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Health and Sport Committee

By Email.

Our ref: A31281330

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Dear Lewis,

HEALTH AND SPORT COMMITTEE REPORT – "More than 50% of the Scottish Budget - What are the expected outcomes from the Health and Social Care 2021/22 Budget?"

I would like to thank the Committee for the report of 10 November 2020 and assure you that the recommendations and comments made have been fully considered as part of the planning work undertaken in advance of the publication of the 2021-22 Scottish Budget.

The annexes to this letter set out in detail the responses to the key points and recommendations in the Committee's report, as follows:

Annex A – main response
Annex B – update on each of the 25 Ministerial Strategic Group (MSG) proposals
Annex C – examples of the set aside budget operating effectively

I look forward to providing evidence to the Committee at the budget evidence session where we can discuss in further detail the points raised by the Committee.

Kind regards,

JEANE FREEMAN

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Committee Recommendation
Link between budgets and outcomes
27. We again request that arrangements be put in place to publish IA budgets by the end of April each year.
Response to Committee's Recommendation
Work has been undertaken with Integration Authorities so that budgets are published by the end of April each year. This was not possible in 2020 due to impact of COVID-19 on staffing capacity, and the information was provided in early June 2020. Once capacity allows in respect of ongoing pressures due to the pandemic, budgets will be published by the end of April each year.
Committee Recommendation
31. … we continue to struggle to identify any coherent link between spend and outcome. Given the billions of pounds under the control of the Integration Authorities and the statutory duty to report outcomes we expect the Scottish Government to provide the Scottish Parliament with a clear linkage to show in every Authority the relationship between spending, outputs and outcomes. *32. Put simply, we want to understand the benefits, outcomes and improvements £9 billion of taxpayers money has delivered to the health of the people of Scotland. We also want to be able to compare performance across Boards. We look forward to receiving that information for 2019/2020 and would seek a commitment for regular publication of such information on an annual basis.*
Response to Committee's Recommendation
The National Health and Wellbeing Outcomes Framework provides a framework for improving the planning and delivery of integrated health and social care services. The priority for Scottish Ministers is to improve people's experience of health and care services and the outcomes that services achieve. In particular, improving the quality and consistency of outcomes across Scotland, so that people and carers have a consistent experience of services and support, whichever Health Board or Local Authority area they live within, while allowing for local approaches to service delivery. Providing such insight strengthens planning and commissioning, helping deliver improved service user pathways and better health and social care services more generally. To ensure that performance is open and accountable, the Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Authorities to publish an Annual Performance Report. The required content of the performance reports is set out in The Public

Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014. In summary, each report must include an assessment of performance in the context of the Integration Authority's strategic commissioning plan and financial statement and how the expenditure allocated in the financial statement has contributed to achieving the national health and wellbeing outcomes.

Information on Integration Authority spending (budgets as part of an Annual Financial Statement and audited annual accounts), outputs (an Annual Finance Report as part of an Annual Performance Report) and outcomes (as set out in Strategic Commissioning Plan) are all publicly available. For ease of access, this information is collated in one document which is available on the Health and Social Care Scotland website (within the "Reports" section called "2019-20 Integration Authority Strategic Commissioning Plans, Annual Performance Reports and Annual Accounts"). This will be published annually as per the Committee's request.

It would be helpful to understand the further specific actions that the Committee would like to be taken forward by the sector, and to discuss this with you at the budget scrutiny session.

Committee Recommendation

COVID-19 Funding and Barnett consequentials

39. We would welcome further clarification on the methodology used for allocating funds and on any implications for longer term funding plans.

Response to Committee's Recommendation

In September 2020, the Scottish Government allocated additional funding of £1.1 billion to support the health and care sector in its response to the COVID-19 pandemic. This funding was allocated based on the additional costs relating to COVID-19, in line with reporting by NHS Boards and Integration Authorities. Allocations were made using a hybrid approach of NRAC share and forecast expenditure. This approach ensured equitable allocation across Scotland as well as reflecting areas where costs differed due to specific local circumstances to ensure that NHS Boards and Integration Authorities were not disadvantaged as a result.

A further £112 million was allocated to Integration Authorities as additional funding committed through the Adult Social Care Winter Preparedness Plan published in November 2020.

Further to these allocations, £491 million has been provided to NHS Boards and Integration Authorities in February 2021. This takes additional funding provided to NHS Boards and Integration Authorities to support their COVID-19 response to a total of £1.7 billion.

