self-directed Support) (Scotland) Act 2013, the Community Empowerment (Scotland) Act 2014 and the Public Bodies (Joint Working) (Scotland) Act 2014 were all introduced following the report by the Christie Commission in 2011.[3] They were designed to encourage significant changes to how services were previously provided, and require public bodies to give people more say in decisions about local services and more involvement in designing and delivering them.

4. This demand for change comes at a time when public sector budgets are under significant pressure owing to ongoing financial constraints, increasing expectations and rising demand for health and social care services, and social care workforce shortages. Councils and NHS boards have now created integration authorities, to which they have delegated their responsibility for planning and ensuring delivery of adult health and social care services.[4] Some have also decided to delegate responsibility for other services, such as children and families and criminal justice. In this report we refer to councils and integration authorities jointly as authorities.

5. In 2010, when the SDS strategy was introduced, councils tended to provide or buy traditional services such as homecare, day centres, care home places and respite care. They would allocate these services to people assessed as being eligible for social care. Following the Changing Lives review of social work in 2006, councils were already aiming to personalise social care services, trying to match people's individual needs and circumstances to services that would suit them best, ie personalisation.[5] Direct payments to enable individuals to buy their own social care services have been an option for many people for at least ten years, predating the SDS strategy.

6. The Social Care (Self-directed Support) (Scotland) Act 2013 was part of the SDS strategy. It gave councils responsibility, from April 2014 onwards, for offering people four options for how their social care is managed:

SDS options	
Option 1	The individual or carer chooses and arranges the support and manages the budget as a direct payment.
Option 2	The individual chooses the support and the authority or other organisation arranges the chosen support and manages the budget.
Option 3	The authority chooses and arranges the support.
Option 4	A mixture of options 1, 2 and 3.

7. Councils already had a legal duty to assess people's social care needs.[6] If they assess someone as needing support and eligible to receive services, they provide, arrange or pay for services to meet these needs. They can require a contribution to the costs if the person has sufficient income. Councils do not have to offer the SDS options to people who do not meet local eligibility criteria. But in those circumstances, councils should inform individuals about where else they can find help, for example voluntary groups and charities, or the local community.

8. We reported in 2014 on councils' early progress in implementing the ten-year SDS strategy and their readiness for the SDS Act.[7] We found that councils still had a lot of work to do to make the cultural and practical changes needed to successfully implement SDS. The report identified risks and benefits in the ways councils chose to allocate money to help individuals. It recommended working more closely with people who need support, their carers and families, providers and communities, to involve them in planning, designing and delivering local SDS strategies.

9. The Scottish Government continues to have a crucial leadership role to play in successful implementation of this transformational strategy. It should be working together with COSLA and other national partners to provide clear direction and guidance and targeted financial support if necessary. It should also be measuring and reporting on the progress and impact of SDS.

10. This is now the seventh year of the ten-year SDS strategy. Implementing the strategy is not just about authorities changing their social work processes and procedures, the way they plan and manage their budgets, and how they work with external providers and communities to ensure a balance of flexible, good-quality services. It is much more than that. Authorities must work in partnership with other people and organisations to transform the way they provide social care, so that individuals have as much choice and control as possible over the social care decisions that affect their lives. This transformation needs to involve not only social work services, but other people in the authority, including: elected members and board members; front-line healthcare and social work staff; other staff whose work affects social care services (eg, finance, commissioning and procurement); third and private sector organisations; and people who need social care support and their carers, families and communities.

About the audit

11. The aim of this follow-up audit was to establish whether councils, integration authorities and the Scottish Government are making sufficient progress in implementing SDS to achieve the aims of the ten-year SDS strategy. We set out to answer four key questions:

- What progress have councils and integration authorities made in implementing SDS?
- What impact is SDS having on people with support needs, carers, families and communities?
- What factors are supporting or impeding effective implementation of SDS?
- How effectively is the Scottish Government supporting implementation of SDS and evaluating its impact?

12. Our methodology included:

- interviews in five case study areas – East Ayrshire, Glasgow, Highland, Perth and Kinross and Western Isles. We met with elected members, chief officers, chief social work officers and senior managers, front-line social work staff, commissioning and finance managers, providers and supported people and their carers
- interviews with 30 public, private and third-sector stakeholder organisations, including providers
- an online survey of supported people and carers with 104 responses, and nine focus groups with 55 participants
- an online survey of social work staff, with 170 responses.

The online surveys were not designed to give statistically representative samples. We have changed people's names in our case studies to protect their anonymity.

13. The online surveys and focus groups provided us with evidence of people's experience of self-directed support. Quotes have been used throughout the report to illustrate examples of common themes from these sources.

14. We have produced four supplements to accompany this report:

- *Supplement 1: Case study of Thomas*
- *Supplement 2: Audit methodology and survey results*
- *Supplement 3: Checklist for councillors and board members*
- *Easy read summary*

Part 1

Directing your own support

Key messages

1 Self-directed support should be offered to people assessed as meeting local eligibility criteria for social care. More reliable data is needed on the number of people choosing each option and this is now being developed. The number of people receiving direct payments (option 1) has doubled between 2010 and 2016, although it is still only 7,530, less than five per cent of the people receiving non-residential social care services.

2 Most people receiving social care services rate them highly. The national *Health and Care Experience Survey 2015/16* found that 81 per cent of people receiving formal social care services rated their overall help, care or support services as either excellent or good. Two-thirds of people felt they had a choice over how their social care was arranged.

3 There are many examples of people being supported in new and effective ways through SDS, and this has greatly improved the quality of their lives. Even a relatively small budget can make a big difference to the life of someone with social care needs and their carers, family and friends. Information and assistance from third sector agencies and organisations is helping people and their families to make decisions and arrange their support.

4 Not everyone with support needs is getting the choice and control envisaged in the SDS strategy. This includes people with mental health problems, who often need more flexible support. There can be good reasons for lack of choice, including protection from harm or limited options in rural or remote locations, but some people feel they have been denied the opportunity to access more effective ways to improve their quality of life.

there are many examples of new and effective support with SDS but not everyone is getting choice and control

Self-directed support should be offered to people assessed as being eligible for social care

15. In 2016, nearly 208,000 adults in Scotland were receiving non-residential social care services through their local authority.[8] This included people receiving direct payments or having a community alarm or telecare, or housing support. The largest group was frail older people (approximately 78,000), who have a decreased ability to withstand illness or stress without loss of function. The next largest groups were people with physical disabilities (60,000) and learning disabilities (12,000). In addition, there were just over 15,300 looked-after children in Scotland and 2,700 registered as being at risk.[9]

16. Not everyone who asks for social care or support is eligible to receive it. Each authority is responsible for setting local eligibility criteria for access to social care services. Authorities assess people's needs using a common framework of four levels of risk – critical, substantial, moderate and low.[10] Most authorities now only consider people assessed as being at critical or substantial risk to be eligible for social care services. This is because there is a decreasing amount of money to spend and an increasing number of people needing support. Assessment should be done in partnership between the assessor, the person with social care needs and, if appropriate, a family member or carer. If a person is not eligible, they should be given information or advice about alternative types of support, for example in their local community.

17. Self-directed support gives options to almost everyone who is assessed as being eligible for social care. This includes children and families, people with physical, sensory or learning disabilities or mental health problems, and older people. The main exceptions are people receiving re-ablement services, which is short-term support to help people regain some or all of their independence, and people assessed as being at risk or lacking capacity to make decisions for themselves. In these circumstances a family member or friend may apply for power of attorney or guardianship so they can make decisions on the person's behalf. Exhibit 1 (page 13) shows the assessment process and the four options for arranging social care services.

18. Everyone assessed or reviewed as being eligible for social care can expect their social worker to discuss and agree with them:

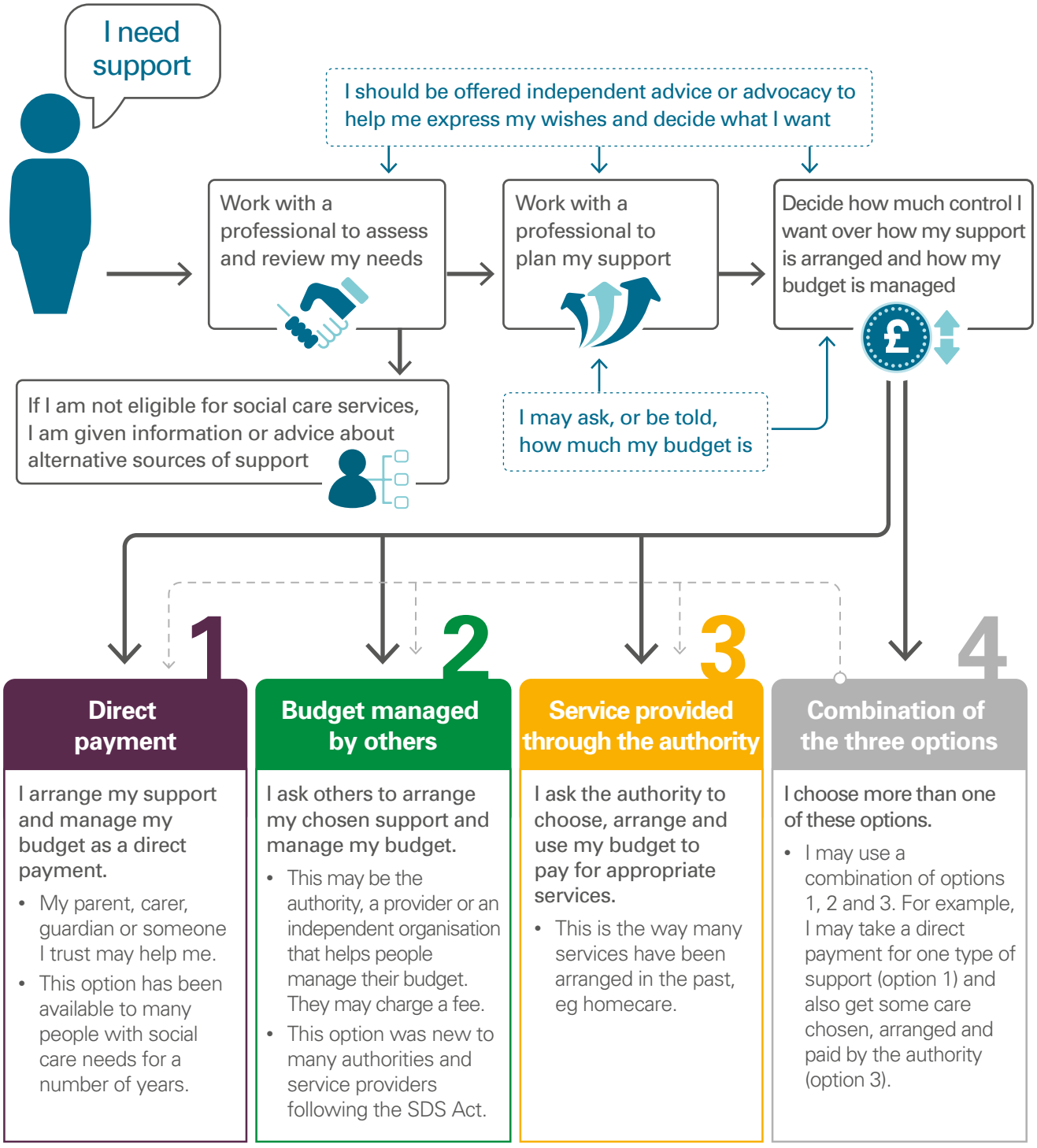
- their personal outcomes, that is how they want their life to improve
- what support would best help them to achieve their personal outcomes, which may be support or activities already run within communities, rather than formal services
- how much money the authority will spend on their services
- how much control they want over arranging and managing their support and budget.

19. Authorities may choose whether, and how much, to charge for services, or what contribution people should make to their budget. Social Work Scotland estimated that income from charging for non-residential social care services was nearly £51 million in 2013/14, less than two per cent of councils' total spending on social care services.[11]

Exhibit 1

How authorities work with individuals to assess their needs and arrange support

Each person should be able to choose their support and how much control they want.



Source: Audit Scotland

20. Personal outcomes are individual so they can be a whole range of things. Some professionals talk about personal outcomes being 'what makes a good life for you'. They include things like:

- being more part of the family and being able to do everyday things with the children
- being able to live at home
- getting help with personal care (for example getting into or out of bed, going to the toilet, washing, dressing, eating)
- keeping in touch with friends and family
- being able to work or to take part in the activities I've always enjoyed
- living independently by getting help with managing day-to-day tasks and finances
- feeling safe from harm
- getting the food I like, prepared the way I like it
- having some time to myself or getting a break from my caring role.

21. The best way to achieve personal outcomes is also very individual. Each of the outcomes above can be met in different ways. For example, given the choice over getting a short break, a carer may prefer to:

- have the person they care for supported by a support worker for a couple of hours a week so the carer can do something they can benefit from, like going shopping, having friends round or resting
- take the person they care for on outings or a holiday, with a personal assistant to help
- have a short break with friends while the person they care for is looked after by someone else
- have someone on overnight duty once a week to be able to get a full night's sleep.

22. *Supplement 1: Case study of Thomas* gives an example of how self-directed support might work when personal outcomes are identified and support is tailored to an individual.

More reliable data is needed on the number of people choosing each SDS option

23. To monitor progress in implementing SDS, national data is needed on how many people are being offered the SDS options, and how many are choosing each option. The Scottish Government and other national partners are working with authorities to develop this data and authorities are working to improve their recording systems. Authorities had to change how they collect and record the information and some have been slower than others to make the

changes, resulting in incomplete data. This work should have been part of the implementation plans for earlier in the strategy in order to understand progress and demonstrate the impact of the strategy and legislation.

24. The most recent data estimates that in 2015/16:

- at least 53,300 people made an informed choice regarding their services and support, resulting in an estimated 27 per cent of all adults receiving non-residential care services
- 11 per cent chose option 1 (direct payment), nine per cent chose option 2 (budget managed by others), 75 per cent option 3 (service provided through the authority) and five per cent option 4 (a combination of options 1, 2 and 3)
- the combined individual budgets for these 53,300 people amounted to £383 million.[12]

25. Progress with SDS should also be measured in terms of whether people are being offered choice and control, and how well their chosen options are helping them to achieve their personal outcomes and improve their quality of life. The national *Health and Care Experience Survey 2015/16* provides some information and SDS Scotland has pilot-tested a survey methodology in three authority areas to provide more detailed information.[13, 14]

The number of people receiving direct payments (SDS option 1) is rising

26. Many people have been entitled to receive direct payments for at least ten years and data on the number of people receiving direct payments has been collected since 2000. It shows an increase of over 100 per cent between 2010 and 2016, from 3,680 to 7,530 people (Exhibit 2, page 16).[15] Not all of these people had necessarily been offered direct payments as one of four SDS options, as some payments were arranged before the SDS legislation came into effect. In 2016, 38 per cent of people receiving direct payments were older people (aged 65 or over), while 75 per cent of adults receiving non-residential care were in this age group.

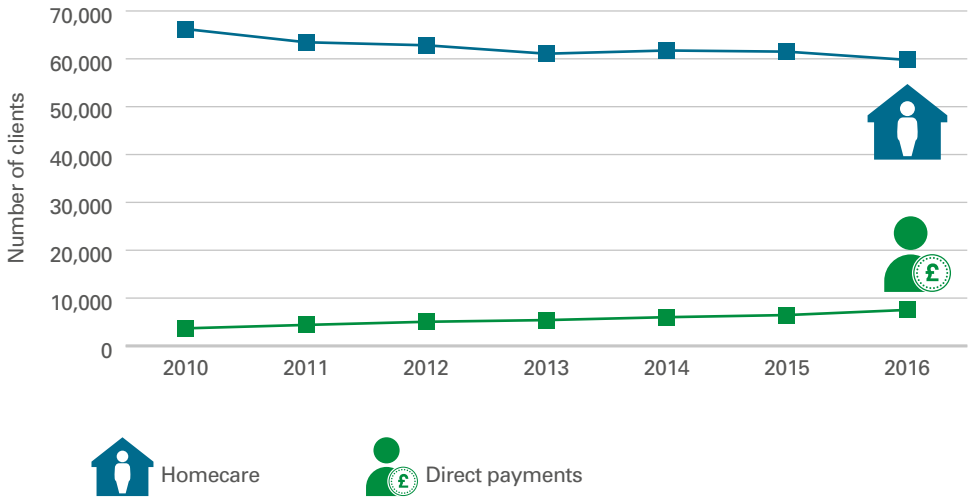
27. At the same time, the numbers of people living in care homes or receiving homecare services through their authority fell between 2010 and 2016. Across Scotland there was:

- a decrease of four per cent in the number of care home placements, to just under 35,000 [16]
- a decrease of ten per cent in the number of homecare clients, to just under 60,000.

Exhibit 2

Number of people getting homecare and receiving direct payments, 2010 to 2016

The number of people using direct payments rose by 3,850 as the number of homecare clients fell by 6,450.



Source: *Social Care Services, Scotland, 2016*, Scottish Government, November 2016

28. The number of people using direct payments ranges from under 50 per 100,000 population (Angus, Dundee, Falkirk and Renfrewshire) to over 250 per 100,000 in some rural and island areas (Highland, Moray, Orkney and Western Isles) and in Edinburgh (Exhibit 3, page 17). This may in part reflect the nature of rural and island communities but there are other factors at play too.

29. The variation between authorities is not necessarily a clear indication of progress with implementing self-directed support because there can be many reasons for using direct payments. For example, people may choose direct payments because they get the information and advice they need to help them manage their budget and arrange their own support successfully. Or it could mean that the authority cannot provide the services they need under options 2 or 3, leaving people to employ personal assistants or make other specific local arrangements for themselves.

Most people receiving social care services rate them highly

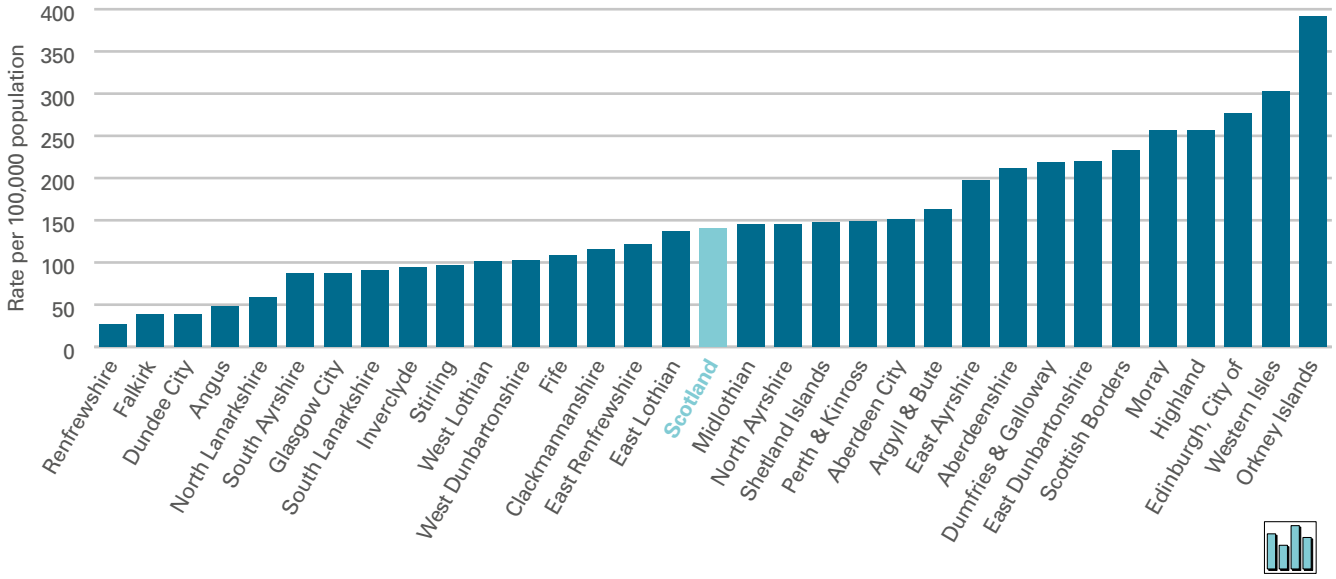
30. The national *Health and Care Experience Survey 2015/16* found that 81 per cent of people receiving formal social care services rated their overall help, care or support services as either excellent or good.[17] In addition:

- 85 per cent said that people took account of the things that matter to them
- 84 per cent felt the help, care or support they received had improved or maintained their quality of life
- 79 per cent felt they had a say in how their help, care or support was provided.