Following detailed quarter 2 review, this funding has been provided in line with the level of pressures reported by NHS Boards and Integration Authorities. Given the exceptional nature of this year, and consistent with the pausing of the NHS Board performance escalation framework, this funding ensures that all NHS Boards can deliver a balanced financial position in 2020-21. All funding for 2020-21 is provided on a non-repayable basis. The financial trajectories of those Boards escalated for financial reasons will be given further detailed consideration for 2021-22, taking into account the ongoing impact of the virus.

The Scottish Government continues to work closely with NHS Boards and Integration Authorities to establish ongoing funding requirements for 2021-22. This is currently being taken forward as part of our annual operational and financial planning process.

Committee Recommendation

49. Given the large number of services which ceased operating during lockdown we are surprised at the lack of information available on "savings" or, at the very least, deferred expenditure. We ask the Scottish Government for information on the total amount of savings or delayed expenditure reported to them in their negotiations on additional funding, including the nature of these savings e.g. supplies, travel costs etc.

Response to Committee's Recommendation

Throughout the pandemic we have worked closely with NHS Boards and Integration Authorities to understand the impact of COVID both in terms additional expenditure relating to the virus and the impact on underlying financial position. The majority of Board and Integration Authority costs are fixed in nature, such as staffing and estates, and any resource where a service has paused has, where possible, been redeployed to assist in the response to the pandemic.

There have, however, been some cost reductions identified by Boards and Integration Authorities and these costs are typically more variable in nature. This includes reduced expenditure relating to travel and consumables, linked to the pause in delivery of certain services. A total of £122 million of cost reductions have been reported at Quarter 3 for NHS Board and health services delegated to the Integration Authorities, with reductions of £13 million identified in social care services within the Integration Authorities. The cost reductions in some areas partially offset additional costs arising in other areas as a result of the pandemic and this has been taken into account when assessing overall net increase in costs and funding required to cover those costs.

Committee Recommendation

50. We also seek detail of how much has been paid to hospices and care homes as sustainability payments across the country and for how long it is envisaged such payments will be made and at what levels?

Response to Committee's Recommendation

At 30 November 2020, £56 million of sustainability payments had been made available by Integration Authorities to National Care Home Contract care homes. (Note that these payments also provide support for additional costs including PPE, staffing, and infection prevention and control measures, as well as for low occupancy that is a direct result of the COVID-19 pandemic.) £14.4 million of sustainability payments had been paid or were in the process of being paid to other social care providers. We expect there to be an increase in the total value of sustainability payments across the social care sector in the final months of the financial year 2020-21 as more claims are completed and processed. Scottish Government collects and monitors data on the ongoing position from Integration Authorities, who are continuing to process claims and provide additional funding to external providers to cover these costs throughout 2020-21.

Currently a total of £559 million has been allocated to Integration Authorities to support health and social care services during the pandemic. This includes funding for sustainability payments to meet forecast costs for 2020-21, in addition to wider social care support, for example for reducing delayed discharges, for loss of income and for other staff costs. This includes £112 million which had been allocated to Integration Authorities as additional funding committed through the Adult Social Care Winter Preparedness Plan published in November 2020. Part of this Adult Social Care Winter Preparedness funding is to support further sustainability payments to care homes and other social care providers.

Hospices have also been supported as part of this process, with £10 million being made available specifically to support the sector.

Sustainability payments to social care providers have been confirmed to continue until March 2021, based on the approach updated in December 2020 as set out in the Coronavirus (COVID-19): financial support arrangements for social care providers guidance. For care home occupancy, this means that all under-occupancy, compared to pre-pandemic delivery levels, that is a direct result of the pandemic will be funded at 80% of the National Care Home Contract (NCHC) rate. While the Committee has asked about care homes and hospices, for completeness, note that the sustainability payment rates for other social care supports and services like day care, respite and non-buildings-based, visiting support like care at home and supported living are also set out in the aforementioned guidance. We continue to work with stakeholders including COSLA, Integration Authority Chief Finance Officers, Scottish Care and Coalition of Care and Support Providers in Scotland (CCPS) to determine support for the social care sector for the pandemic in financial year 2021-22.

Committee Recommendation

51. In relation to staff whose areas were not operating and who were not redeployed, we ask for detail covering the duties undertaking by these staff during lockdown.
Response to Committee's Recommendation
Decisions about staff redeployment are taken at board level on the basis of demand for services within the board area, and informed by clinicians' judgement about how best to deploy clinical staffing to provide effective care. At times this has occurred rapidly throughout the pandemic. Whilst there may be instances in services that have been stood-down, where staff do not have the specific skills, experience or pre-requisite qualifications to be effectively deployed in another area of acute care, we would expect that in the vast majority of circumstances clinical staff are capable of being effectively redeployed with appropriate supervision. Equally, where as a result of the pandemic, staff have been required to work from home, boards have been able to successfully redeploy staff into a variety of other roles, including Contact Tracing.
Committee Recommendation
60. We are disappointed to learn about delays in payments being passed on. We recognise the need to evidence these claims but have noted the simpler requirements placed by Scottish Government on accessing additional funds by Partnerships (and Local Authorities). We therefore ask the Scottish Government to ensure requirements imposed by IAs are proportionate and appropriate recognising the essential and emergency nature of the services being provided.
Response to Committee's Recommendation
The Scottish Government has been clear from the outset that we expect sustainability payments to be made to social care providers in a timely manner to support providers' cash flow during the pandemic. In order to meet their statutory duties to ensure public money is properly accounted for and to meet audit requirements, Integration Authorities and Local Authorities are required to have sufficient evidence before making payments. We recognise that providers and commissioners are responding to the ongoing pandemic, and that a streamlined process for sustainability payments is essential to minimise the administrative burden on providers, Integration Authorities and Local Authorities. Therefore, during November 2020, together with COSLA we engaged with a group of representatives from across the social care sector (including Integration Joint Board Chief Finance Officers, Coalition of Care and Support Providers in Scotland (CCPS), Scottish Care and Trade Unions) to inform the development of a revised approach for provider sustainability payments from December 2020. This included a simplified approach to evidence to support providers' claims, for consistent adoption across the country. We published guidance setting out the new approach, including the streamlined approach to supporting evidence, on 4 December 2020. The guidance will be periodically reviewed in partnership with representatives from the sector to ensure that the arrangements in place remain appropriate. The arrangements for sustainability payments have

been confirmed until the end of March 2021. We continue to work with stakeholders to determine support for the social care sector for the pandemic in financial year 2021-22.

COVID-19

Committee Recommendation

86. We are aware that Health Boards and HSCPs have prepared remobilisation plans and would welcome further clarification on the basis of these plans and detail of when the backlog in treatments and waiting lists is expected to be resolved. It would also be helpful to know how any such plans might be affected by any return to emergency measures in the health system as a result of increased COVID-19 infections and admissions.

Response to Committee's Recommendation

We are acutely aware of the pressure that COVID-19 has created, particularly in the delivery of secondary care services.

The Director of Planning and Strategy, wrote to Territorial Board Chief Executives on 3 July (and National Boards on 14 July) 2020 to ask them to work with their partners in producing Remobilisation Plans to cover the period August 2020 to March 2021. These plans were to be submitted at the end of July. The letter provided guidance on the issues to be addressed in the plans, specifying that they should reflect the requirements of 'Remobilise, Recover, Re-design: the Framework for NHS Scotland '– published in May 2020, including the three core tasks for the NHS of:

- Moving to deliver as many of its normal services as possible, as safely as possible
- Ensuring we have the capacity that is necessary to deal with the continuing presence of COVID-19
- Preparing the health and care services for the winter season, including replenishing stockpiles and readying services.

The resulting plans, which were approved for publication at the end of September, included projected activity levels across key areas of service, to indicate the anticipated capacity and timing for the restarting of services paused during the initial phase of the pandemic.

More recently, the Interim Chief Executive of NHS Scotland wrote to Boards on 21 December to recognise that the rising number of COVID cases, combined with other winter pressures, is likely to reduce Boards' ability to continue to deliver planned care as anticipated, and to provide permission for these services to be stepped back down during January and February, if required to free up capacity to respond to these increasing pressures. However, the expectation remains that Health Boards should continue to provide planned services where these can be delivered safely and effectively, as well as maintaining urgent elective and vital cancer services including national cancer screening programmes.