Exhibit 3

Variation in number of people with direct payments per 100,000 population, 2015/16

The rate of direct payments varies between authorities from under 50 to over 250 per 100,000 population.



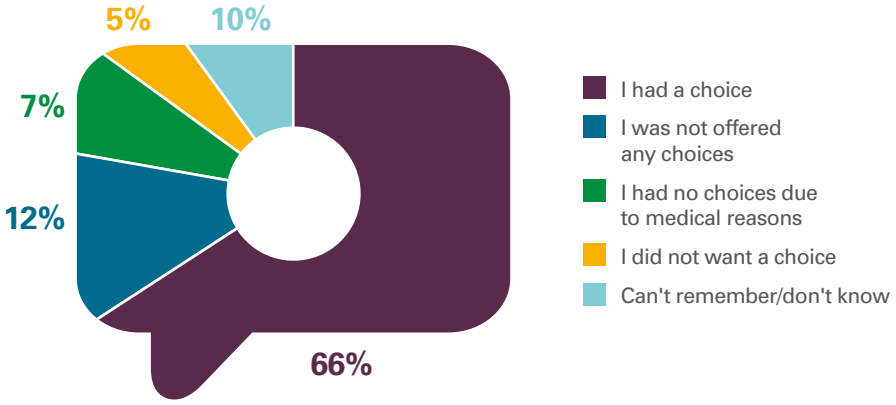
Source: *Social Care Services, Scotland, 2016*, Scottish Government, November 2016

31. The 2015/16 survey asked for the first time whether or not respondents had a choice in how their social care was arranged. Two-thirds said they did have a choice (Exhibit 4).

Exhibit 4

Choice in how social care was arranged, 2015/16

Two-thirds of people felt they had a choice about how their social care was arranged in 2015/16.



Source: *Health and Care Experience Survey 2015/16*, Scottish Government, May 2016

SDS is helping to meet people's needs in new and effective ways

32. There are many examples of people's needs being met in new ways as a consequence of self-directed support, and this has significantly improved the quality of their lives (Case study 1). New approaches to meeting people's personal outcomes should be possible within any one of the four SDS options, although most of the stories we found were with options 1, 2 or 4.

> "I am the boss.
> Supported person employing three personal assistants with a direct payment
>
> I can get rid of them if I don't like them.
> Supported person choosing his support staff
>
> It has given me independence, enabled me to feel productive and valued once again, and has improved my quality of life.
> Supported person"

> "We've already been able to have a more flexible relationship with the service provider we were using. I don't think this would have happened without SDS. Our service was always at their convenience before.
> Family member of someone with support needs"

Case study 1

Margaret has been able to arrange flexible support with a direct payment and help from a local agency

Margaret is an older person living in a house on a croft on the Western Isles. She needs some extra support as she has suffered two strokes and is no longer as physically mobile as she once was. She has two daughters – one lives on the mainland and the other lives a couple of miles away. The latter was helping to support her mother and taking her to appointments and shopping.

Margaret was assessed for social care assistance after her husband (who had previously been receiving support) passed away. She now receives seven hours' help a week from two personal assistants (PAs). One assistant spends an hour each Monday and Tuesday to help around the house. The second spends five hours on a Thursday to take her shopping and out to lunch. She has built up a good relationship with both PAs.

Margaret gets the support she needs. Although her daughter who lives locally still helps look after her mother, there is now less reliance, and therefore less stress, on her trying to fit this in while working full time.

Voluntary Action Harris charges an £18 a month fee to organise payslips and general employment of the two PAs, which has taken the burden from Margaret's daughter.

Source: Audit Scotland

33. A number of parents responded to our user survey with positive experiences of SDS.

> My disabled daughter's life has changed completely due to SDS. She now has a healthy lifestyle which includes a timetable of fitness classes, gym and swim activities that she attends along with her carers. She attends clubs to socialise with friends, goes to the cinema and bowling etc. She now leads the life of other 30-year-old girls. Prior to SDS she stayed home and watched videos! The transformation in her life has improved her health and wellbeing massively.
> Parent

34. There are many examples of where SDS has allowed a relatively small budget to make a big difference to the life of someone with social care needs and their carers, family and friends. A little support can also have a great impact in improving carers' lives.

> We may not get loads of support, 15 hours a week, but it's good respite, at times that are good for my son and for us. He gets to choose what he wants to do.
> Parent

> My life as a carer has also changed for the better. Now that my daughter has SDS, I have free time to pursue a life of my own. I have time to meet with friends, catch up with household work, pursue some of my own interests and generally have time for myself.
> Parent

35. Authorities and the Scottish Government currently fund agencies and organisations to help people find and employ personal assistants (PAs), or make other suitable arrangements. This help can make a big difference (Case study 1, page 18). Individuals and carers we heard from spoke about how helpful support organisations were in providing information and general support to those with budgets under SDS options 1 or 2.

> Having a proper budget and being able to find a small organisation to manage the support has been a godsend. I don't have to worry about organising shifts etc and they are very creative and positive.
> Carer

Not everyone is getting the choice and control envisaged in the SDS strategy

36. Different groups of people receiving social care services are experiencing different levels of choice and control. Our case study work, stakeholder interviews and a user experience survey in three authority areas, found two main groups of people who have less choice and control than other people over

the support and care they receive.[18] These are people who do not have carers, personal assistants or friends and family to support them, and people aged 85 and over. These two groups can also overlap.

37. Evidence from our case studies and third sector organisations shows that people with mental health problems may also experience less choice and control over the way they receive social care services. Mental health conditions can fluctuate over time and more flexible approaches are therefore needed in order to provide the right support at the right time. With careful planning, SDS should be flexible enough to meet an individual's changing needs (Case study 2).

Case study 2

With careful planning, SDS can work well for people with mental health conditions

Matthew was very unwell for around five years and was eventually diagnosed with paranoid schizophrenia. At this time he was told he could not go back to his flat and so he moved in with his mum. As he began to feel better, he and his support team agreed he would move to supported accommodation, where he has continued to improve due to the different kinds of help he receives.

Matthew chose SDS option 2, with support organised and paid for through his provider. He now has his own flat which is quiet and in an area close to his mum. Support workers have helped him to get into a routine with paying his rent, keeping his flat tidy and ensuring he takes his medication. He also feels that he always has someone to talk to if he is feeling unwell.

Matthew is really interested in football and his support package has allowed him to go to Manchester as part of a supported group to watch Manchester United. He is also now a volunteer coach at a Scottish Premiership football club.

Matthew really feels that he is developing and achieving his goals. He is looking to cut down his current support hours of ten hours a week and planning an independent trip to Newcastle to watch a football match.

Source: Audit Scotland

38. In our 2016 *Social work in Scotland* report we highlighted the challenge of ensuring smooth transitions from children's to adult services.[19] In our focus groups and survey we heard from carers of young adults about difficulties in the transition between the two separate services with SDS, and in particular the different legislation and budget arrangements.

> "Transition has been stressful and the process has been drawn out and incomplete.
> Parent
>
> Transition to adult services is only a few months away and there is no plan.
> Parent"

39. Research carried out by Learning Disability Alliance Scotland (LDAS) looked at the difference that SDS made to people with learning disabilities. It found that people who had a self-directed support budget had more control over their support package and their plans but this had not yet led to significantly better outcomes.[20]

40. It is up to individual authorities to decide the detail of their social care policies and this can lead to frustrations among individuals and carers about differences in the way that social care and SDS is implemented between areas. This includes both how assessments are made and what people's individual budgets can be spent on.

> "I also hear of other people who do get mileage and expenses paid in their budget. There does not seem to be one rule for all when it comes to what you can spend it on.
> Parent
>
> Depending on the level of support needs, where you live and what service you can find, it is a bit of a lottery.
> Parent"

41. Frustrations about lack of choice or flexibility are not exclusive to particular user groups. We heard through our focus groups and user survey that some individuals and carers in all user groups feel that they don't ultimately have choice and control over the support they get. Fewer than half of our survey respondents felt that they could change their support if they needed to.

42. Some people feel they have been denied the opportunity to access more effective ways to improve their quality of life. The ways in which people feel they are denied choice and control can be quite subtle, for example being told about SDS by their social worker then told: 'You probably don't want to do that'. Or people can feel they were pushed down a certain route to suit the local authority or to fit in with the provider rather than the person needing support.

> "The council were horrendous to deal with and at every point tried to talk us out of SDS.
> Daughter of older person"

43. It would be unrealistic to expect everyone to have choices in all circumstances. For example, some people may be unable to have the support they wish because:

- their social worker prevents it for good reasons, eg to protect the individual
- what they want does not exist or they cannot find it where they live
- the cost of what they want is more than their budget.

In these circumstances, people and professionals need to work together to find suitable, alternative solutions where possible.

Part 2

Assessing needs and planning support

Key messages

1. Social work staff are positive about the principles of personalisation and SDS but a significant minority lack understanding or confidence about focusing on people's outcomes, or do not feel they have the power to make decisions with people about their support.