The Clinical Prioritisation Framework was published in November 2020. The Framework was developed by a short life Clinical Prioritisation Group, tasked with delivering key principles to support the prioritisation of elective care across NHS Scotland. The Group is chaired by the Deputy Chief Medical Officer and included Senior Clinical and Managerial representation from across NHS Scotland. The Framework sets out the principles that NHS Boards should follow when considering decisions around prioritising cases on their elective care waiting lists during the COVID-19 pandemic. The expectation is that NHS Boards will follow the principles of the Framework to categorise patients based on their particular clinical needs. This will allow NHS Boards to ensure that the patients with the greatest need are treated quickest. This is especially important given the additional pressures winter places on health services, as well as the continuing need for the NHS to respond to COVID-19. Our next step is ensuring implementation across NHS Scotland and timely, effective engagement with affected patients.
Committee Recommendation
87. We urge the Scottish Government to produce a method by which the outcomes of patients delayed as a consequence of lockdown can be measured in order to assess for the future whether putting the NHS on an emergency footing is a proportionate response.
Response to Committee's Recommendation
The Scottish Government recognises the vital importance of accounting for the indirect impact of COVID-19 on health and work on outcomes is ongoing. The Scottish Government's COVID-19 four harms dashboard is updated every Monday: https://data.gov.scot/coronavirus-covid-19/.This brings together data on the four harms of COVID-19 (direct harm, indirect health harm, social and economic). From the perspective of indirect health harms this includes data on A&E attendances, emergency and planned admissions, excess deaths and proportions of people avoiding contact with their GP. An overview of key analysis and evidence on the four harms in support of COVID-19 decision-making was published on 11 December 2020. This included the latest evidence on Harm 2 including data on excess deaths, use of NHS services and population health: https://www.gov.scot/publications/covid-19-framework-decision-making-assessing-four-harms-crisis/ Further updates of this publication are planned in 2021 as data and research on patient outcomes becomes available.
Committee Recommendation
88. We also urge the Scottish Government, Health Boards and the IAs to take the opportunity presented to look at the innovative practices and processes that have been created across the country and ensure these are both embedded and shared widely.

Response to Committee's Recommendation

The Scottish Government recognises that innovative practices have been developed during the pandemic and the need to ensure that such good practice is adopted and shared. Set out below are examples of initiatives that will contribute to this and that promote new and collaborative ways to improve access to health services.

The Scottish Access Collaborative (SAC) supports sustainable delivery to secondary care services within Health Boards to support the implementation of sustainable delivery across NHS Scotland. As part of this SAC has launched a virtual development programme starting in March 2021 to support Boards in implementing the Bringing it Together Programme to improve efficiency in tackling long waiting patients in most challenged specialties.

The Modernising Patient Pathways Programme (MPPP) aims to support redesign in order to provide opportunity to navigate clinical interactions which will maximise value for patients by avoiding waste and prioritising patient empowerment, thus ensuring patients access support when it is required and is provided by the most appropriate person who can optimise support. Patients interact at multiple points along the continuum of care, and MPPP has a number of workstreams aligned to these areas to ensure patient gain access to services which are focused on the provision of sustainable care. Examples include: national roll outs of Colon Capsule Endoscopy and Cytosponge services to support diagnostic capacity, offering a non-invasive alternative to Colonoscopy and Upper GI Endoscopy respectively. In addition Active Clinical Referral Triage, Patient Initiated Reviews, Intelligent Liver Function Testing (iLFT) and a number of nationally agreed symptom based pathways have been developed to support service redesign.

Financial Stability of Health Boards

Committee Recommendation

Brokerage and 3-year budgeting

*92. [*In 2019-20 however, four NHS Boards required additional financial support from the Scottish Government, with a cumulative total of £41 million.] *We understand these sums fall to be repaid along with any future brokerage payments required. We are not convinced the aim of all Boards returning to financial balance over the 3-year period with all brokerage repaid will be achieved and ask for confirmation the above remains the policy along with details of any anticipated brokerage payments for 2020-21.*

Response to Committee's Recommendation

Recognising the exceptional nature of 2020-21 and the impact on delivery of financial plans, funding will be provided to support in-year financial balance across all NHS Boards. This position will be revisited for 2021-22, with due consideration for any ongoing impact of the virus. Our immediate priority is to support Boards in their response to COVID-19 and to develop plans for 2020-21. We will keep the Committee updated as we return as soon as possible to three year financial planning.
Committee Recommendation
96. We ask the Scottish Government whether they consider unachieved savings are matters to be covered by Barnett consequentials and for an updated estimate of the level of unachieved savings across all boards and how those shortfalls will be funded in this and future financial years.
Response to Committee's Recommendation
Due to the reprioritisation of operational plans within NHS Boards and Integration Authorities, with resources being redirected to respond to COVID, there has been an impact in delivery of planned savings in 2020-21. We will ensure that our health and care services receive the funding that they require to support them in the response to the pandemic and will provide funding to meet shortfalls in savings plans, in order to support all Boards in delivering financial balance in this financial year. We will continue to work with NHS Boards and Integration Authorities to support the achievement of future savings and financially balanced and sustainable delivery of services. As at Quarter 3, the forecast shortfall of savings for 2020-21 for NHS Boards and Integration Authorities is £150 million.
Committee Recommendation
COVID-19 efficiencies and innovations *98. [*A number of witnesses and submissions indicated operational efficiencies had emerged as a consequence of changes required to address the pandemic.] *We strongly support the decentralisation of decision making wherever possible and empowerment of leaders to make and be accountable for decisions. We also applaud other initiatives which have emerged as a consequence of the approach to the pandemic and ask the Scottish Government what financial assessment has been made of the implications of the changes which have emerged.*
Response to Committee's Recommendation