2. People using social care services and their carers need better information and help to understand SDS and make their choices. Many of those we heard from in our survey and focus groups were not aware of SDS before they were assessed. People need the information in the right format and at the right time and place.

3. The process of getting access to SDS options 1 and 2 can be long and bureaucratic. When this happens people feel frustrated about the process.

4. Front-line staff who feel equipped, trusted and supported are better able to help people choose the best support for them. What makes this possible for staff is effective training, support from team leaders or SDS champions, and permission and encouragement from senior managers to use their professional judgement to be bold and innovative.

5. Creative types of support can introduce some risks or uncertainty for supported people, carers, providers and staff. This means there can be difficult decisions to make. Authorities must also think about how they spend public money when people want to spend their budget on more creative types of support. People and professionals must work together to find an appropriate balance between the risks and the potential benefits in terms of a person's outcomes.

social work staff need more support to help people be creative about their social care

Support is not consistently targeted at people's personal outcomes but this is improving

44. Social workers and social work staff have a pivotal role in assessing and reviewing people's support needs and planning the right support with them. If they do not identify, agree, record and review people's personal outcomes with them, staff cannot be sure that support is targeted at the right things or whether it is making the best difference to the quality of people's lives.

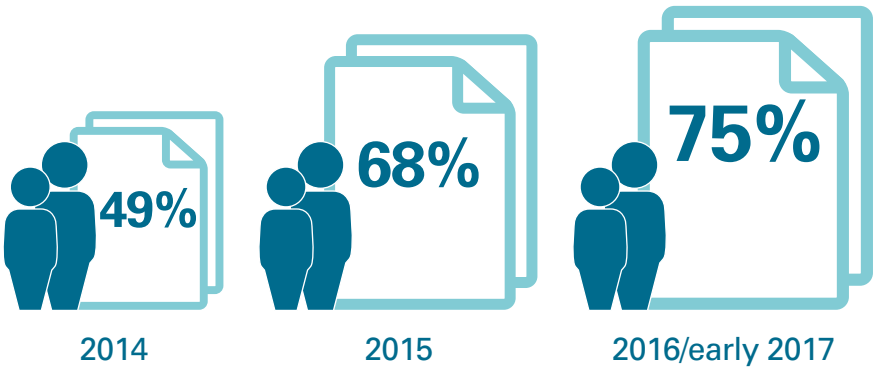
45. The front-line staff we met were generally positive about personalisation and SDS. However, several expressed concerns that not all staff understood what personal outcomes are, and therefore did not identify outcomes and use them to help develop individuals' support plans. For example, they might record something like 'needs five hours a week of homecare' as an outcome. What the person might actually need is to get help to live at home, and there may be other ways of achieving that besides homecare.

46. An increasing proportion of support plans set out the individual's desired outcomes (Exhibit 5). The Care Inspectorate reviewed 1,465 support plans across 15 authorities during its most recent programme of inspections of older people's services and found that in 2016 and early 2017, 75 per cent of plans set out the individual's desired outcomes. Our survey of social work staff shows that two-thirds of respondents felt confident or very confident supporting people to identify their outcomes.

Exhibit 5

Percentage of older people's support plans that set out the individual's outcomes, 2014 – 2016/17

An increasing percentage of support plans include the individual's outcomes.



Source: Care Inspectorate

People using social care services and their carers need better information and help to understand SDS

47. In the national *Health and Care Experience Survey 2015/16*, 76 per cent of people receiving formal social care services said they were aware of the help, care or support options available to them. Many of the individuals using social care services and their carers that we heard from in our survey and focus groups were not aware of their rights under SDS before they were assessed. In some cases their social worker explained it to them. Others were told about it through external support and information organisations or friends and relatives.

48. We also heard from a number of individuals and carers that, even at the point of assessment, there was a lack of information and support. Fewer than half of our user survey respondents said they had the information they needed to make decisions about their support. When asked what could be done to improve their experience of SDS, survey respondents said they wanted more information.

Authorities and national and local organisations have produced a range of information. However, this may not be available for people in the right format or at the time and place where it is needed. Some people say it is too much to take in all at once.

> More information available about support services available, ways of using the direct payment and more help with support planning. I was given no information from my social worker and had to find out about services myself.
> Supported person
>
> More training for everyone – people using SDS, their families and social workers as there is still not enough informed information freely available.
> Family member of service user with Alzheimer's Disease
>
> We were given a list of organisations to select support from, when queried if we could use organisations not on the list, social worker did not know the answer!!
> Family member

49. There are also some fears and misunderstandings about what SDS is. For some of the focus group participants and survey respondents, there was a fear that SDS would result in a reduction to services they were already getting. This came from a general awareness that public service budgets are decreasing.

> It feels like a way of reducing costs.
> Carer
>
> Don't ask for it [SDS] as you will be reassessed and money and support taken away from you.
> Supported person

The process of accessing SDS options 1 and 2 can be long and bureaucratic

50. Through our user survey, focus groups and discussions with third-sector organisations, we were told that people have to be determined and persistent to access SDS options 1 or 2 because the process can be lengthy, with many stages and forms to fill in. The amount of time taken to get an SDS budget and arrange the chosen support varies. There are many reasons for this, including the complexity of support needs, availability of suitable support, size of the budget to be approved, and whether people feel they have been offered an adequate budget or services. But if people applying for SDS are already at crisis point, any unnecessary delay in getting support puts added pressure on them, their carers and family members.

> I manage an SDS budget for my son who has [severe physical and learning disabilities]. I found the process of getting a social worker and an assessment for my son to be laborious and the procedures invoked to be opaque. The whole process between initial calls to social work and payment of a small budget of £1,500 took almost two years.
> Parent

> It has been messy and over one year just filling the forms and completing the assessments and I still have yet to get a decision from the resource allocation group about budget for my son.
> Parent
>
> Applying for this took over a year and caused me more stress that I didn't need.
> Parent

51. Many people who told us their stories through our survey and focus groups were happy with their final outcomes but found the process of requesting support and accessing SDS frustrating and bureaucratic. In some cases, they felt there was a lack of openness around the processes and felt that decisions were made behind closed doors.

> You have to be knowledgeable about it and stand your ground about what you and your young person want from it as councils will be budget led rather than needs led. It was not easy getting the support for our daughter as we are aware it is a significant package however it has changed her life.
> Parent
>
> The process by the council is long, unwieldy and bound in secrecy, for example we are not told how the budget was calculated and how the budget decision was reached.
> Parent
>
> I feel voiceless and apologetic – that I should be grateful for getting anything.
> Parent

Front-line staff who feel equipped, trusted and supported are better able to help people choose the best support for them

52. We met front-line staff who are well informed about SDS. Over half of respondents in our social work staff survey felt confident or very confident in their understanding of self-directed support and explaining it to people. These well-informed staff feel confident about discussing with people what makes a good life for them, helping to identify outcomes, thinking creatively about how to achieve them, and discussing budget and SDS options. They:

- had attended training courses designed to inform them and give them space to reflect
- have team leaders, or SDS champions, or both of these, they can call on when they need help
- feel they have permission from their senior managers to think differently and use their professional judgement to be bold and innovative.

These staff feel equipped, trusted and supported (Case study 3, page 26).

Case study 3

East Ayrshire Health and Social Care Partnership is supporting staff to help people be creative

- Practitioners were regularly reminded by managers and directors that they had permission to do the right thing for people and be innovative.
- Good examples were shared with the Integration Joint Board and SDS steering group, often inviting people themselves to come and tell their stories.
- Peer mentors were in place to help staff who had less experience working with SDS.
- Two dedicated finance officers would help social work practitioners with the finance parts they were less comfortable with, and would meet people who use social care services to discuss their budget.

Source: Audit Scotland

53. We also met front-line staff who are well informed about SDS but do not feel so confident or feel a bit constrained. They feel their training has been good and have SDS experts to consult when they need. But they feel their team leaders and managers may override their recommendations if they try to be creative and some feel that financial pressures take precedence over creativity. These staff do not feel their senior managers are encouraging them to be creative. Some communicate this to the people or carers they work with:

> "In my view, social workers have become gate keepers for resources – they know the decisions being made at head office are wrong, and in some cases counter to the legislation, but they have no power to do anything."
> Parent

54. Some front-line staff find it difficult to consider anything other than relatively standard services, such as homecare, because their priority is to make sure they keep people safe and well. But given the choice, people with support needs may opt for alternatives that have some risks but achieve better outcomes for them. Alternative solutions can also be cheaper in the long run. It is important therefore that staff consider not only the risks but also the benefits, both in terms of outcomes and costs.

Offering people choice and control is challenging authorities' position on taking risks

55. Creative types of support can introduce some risks or uncertainty for supported people, carers, providers and staff. Giving people more control over their budgets and support can also introduce risks. This means there can be difficult decisions to make and not everyone involved will necessarily agree. Social work staff must use their professional judgement but must also consider

a person's right to make their own decisions as they work together to balance the risks with the potential benefits. Being too cautious about taking risks can constrain people's choices disproportionately; not being cautious enough can go against authorities' duty of care to people. If something goes wrong, it is the authorities that are held responsible or have to meet additional costs.

56. Authorities are also responsible for spending public money properly. They are rightly concerned with how much they are spending on social care and what they are spending the money on. But as people choose more creative types of support to improve the quality of their lives with SDS, social work staff are often faced with difficult decisions (Exhibit 6). If people disagree with decisions, authorities may face negative media coverage or other public challenge.

Exhibit 6

Challenging scenarios in relation to risk

Authorities and staff face difficult decisions when balancing people's rights to choice and control with their other responsibilities.

- Asma is a lone parent with two children. Her son has complex support needs and requires round the clock supervision to keep him safe. A social work assessment concluded that Asma needed some respite to help her continue caring for her son. It also recommended that her son would benefit from regular contact with his extended family. However, none of the respite options available were suitable for her son, and Asma has no family living in the UK. A support agency had previously helped her use her respite budget to organise a trip overseas to visit her parents, siblings and extended family. She was able to spend quality time with her daughter while her family cared for her son and got to know him better. Asma wants to do the same again next year.