There have been a number of efficiencies and improvements achieved as a result of operational changes in response to the pandemic. Examples of this include staff working remotely and the increased use of telephone or video appointments for patients, where appropriate. A more detailed review of these areas will be undertaken across the sector as part of the planning process for 2021-22. In addition, there have also been a number of other benefits, such as increased productivity where the impact cannot yet been fully assessed.

We will continue to work with NHS Boards and Integration Authorities to consider longer term financial sustainability through their remobilisation plans and recognise the importance of building on innovation achieved during the pandemic.

Committee Recommendation

101. We ask the Scottish Government to indicate when they will be returning to the planning process, and when they intend to assess the impact of COVID-19 in terms of this financial year and the period reflected in the Medium Term Financial Framework.

Response to Committee's Recommendation

As a result of the pandemic and the ongoing uncertainty it has created, Boards will be required to provide a one-year financial plan for 2021-22 covering both the core NHS Board operational position as well as the forecast impact of COVID for the next financial year. The planning process will be further developed as we move into 2021-22, with the intention of returning our focus to the medium term, in line with the Financial Framework, as soon as possible.

Committee Recommendation

103. We ask the Scottish Government to indicate when they will be evaluating the productivity savings that could be made through Regional working and the extent to which these opportunities have increased as a consequence of learning during the pandemic.

Response to Committee's Recommendation

The pandemic has driven change in service delivery due to immediate need with innovation and collaboration achieved at pace. It is recognised that as we work to renew and reform services, this innovation and collaboration must be embedded and built upon to drive further financial and service improvements.

Due to the significant uncertainties of responding to COVID-19, the complexity of the planning process, and the capacity of resources across the sector, it is not yet possible to fully assess the impact of productivity savings that could be made through regional working.

We will continue to work with NHS Boards and Integration Authorities on to consider longer term financial sustainability through their remobilisation plans, and will keep the Committee updated on progress.

GP attendance and use of hubs

Committee Conclusion

We have received numerous reports from constituents of GPs refusing to see people, including one case where a woman with a breast lump was refused a GP appointment.
111. While the extent of such incidents is unclear we are clear there is a need to ensure consistency in service delivery and accessibility across GP practices with clear information being available to the public.

Response to Committee's Conclusion

It is essential that those who need a GP appointment have access and that this access is provided safely. General practices are following Health Protection Scotland's advice to restrict face to face appointments in primary care settings, reserving it for those consultations where it is clinically necessary. These measures are not just to prevent the general transmission of COVID-19 but to protect general practices as medical spaces for patients who have a clinical necessity for face to face attendance including cancer screening. To help patients understand that GP appointments continue to be available and how they are operating a range of local and national communications have taken place.

Committee Recommendation

*120. [*We will return to the subject of data and measuring GP productivity and outcomes in our forthcoming report on Primary Care]. *At this time we ask the Scottish Government to bring forward evidence of what change there has been to GP throughput of patients during the pandemic together with details of the work undertaken in GP surgeries during the last 7 months.*

Response to Committee's Recommendation

Workload and output of GPs is not measured and the Scottish Government does not hold data on GP throughput or activity.

GPs have been providing invaluable support in the COVID-19 Community Hubs and Assessment Centres and it is important to note that this has been provided alongside their continuing role in providing GP services in the community.

General Practices remain open. There have been cases where some practices have had to temporarily reduce or stop all services because staff have been ill or had to self-isolate but local arrangements to ensure continuing care were put in place.

There will continue to be a restriction on face-to-face appointments as long as there is a danger of a patient contracting COVID-19 in a primary care setting. In the meantime all patients are still able to get an appointment by telephone or video call, and face-to-face appointments will be available where this is clinically necessary.