- Ruby is eight years old. She is diagnosed with autism and physical disabilities and attends a special school. Her parents receive a small direct payment to help them with holiday periods when she is not at school. They want to spend it on family visits to the cinema and going out for pizzas. It would only pay for Ruby's cinema tickets and pizza, not the other family members. Although it is not for care and support, they feel these family outings meet her outcomes of spending quality time with the family and expanding her experiences beyond her familiar routines, and it gives some respite to her parents.

- George is 78. He had a series of strokes which have left him less mobile and almost without the use of one hand. He lives alone and has homecare visits three times a day to help with personal care and meal preparation. George chose SDS option 2 because he wanted to choose his support but did not want to employ personal assistants himself. He has recently fallen a few times after tripping on his worn living room carpet. He wants to save his Saturday homecare budget, when his sister can help him instead, and spend the money on a new carpet.

Source: Audit Scotland

57. It is for councils and integration authorities to decide how best to meet their priorities and responsibilities. But there is a risk that the pressures from rising demand and limited budgets cause senior managers, councillors and board members to be more cautious about what they spend public money on. This is potentially at the expense of better outcomes for people, and possibly at more financial expense in the longer term. For example, a man with mental health problems found that playing golf helped him to manage his symptoms. Had the authority not been willing to pay for his annual golf club membership he is likely to have had ongoing crises, requiring professional help and possibly a hospital admission. But the authority risks being criticised in the local media for paying someone's golf club membership fee.

58. Authorities have developed their own local guidance on what people can spend their SDS budgets on, to reflect their own local circumstances and decisions (Case study 4). This means it depends where you live whether you get certain types of support.

Case study 4

NHS Highland and Highland Council issued letters to people using social care services, and carers, about what they can and cannot spend their direct payments on

They did this in response to what was considered inappropriate spending, and to achieve greater consistency of understanding about what is allowed. Staff explained that, previously, budgets could be used to buy items like iPads or garden equipment, to get help with cleaning, or to pay for transport. The letter clarifies that these are not normally permitted without very clear justification in terms of agreed outcomes. Staff and service users interpreted this as a change in the rules, although it was intended only to provide clarification.

For some front-line staff, this perceived tightening of rules has led to further confusion over what they can include in support packages. One front-line worker said: 'At the moment social workers think "I don't know if we can do that…" and the person thinks "I don't know if I can do that…" so we end up not doing it. We're not sure what we're allowed to do.'

Source: Audit Scotland

Authorities have chosen varying approaches to how they set and approve people's individual budgets

59. Our 2014 SDS report set out the risks and benefits of two main approaches to setting individual budgets. The majority of councils were using a Resource Allocation System (RAS), which allocates budgets based on a scoring system for people's assessed support needs. Each point scored is worth a fixed amount of money. Other councils were using an equivalency model, where people are given budgets based on the equivalent value of the services they would have got before SDS. Since then, some authorities have refined their RASs or equivalency calculations. Whatever the approach they use, they have approval processes to check and authorise each budget and support plan.

60. Authorities use team leaders, managers and panels – or a combination of these – to scrutinise and approve budgets and support plans. This is to ensure that budgets are spent appropriately and decision-making is consistent across the authority. In 2014, we found that Perth and Kinross Council was alone in its delegated approach to allocating budgets and the authority continues to do this now (Case study 5). One team in Highland is trialling a similar delegated authority approach to allow social workers to authorise packages costing up to £150 a week.

61. Having delegated authority for budgets makes front-line staff feel trusted and empowered to make professional judgements, seeking help or supervision only when they need it. Staff in Perth and Kinross were positive about this but were also very aware of the authority's limited budget and felt the pressure to be careful about how much spending they approve.

Case study 5

Staff in Perth and Kinross have delegated authority to approve individual budgets of up to £200 a week

In Perth and Kinross, social work staff agree a support plan with an individual and then calculate how much it will cost. If it falls within a low cost band, they approve the spending themselves:

- up to £200 a week – front-line staff are allowed to authorise
- between £200 and £400 a week – a team leader can authorise
- over £400 a week – a service manager must authorise, and may call a panel meeting to consider it before final approval.

Front-line staff reported feeling confident in being able to authorise care and support arrangements for their clients, and in ways designed to meet outcomes. Staff feel they can authorise spending on almost any type of support, activity or individual item that helps to meet an individual's agreed outcomes.

To monitor spending and manage the budget, the system provides team leaders with weekly statistics on budgets approved by staff in their team. This allows benchmarking and identifies any staff approving excessive packages.

Finance managers had initially feared that staff would approve packages just under the maximum level, but the average package approved is well below that. Front-line staff identified several factors which have helped them reach this position:

- team leaders have been checking work and outcomes to make sure they are outcomes
- good examples are constantly shared as they are developed
- a buddy system pairs people who are less confident about outcomes with people who have more experience
- team leaders challenge their staff about their decisions.

Source: Audit Scotland

Part 3

Commissioning for SDS

Key messages

1 Authorities are experiencing significant pressures from increasing demand and limited budgets for social care services. Councils' total spending on all services decreased by five per cent in real terms between 2011/12 and 2015/16. At the same time, their spending on social work services alone increased by 8.6 per cent.

2 Within the context of these pressures, authorities' approaches to commissioning can restrict how much choice and control people may have. Authorities do not have clear plans for deciding how to re-allocate money from one type of service to another as more people choose alternative services. There also needs to be flexibility in provider contracts or agreements so that not everyone gets the same service, which may not be the best way to achieve people's outcomes.

3 SDS option 2 is not yet fully developed. Option 2 was introduced in the SDS Act as a new way for people to control their support without having to manage the money. Of all the options, it is the most different between authorities in the extent to which people can choose their support and their provider.

4 Changes to the types of support available to people are happening slowly. Day centres are the main type of service that has seen changes to provide more personalised support. While there is investment in developing new, alternative and preventative types of support within local communities, it is too soon to see the potential long-term benefits from this.

5 Choice and control within a support service can often mean demand for greater flexibility from staff. This can have an impact on their health and wellbeing and their work-life balance, making recruitment and retention, already difficult, even harder.

changes to social care provision are happening slowly

Authorities are experiencing significant pressures from increasing demand and limited budgets for social care services

62. Councils spent £3.4 billion on social work services in 2015/16.[21] We recently estimated that social work spending would need to increase by 16-21 per cent between 2015 and 2020 if councils and integration authorities continue to provide services in the same way as before.[22] Authorities have responded to the pressures from rising demand and limited budgets in the following ways:

- Significantly reducing spending on other services. Social work spending increased by 8.6 per cent in real terms (taking account of the effects of inflation) between 2011/12 to 2015/16. At the same time, councils' total spending on services decreased by five per cent (in real terms).[23] Integration authorities now plan health and social care services with a combined budget.

- Reducing the workforce either by not replacing staff who have left or through voluntary severance and early retirement schemes.

- Tightening their eligibility criteria so that fewer people qualify for social care support. The proportion of older people supported in care homes in Scotland has decreased from 38.4 to 33.3 per 1,000 population between 2010/11 and 2015/16; the proportion of people receiving homecare has also decreased, from 60.8 to 49.0 per 1,000 population.[24]

- Reducing the size or scope of people's individual budgets. This has been seen in Glasgow particularly, where the personalisation programme has met its targets of reassessing thousands of people and making overall savings of 20 per cent. This was not only through reducing individual budgets but by reviewing eligibility and doing targeted reviews of specific types of need and support.

- Decreasing the scale of their in-house services and expanding their use of services provided by the third and private sectors, which are generally cheaper to provide, often as a result of competitive procurement. In addition, three authorities have set up arm's-length external organisations (ALEOs) to run as separate service providers (Aberdeen City, Glasgow and Scottish Borders). In 2016, almost a third (32 per cent) of homecare hours were provided to people solely receiving authority services, compared to nearly half (47 per cent) in 2010. The proportion varies across authorities. For example, in Perth and Kinross the percentage of homecare hours provided to people solely receiving authority services fell from 44 per cent in 2010 to 11 per cent in 2016, in West Dunbartonshire, the authority has continued to provide over 80 per cent of services from 2010 to 2016.[25]

Authorities' approaches to commissioning can restrict people's choices

63. Commissioning is at the heart of developing and delivering health and social care services. It is the process that determines what services are available to people when they need social care. However, it is about much more than authorities organising and buying services; it also involves planning services for ten to 15 years ahead that will:

- meet future demands

- give people the choice and flexibility to direct their own support

- make effective use of authorities' limited resources, such as money, skills and equipment.

This long-term, strategic approach can help provide joined-up health and social care services. Well-planned investment in social care can help prevent or delay admissions to relatively expensive hospital or residential care, or help people return to daily life afterwards, in line with Scottish Government priorities.

64. The SDS Act makes councils responsible for promoting a variety of types of support and a range of providers so that people have genuine choice about what social care services they receive. Authorities' actions to promote different types of support and a range of providers should be part of their approach to strategic commissioning. All integration authorities have produced strategic commissioning plans. However, the plans do not make it clear how decisions will be made about re-allocating money from one service to another as more people choose alternatives to existing services.[26] These decisions are especially difficult within the context of the demand and budget pressures. Changing or withdrawing services that some service users are happy with is also a challenge. But without clear criteria for making these decisions, there is a risk that social care services and support are not developed as planned and some people will not get the support they need in the future.

Contracts need to address personal outcomes

65. When authorities buy social care services or support they normally have a contract, service level agreement or grant agreement. As support is targeted at a person's individual outcomes, there needs to be flexibility in the contracts or agreements so that not everyone gets a standard service. An individual may want to vary the support they get, who provides it and when they get it. An example is choosing what time you want help to get up in the morning and go to bed at night.

66. A standard contracted service may not be the best way to achieve some people's outcomes. If authorities contract providers to successfully meet people's outcomes, rather than simply to provide a fixed number of support hours, people and providers would be able to work together more flexibly and creatively to personalise the support and target the individual's personal outcomes. Authorities, providers and service users would have to agree the best support within the budget available. Our case study of Thomas (Supplement 1 ⬇) shows how this can work.

SDS option 2 is not yet fully developed

67. If sufficient flexibility and choice is not available through SDS option 3 (the authority arranges the support, often as part of a standard contract), and someone does not want to take a direct payment (option 1), then option 2 may be the answer. Option 2 was introduced in the SDS Act as a new way for people to control their support without having to manage the money. Someone else arranges their chosen support and administers their budget on their behalf, usually a third sector organisation or the authority itself. There were few examples of option 2 when we reported in 2014, and we recommended further guidance on the practical issues relating to option 2. COSLA and the Scottish Government worked with CIPFA to produce further guidance on resource implications and management considerations of SDS for councils.[27]

68. In practice, option 2 looks quite different from one authority to another. At one end of the scale it looks very like option 1 (direct payments) but without the responsibility for handling the money and arranging the services. At the other it is very like option 3 (services provided through the authority) except you get to choose the provider. The closer it is to option 1, the more scope there is for flexibility, choice and control over the type of support.

69. Many authorities have framework agreements with providers, which means they have a contract, with agreed terms, but no commitment to buy services. Contracts are often awarded through competitive tendering so that every provider with a framework agreement must offer their services at the agreed price per hour of support and to specified quality standards. People who choose option 2 can select a provider with a framework agreement and make an individual contract with that provider for the support they want. The individual contract must be within the terms of the framework agreement.

70. However, if people who choose option 2 want to use a provider that does not have a framework agreement, or arrange services that are not in the framework agreement, their choices may be constrained. Some authorities, for example Glasgow, confine people on option 2 to providers with framework agreements. Others, for example Perth and Kinross, use framework agreements but will arrange individual contracts with other providers that people choose, if appropriate. Authorities must be clear about both the benefits and constraints in the way they use framework agreements (Exhibit 7, page 34). They must also consider the need to sustain and develop a range of provision that gives people choices.

Changes to the types of support available to people are happening slowly

71. When we reported in 2014, councils were in the process of identifying exactly how much they were spending on different elements of their services, including both in-house and bought from the third and private sectors. Case study authorities reported more changes in the types of services and range of provision between 2010 and 2016. But changes are happening slowly and it is more difficult for authorities to allocate a budget to new developments within the current demand and financial pressures.

72. Day centres are the main type of service that has seen changes. This is happening in all five case study areas. To attend day centres, typically people are transported by bus or taxi from their homes or residential care. At the centres, staff help them to take part in a range of activities, often with other people receiving support. However, some people are choosing alternatives to day centres or are being referred to community-based activities instead. But not everyone chooses to stop attending a day centre. When day centres close altogether, it can be disappointing and disruptive for people who want to remain and do not want alternatives.

> "Things are better now than the day centre, better when you are out with your support. I am the boss of the support and tell them what I want to do.
> Man with learning disabilities
>
> Over many years, the council has worked well with service users and their carers…to provide first class services for the learning disabled in the area, including day centre and respite services. Recent developments, linked to the rollout of Self Directed Support, have led to the authority indicating that 'services will become less financially sustainable'…We are very concerned that the services will be closed or reduced significantly.
> Parent"

Exhibit 7

Flexibility of framework agreements for option 2

Authorities must strike a balance between the advantages of rigid framework agreements and the benefits of additional flexibility.

	Advantages	Disadvantages
Having framework agreements	• People have a list of providers to choose from, each of which has a contractual commitment to agreed quality standards and price • Having an agreement in place beforehand makes the process quicker and easier when people choose their providers/services • For an authority with large numbers of service users and providers, it can save a lot of administration time	• It may be more difficult to develop flexible support or outcomes-focused contracts in future within a fixed framework agreement
Set minimum quality standards	• Authorities, and people who need support and their carers, have a contractual assurance about the financial stability of the providers and the minimum quality of services they can expect • Authorities can introduce standards into the agreement over and above the national care standards, eg length of time to reply to requests or complaints, frequency and timing of payments, or information that must be provided to service users	• None
Set maximum price per hour	• Authorities, and people who need support and their carers, know the services will cost them no more than the maximum price	• High-quality or specialist providers may not be able to provide a service for under the maximum price • Providers may use the maximum price even if they could provide the service for less • Having a price based on hours makes it hard to progress to outcomes-based contracts
Set a fixed price per hour	• Providers need not compete on the basis of price, leaving them to concentrate on the nature and quality of services when they tender for a framework agreement	• There may be less incentive for providers to compete on quality if they are paid the same price whether the quality of service is at the minimum standard or higher
No set price limits	• Providers can strike their preferred balance of costs and quality and make this known. People can then choose a provider knowing what cost and quality is being offered	• In areas where there is a shortage of providers, the prices may be higher than in other areas because there is little competition

Cont.

Exhibit 7 (continued)

	Advantages	Disadvantages
Offering framework agreements through competitive tender	• Providers are incentivised to keep costs down because they are not guaranteed to be on the list, even if they meet minimum quality standards and maximum price requirements • Authorities can choose to go through a regular, single tendering exercise, which saves on the costs of irregular, individual exercises	• Additional flexibility that allows people on option 2 to choose alternative providers incurs extra costs for the authority, mainly in staff time, to arrange a contract with a provider • Providers not selected may go out of business, reducing choices for people
Open list of framework providers or frequent opportunities to apply	• New providers or additional provision can be made available to people whenever it is created • If people choose a non-framework provider, that provider can then apply for a framework agreement	• There is an administrative overhead for authorities each time a provider applies for a framework agreement • Reduces the competitive element as there is not a single competitive tender
Closed list or infrequent opportunities to apply	• Reduces the administrative overheads for the authority, which can be significant in areas with many providers • Incentivises providers to keep their quality standards high and costs down, or risk being excluded from the framework with limited opportunity to get back on the list	• If people are only permitted to choose a framework provider under option 2, the only way they can choose a non-framework provider is to take a direct payment (option 1), with the additional responsibilities, as well as the flexibility, that entails • May limit developments or innovation from providers if they cannot immediately apply for a framework agreement.

Source: Audit Scotland

73. Where day centres can be adapted or expanded to develop other community-based facilities, it can be a very positive move (Case study 6, page 36). Although this is not a new approach, personalisation and self-directed support are helping to encourage changes like this.

Authorities are developing more community-based activities and facilities

74. The SDS strategy intends that people who are assessed, whether they are eligible or not, should be signposted or referred to community-based supports, activities or facilities if these will meet their needs. Often, community-based services can help prevent or delay people from needing more health or social care support later. In all five case study areas, authorities were working to develop this type of preventative service. For example, in Glasgow, each of the three localities has local area coordinators. In Perth and Kinross, each locality has an early intervention team to put people in touch with community-based support before they reach the point of needing more health or social care support, or both of these. For example, there is a choir for people who suffer from chronic obstructive pulmonary disease (COPD). While it is a fun and sociable activity, it also alleviates the symptoms of participants' illness.

Case study 6

Expanding day centres into community-based facilities can benefit communities and supported people

In Brora, Highland, a day centre for people with learning disabilities lost a few service users when they chose other types of support or moved away. The community took over the centre and expanded its activities to include the whole community. It is now set up as a social enterprise, with some core funding from the authority to employ a coordinator. It is now a very inclusive centre where anyone is welcome, and is also open during evenings to give young people a place to go.

Perth and Kinross had a traditional day centre which transported people in from surrounding areas by bus. Staff now go out to provide support rather than having everyone transported to the centre. The authority is looking at how it can use the free space now available in the centre, for example by introducing community cafes.

Source: Audit Scotland

75. In some rural or remote areas, authorities are working closely with local communities. This is not necessarily to develop additional choices or preventative services, but to find ways of providing support to people who otherwise would have none. Individual, local solutions are being developed and greatly improving the quality of some people's lives (Case study 7).

Case study 7

Local solutions grow from local communities

Macaulay College is a company set up for the benefit of the community based on the Isle of Lewis. The project is run by a couple and started in 2010. It currently has 24 students – all adults with additional needs – aged 16 to late 50s. It provides various activities including animal care, a wood workshop and ceramics.

Boleskine is a rural village in Highland where a group of people were receiving no support services because the integration authority and independent sector could not recruit support staff. A small pool of potential carers wanted to help in their own community but didn't want to work for the council or a private or third-sector provider. The authority (NHS Highland) asked Highland Home Carers, an independent provider, to help by giving care workers help with employment administration. Now people are able to take a direct payment and buy their care services from local people. There is a similar initiative on the Black Isle in Highland.

Source: Audit Scotland

Providers are at different stages in changing their services to give people more choice and control

76. There is variation among providers in the extent to which they have prepared for SDS. A recent survey of third-sector providers found that 48 per cent had increased training in personalisation and many felt that their workforce also needed regular refresher training.[28] The most common and pressing skills shortage among their staff is a lack of understanding of outcomes.

77. Individual staff providing social care have a significant influence on the flexibility and quality of care that people who use the services experience. Choice and control within a support service can often mean demand for greater flexibility from staff. This can cause tensions, as it can mean unpredictable or fragmented shift patterns, rapid and unscheduled changes in rotas, or staff having to be on unpaid standby. These have implications for the staff, for their health and wellbeing and their work-life balance, making recruitment and retention, already difficult, even harder.

78. If providers do not become more flexible then people who need support may be prevented from choosing or finding the support that will improve their quality of life. Social care staff also have a right to reasonable working terms and conditions.

Workforce shortages are making it difficult to develop a range of services

79. Many authorities and providers have difficulties recruiting staff, either for in-house services or the organisations they have contracts with. Social care is not widely seen as a positive career choice for younger people, especially in areas where there are other better-paid jobs, such as working in a supermarket. This low pay along with antisocial hours and difficult working conditions are reasons why providers have difficulty in recruiting staff. The cycle of continually recruiting and training staff is costly and could potentially have an impact on the quality of services provided.[29] The Scottish Government and authorities recognised this problem and agreed to begin addressing it by jointly investing in the living wage for social care workers from October 2016, and this commitment has continued into 2017/18. But where employment rates are high, for example in Perth and Kinross where unemployment is 1.2 per cent, there are still difficulties in recruiting and retaining social care workers and the authority is trying new ways to make people aware of social care as a potentially positive career, including targeted advertising.[30]

80. In the Western Isles, there is a relatively large proportion of older people in the population, therefore older people are looking after other older people. It is difficult to recruit younger carers, and also male carers, from these communities. This is not sustainable, and the authority is trying to recruit younger people into the caring profession through joint work with Skills Development Scotland.

Part 4

Implementing the national SDS strategy

Key messages

1 The Scottish Government took an inclusive approach to developing the SDS Act and guidance. Since 2011/12, it has spent £60.37 million on supporting SDS implementation and has committed another £9.51 million in 2017/18. When dedicated funding comes to an end, there is a potential threat to the provision of independent information, advice and advocacy, which helps individuals to choose and control their support.

2 SDS implementation stalled during integration of health and social care services. Changing organisational structures and the arrangements for setting up, running and scrutinising new integration authorities inevitably diverted senior managers' attentions. Some experienced staff are also being lost through early retirement and voluntary severance schemes as the pressures on budgets mount.

3 The Scottish Government and COSLA have produced a 2016-2018 implementation plan for the ten-year strategy, which they developed in collaboration with partner organisations following a period of consultation and review. It reflects the experience and lessons learned from implementing SDS up to that point. The plan sets out actions for the partners that target six significant remaining challenges.

4 Our evidence – from people who need support and their carers and families, social work staff and managers in authorities, and third and private sector organisations – shows many examples of positive progress in many different ways. But there is no evidence that authorities have yet made the transformation required to fully implement the SDS strategy.

5 The Scottish Government should provide joined-up, strategic leadership across the range of its policies to ensure that SDS becomes a core part of how people with health and social care needs are supported to improve their quality of life.

Scottish Government, COSLA and other partners are targeting six significant challenges

The SDS strategy set out an ambitious vision for changing social care by 2020

81. In the SDS strategy, the Scottish Government and COSLA set out a vision they shared with many people who need support and who provide support. Social care would be transformed so that people could choose how they live their lives and, if they want, control how their support is provided. The strategy set out seven success measures:

- Better quality of life for individuals.
- Radical increase in uptake of SDS and direct payments.
- A sustainable network of advocacy and peer support organisations.
- A sustainable network of independent support organisations for training and supporting personal assistants.
- A proficient body of trained, experienced personal assistant employers.
- An appropriate workforce of trained personal assistants, with regulated employment conditions.
- Improved partnership working between people receiving support, public bodies and third and private sector providers.

82. The SDS Act was part of the strategy and was intended to speed up some of the major changes required to successfully implement SDS. In 2014, we reported that at every stage of developing the SDS Bill, regulations and statutory guidance, the Scottish Government consulted with and involved:

- councils
- people who use services, and their carers
- organisations representing people who use services
- third and private sector providers
- other relevant organisations.

Participants saw it as a very positive and inclusive approach.

The Scottish Government has spent, or committed, almost £70 million to help implement SDS

83. The Scottish Government has spent £60.37 million between 2011/12 and 2016/17 supporting SDS implementation. It has committed another £9.51 million in 2017/18 (Exhibit 8, page 40). It is working with partners to monitor and evaluate the projects it has funded and has published evaluation reports. It has also contracted Inspiring Scotland, a third sector organisation that facilitates and supports innovative projects, to help funded organisations manage and evaluate their projects and share the learning, and to report back to the government.

Exhibit 8

Scottish Government funding for SDS implemention

The Scottish Government has spent £60.37 million and forecasts another £9.51 million in 2017/18.

(£ millions)	2011/12	2012/13	2013/14	2014/15[1]	2015/16	2016/17	2017/18
Support in the right direction fund	1.00	1.50	2.60	2.30	2.90	2.86	2.96
Innovation fund	1.00	1.80	1.90	1.60	1.20	1.20	1.23
Local authority transformation	1.20	6.80	11.00	6.00	3.52	3.52	3.52
Other (including national strategic partners)	0.00	0.20	1.90	2.10	1.00	1.27	1.80
Total	**3.20**	**10.30**	**17.40**	**12.00**	**8.62**	**8.85**	**9.51**

Note: 1. The SDS Act came into force in April 2014.

Source: Scottish Government

84. The *Support in the Right Direction* programme funds 34 independent organisations to support people to identify their personal outcomes and make informed decisions about their support. The government reports that in the six months from October 2015 to March 2016:

- 3,200 people were supported to access their existing community resources
- 2,400 individuals received training and development support
- 1,000 people received brokerage support, ie support from an external agency to buy services.
- 950 people were helped to set up and manage their care packages
- 800 people were helped to employ and manage personal assistants.[31]

The *Innovation Fund* programme is helping 21 third sector social care providers to develop their ability to deliver flexible and creative support and develop their staff.[32]

85. The Scottish Government has given no indication yet of what support, if any, it will give from 2018/19 onwards to further support SDS implementation. The third sector organisations involved fear that with no future funding they will be unable to continue supporting people, and authorities feel unable to take over the additional cost of funding them. This poses a potential threat to the provision of independent support for individuals. The Scottish Government should work together with COSLA, providers and people who need support to agree very soon what independent help people will need in future and how this should be funded.

86. When developing implementation plans for the remaining years of the SDS strategy, the Scottish Government should work with COSLA and other partners to agree how any future financial support should be allocated. As part of that process, they should take into account how authorities' local commissioning strategies will inform future spending priorities.

The Scottish Government and partners underestimated the scale of the changes needed and the challenges in implementing SDS

87. The Scottish Government and partners underestimated the scale of the changes needed and the challenges in implementation, some of which could not have been foreseen in the early years of the strategy. The underestimated work includes:

- the time and costs involved in reviewing and changing systems and processes, such as changing computer software to incorporate ways of recording and reporting individual outcomes
- developing resource allocation systems to allocate people their individual budgets
- training and supporting staff on SDS and on identifying outcomes with people who need support
- involving staff from finance, procurement, audit, and other council services
- developing new and more flexible service provision while demand for existing services was rising and budgets were decreasing, making it difficult to release money to pay for new developments.

88. Work that was not anticipated includes:

- training and supporting a range of health professionals who contribute to, or influence, SDS implementation within the new integration authorities
- having to tighten individual budgets and eligibility criteria as a result of sustained budget pressures
- working with a smaller workforce and losing experienced staff through voluntary severance and early retirement.

89. At the same time, not long after the SDS Act came into effect, the Scottish Government team began to have less direct engagement with authorities and third sector organisations in order to take a more strategic role in leading the implementation of SDS. This resulted in a feeling among those implementing SDS that it now had a lower profile in the Scottish Government and that implementation lost its momentum during integration. However, the team is now working with its partners to give a clear direction for the next stages of the strategy.

SDS implementation stalled during the formal integration of health and social care

90. The Public Bodies (Joint Working) (Scotland) Act 2014 required councils and NHS boards to integrate their health and social care services by April 2016. This meant that the senior managers who took the lead in implementing SDS in councils became involved in changes to organisational structures and arrangements for setting up, running and scrutinising the new health and social care integration authorities. The integration work had the effect of diverting the attention of managers already preoccupied with the challenges of increased pressure on budgets. In addition, some experienced staff have left, or are leaving, through voluntary severance and early retirement schemes, leaving gaps in knowledge and in relationships with supported people, carers, and third and private sector organisations.

91. With integration arrangements now in place, more professionals with healthcare backgrounds have only recently been introduced to social care and SDS. They will need training and help to understand the practicalities of SDS and its potential to help people avoid or delay hospital stays or return to daily life afterwards.

The Scottish Government, COSLA and its partners are targeting six significant challenges

92. The Scottish Government and COSLA have produced a 2016-2018 implementation plan for the strategy, which they developed in collaboration with partner organisations.[33] They include Self Directed Support Scotland, Social Work Scotland, Scottish Social Services Council, Coalition of Care and Support Providers in Scotland, Scottish Care, Care Inspectorate and Healthcare Improvement Scotland. The plan was developed following a period of consultation and review and reflects the experience and lessons learned from implementing SDS up to that point. It identifies four strategic outcomes and the actions partners will take to help achieve each outcome (Exhibit 9, page 43). The actions include specific activities to address six significant ongoing challenges:

- developing good flexible commissioning and procurement arrangements
- supporting people to achieve their agreed outcomes creatively while balancing any associated risks
- managing demand and expectations by using resources, such as money, people and buildings, effectively and developing a shared understanding of how to meet future demand in the context of reduced public funding
- increasing awareness and understanding of SDS among the workforce, supported people, carers and communities
- keeping SDS as a high priority within other public sector reform policies and strategies, especially the new integrated arrangements
- making systems and processes easier and clearer so they work best for people who need support rather than the organisations who help to provide it.

93. These are broad areas and they include addressing the challenges identified in this report. They also give a clear guide to help authorities, and third and private sector organisations, move forward after the recent stalling of progress.

Authorities have not yet made the transformation required to fully implement SDS

94. Our evidence – from people who need support and their carers and families, social work staff and managers in authorities, and third and private sector organisations – shows many examples of positive progress in many different ways, but there is no evidence that authorities have made the transformation required to fully implement the SDS strategy. More people need to be better informed and empowered to choose and control their support; a significant minority of social work staff need further training and support to help them develop their skills, knowledge and confidence; commissioning needs to drive changes in services to give people choices and flexibility.

Exhibit 9
Strategic outcomes 2016-2018

- **Supported people have more choice and control:** Citizens are engaged, informed, included and empowered to make choices about their support. They are treated with dignity and respect and their contribution is valued.
- **Workers are confident and valued:** People who work in health and social care have increased skills, knowledge and confidence to deliver self-directed support and understand its implications for their practice, culture and ways of working.
- **Commissioning is more flexible and responsive:** Social care services and support are planned, commissioned and procured in a way that involves people and offers them real choice and flexibility in how they meet their personal outcomes.
- **Systems are more widely understood, flexible and less complex:** Local authorities, health and social care partnerships and social care providers have proportionate, person-centred systems and participatory processes that enable people who receive care and support to live their lives and achieve the outcomes that matter to them.

Source: *Self-directed Support Strategy 2010-2020: Implementation Plan 2016-2018*, Scottish Government and COSLA, 2016

95. The four outcomes in the implementation plan are difficult to measure and monitor (Exhibit 9). Evidence needs to come from:

- people who receive social care support
- their carers and families and communities
- the workforce, including front-line staff and managers in authorities
- support providers and their representative organisations
- national and community-based organisations and groups who support and represent people
- the bodies that regulate and scrutinise health and social care
- research and evaluation.

96. In our 2014 report, we acknowledged that it was too soon to expect to see a major impact. We recommended that the Scottish Government and its partners develop a strategy to measure and report on progress towards the intended outcomes of the SDS strategy. The Scottish Government, COSLA and their partners now have detailed actions and success measures. These are set out in the implementation plan and should be reported regularly. Now that health and social care integration is established, and there are clear expectations on the new authorities to report on their performance, the Scottish Government and authorities should also agree how to report the progress and impact of the significant changes still expected in implementing self-directed support.

97. Councils, health boards and the new integration authorities are working on a number of national policies, targets and reviews. Consistent and coordinated policy guidance and expectations from the Scottish Government and COSLA will help them to deliver on these major policies. The Scottish Government should work with COSLA and other partners to provide joined-up, strategic leadership across the range of its relevant policies to ensure that SDS becomes a core part of how people with health and care needs are supported to improve their quality of life.

Endnotes

1 Social Care (Self-directed Support) (Scotland) Act 2013.

2 *Self-directed Support Strategy*, Scottish Government, 2010.

3 *Commission on the Future Delivery of Public Services in Scotland*, Christie Commission, June 2011.

4 Public Bodies (Joint Working) (Scotland) Act 2014.

5 *Changing Lives: Report of the 21st Century Social Work Review*, Scottish Executive, 2006.

6 Social Work (Scotland) Act 1968; NHS and Community Care Act 1990.

7 *Self-directed support*, Audit Scotland, June 2014.

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9 *Children's Social Work Statistics Scotland 2015-16*, Scottish Government, March 2017.

10 Scottish Government and COSLA guidance on a national framework for eligibility criteria, 2009.

11 *Charges Applying to Non-residential Social Care Services 2016/17*, COSLA, 2016.

12 *Self-directed support, Scotland, 2015-16*, Scottish Government, July 2017.

13 *Health and Care Experience Survey 2015/16*, Scottish Government, May 2016.

14 *Self Directed Support User Experience Survey – What people said*, Self Directed Support Scotland, June 2016.

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16 *Care Home Census for Adults in Scotland*, NHS Scotland, October 2016.

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20 *Still Waiting: Self Directed Support - Two Years on*, Learning Disability Alliance Scotland, 2016.

21 Councils' audited annual accounts, 2015/16.

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- 26 *An overview of strategic commissioning plans produced by Integration Authorities for 2016 - 2019*, Scottish Government, October 2016.
- 27 *Guidance Notes on Self-directed Support*, Chartered Institute of Public Finance and Accountancy (CIPFA), July 2015.
- 28 *The enablers and barriers to voluntary sector organisations providing personalised support through Self- directed Support*, University of Strathclyde, 2016.
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- 30 ONS Claimant Count, Office of National Statistics, July 2017.
- 31 *Self-Directed Support: Support in the Right Direction Fund, Year 1 Progress Report,* Inspiring Scotland, May 2016.
- 32 *Self-Directed Support: Innovation Fund, Year 1 Progress Report*, Inspiring Scotland, May 2016.
- 33 *2010-2020 Self-directed Support Strategy: Implementation Plan 2016-2018*, Scottish Government and COSLA, 2016.

Self-directed support

2017 progress report

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East Lothian
Health & Social Care Partnership

Appendix 4

REPORT TO: East Lothian IJB – Audit and Risk Committee

MEETING DATE: 24 October 2017

BY: Chief Internal Auditor

SUBJECT: Internal Audit Report – Non-Residential Charging

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1 PURPOSE

1.1 To inform the Audit and Risk Committee of the recently issued audit report on Non-Residential Charging.

2 RECOMMENDATION

2.1 That the Audit and Risk Committee note the contents of the Executive Summary and Action Plan.

3 BACKGROUND

3.1 A review of the internal controls surrounding Non-Residential Charging was recently undertaken as part of the East Lothian Council Audit Plan for 2017/18.

3.2 The main objective of the audit was to ensure that the internal controls in place were operating effectively.

3.3 The main findings from our audit work are outlined in the attached report.

4 POLICY IMPLICATIONS

4.1 None

5 INTEGRATED IMPACT ASSESSMENT

5.1 The subject of this report does not affect the wellbeing of the community or have a significant impact on equality, the environment or economy.

6 RESOURCE IMPLICATIONS

6.1 Financial - None

6.2 Personnel - None

6.3 Other - None

7 BACKGROUND PAPERS

7.1 None

AUTHOR'S NAME	Mala Garden
DESIGNATION	Chief Internal Auditor
CONTACT INFO	01620 827326
DATE	13 October 2017

EAST LOTHIAN COUNCIL – INTERNAL AUDIT
NON-RESIDENTIAL CHARGING

1. EXECUTIVE SUMMARY

1.1 Introduction

As part of the Audit Plan for 2017/18, a review was undertaken of the Charging for Non-Residential Social Care Services. A summary of our main findings is outlined below.

1.2 Areas where Expected Controls were Met

- A Charging Policy for Non-Residential Social Care 2017/18 is in place. The Policy was recently updated and sets out the services to be charged in 2017/18, the charges applicable for each service and the financial assessment process.
- For a sample of services reviewed, we found that the charges applied were in accordance with the agreed rates.
- Appropriate arrangements are in place for the administration of the home meals service.

1.3 Areas with Scope for Improvement

- There was a delay in finalising the charges for Non-Residential Social Care Services for 2017/18, resulting in charges being applied at the previous year's rates for the first three months of the financial year. *Risk – loss of income to the Council.*
- In some cases, there was a lack of documentation on file to support the income and capital figures used in financial assessments. *Risk – lack of a clear audit trail.*
- The capital thresholds currently applied in the financial assessment process require review. *Risk – failure to follow the COSLA guidance.*
- At present, there is a lack of consistency in the de-minimis limit being applied to the charging of Non-Residential Social Care Services. *Risk – loss of income to the Council.*
- There has been a delay in resolving the issues surrounding the charging arrangements for Council tenants with community alarms, resulting in a loss of income to the Council. *Risk – failure to collect all income due.*

1.4 Summary

Our review of the Charging for Non-Residential Social Care Services has identified a number of areas with scope for improvement. Detailed findings and recommendations are contained in our main audit report.

Mala Garden
Internal Audit Manager **September 2017**

EAST LOTHIAN COUNCIL – INTERNAL AUDIT
NON-RESIDENTIAL CHARGING

ACTION PLAN

PARA REF	RECOMMENDATION	GRADE	RESPONSIBLE OFFICER	AGREED ACTION	RISK ACCEPTED/ MANAGED	AGREED DATE OF COMPLETION
3.1.2	Management should ensure that information published on the Council's website is updated to reflect the current charges for Non-Residential Social Care Services.	Medium	Group Service Manager – Planning and Performance	Agreed		In Place
3.2.1	Management should ensure that the annual revision of charges is approved timeously to enable the updated rates to be applied from the start of the financial year.	Medium	Group Service Manager – Planning and Performance	Agreed		February 2018
3.3.1	Management should seek to resolve the issues surrounding the charging of community alarms for Council tenants as a matter of urgency.	High	Group Service Manager – Planning and Performance in conjunction with other relevant Service Managers	Agreed – will require input from a number of service areas including Council Resources and Community Housing		March 2018
	Management should ensure that regular reconciliations are carried out between the list of service users held by Telecare and the list held by the Debtors section.	Medium	Group Service Manager – Planning and Performance	Agreed		October 2017

PARA REF	RECOMMENDATION	GRADE	RESPONSIBLE OFFICER	AGREED ACTION	RISK ACCEPTED/ MANAGED	AGREED DATE OF COMPLETION
3.4.1	Management should review the Mosaic system parameters with a view to incorporating the state pension qualifying age within the income thresholds. Management should review the capital thresholds currently applied in the financial assessment process.	Medium	Group Service Manager – Planning and Performance	Agreed		March 2018
3.4.3	Appropriate documentation should be held on file to support the income and capital figures used in financial assessments.	Medium	Service Manager – Benefits	Agreed		October 2017
3.4.4	Management should review the current arrangements in place for raising invoices. Management should review the current arrangements whereby no contributions are being sought from service users whose assessed maximum contribution is less than £12.50 per week. Management should ensure that invoices clearly indicate if the rate charged is a weekly rate or an hourly rate.	Medium	Group Service Manager – Planning and Performance	Agreed – will be addressed as part of a wider business review Agreed Agreed		December 2017 March 2018 October 2017

Grading of Recommendations

In order to assist Management in using our reports, we categorise our recommendations according to their level of priority as follows:

Level	Definition
High	Recommendations which are fundamental to the system and upon which Management should take immediate action.
Medium	Recommendations which will improve the efficiency and effectiveness of the existing controls.
Low	Recommendations concerning minor issues that are not critical, but which may prevent attainment of best practice and/or operational efficiency.