Some treatments are currently not available because they cannot be given remotely but can be postponed safely. Where this happens it is expected that patients receive the support of their GPs.

How far has the Integration Agenda progressed?

Committee Recommendation

125. We note the ongoing work by the Integration Leadership Group which was due to meet every 6 weeks and seek an update on the current position in relation to each of the 25 proposals.

Response to Committee's Recommendation

The Integration Leadership Group completed its work in early 2020, with its last meeting taking place in January 2020. Similarly, some of the work due to take place since that time has been de-prioritised as resources have rightly been redirected to the COVID pandemic response.

In December 2020, we engaged with colleagues and key partners to obtain updates for each of the 25 MSG proposals. It is encouraging to see, in the updates received from a broad range of partners, the commitment to progressing the work of integration. Work continues on a number of the proposals, with good progress being made in challenging circumstances. While some update responses are pending, having been paused/delayed due to the pandemic, we expect to be in a position to provide substantive responses to those outstanding items shortly.

The Committee will be aware of the Independent Review of Adult Social Care. We will reflect on the recommendations from the Independent Review when available, including the extent to which they build or supersede the MSG work taking place in the medium to longer term.

A summary of the updated proposals information is provided in Annex B.

Committee Conclusion & Recommendation

134. In 2016 we suggested the problems caused by the Adults with Incapacity Act (AWI) leading to delayed discharges should be resolved quickly. We noted the Scottish Law Commission 2014 report on adults with incapacity which included a number of recommendations and contained a draft Bill which included changes to address the issues with the AWI Act. We are

disappointed no action has been taken to address this otherwise intractable problem in this session and seek an update on the timetable for reform of this aspect of mental health legislation.

Response to Committee's Conclusion & Recommendation

The following timeline is provided to inform the Committee on what action has been taken since the Scottish Law Commission 2014 on adults with incapacity.

Scottish Law Commission AWI Report 2014

Following the decision on Bournewood, the Scottish Law Commission, which had prepared the Report on Incapable Adults which led to the Adults with Incapacity (Scotland) Act 2000 (AWI Act), was approached by a number of bodies including the Mental Welfare Commission, ENABLE Scotland and the Mental Health and Disability Subcommittee of the Law Society of Scotland to examine the implications of this decision for the law in Scotland. The matter was included in their eighth programme of Law Reform and resulted in the Report on Adults with Incapacity in 2014.

This report focussed on issues around deprivation of liberty for persons lacking in capacity. In making their recommendations, the Commission assessed recent case law from the European Court of Human Rights, and courts within the UK, including the Cheshire West decision, to identify the circumstances in which a placement in residential care accommodation or restrictions placed on a person in hospital for treatment or assessment would constitute a deprivation of liberty and must be authorised in law to comply with Article 5 ECHR.

The Commission recommended measures to prevent a person from leaving hospital, whether that person is in hospital for treatment or assessment, where the medical practitioner is of the view that the person is incapable of making decisions as to whether to leave hospital or not, and measures to authorise a significant restriction of the liberty of an incapable adult within a community setting by means of a 'statement of significant restriction'.

2016 Consultation

The Scottish Government consulted on this report at the start of 2016. The main themes emerging from this consultation were:

- There is a compelling need to ensure a lawful process is in place for those persons who may need to be deprived of their liberty in community or hospital settings and lack capacity to agree to such a placement.
- The changes proposed by the Scottish Law Commission would result in a huge workload for an already pressurised system and workforce.
- Any changes to the law should take place within the context of a wider revision of AWI legislation.

In addition, the consultation paper sought views on what changes, if any, should be made to the current legislation. The most popular areas for change were:

- A move to a form of graded guardianship.
- Consideration of a change of jurisdiction for AWI cases from the Sheriff Courts to a tribunal.
- Creation of a short term /emergency placement order that can be used at short notice.
- Consideration of changes needed to implement the Convention on the Rights of Persons with Disabilities (UNCRPD).

An analysis of the consultation responses was produced in June 2016.

2018 Consultation

An AWI team was formed shortly the analysis of consultation responses with a view to looking at taking forward the outcomes of the consultation. A discussion document was produced in order to stimulate thought and ideas before an extensive programme of stakeholder engagement. The purpose being to produce a consultation paper on wider reform of AWI legislation.

A consultation paper was produced with the consultation going out from 31st January 2018 – 31st March 2018. The findings were presented in June 2018 and stakeholder working groups were set up to look at the topics that produced the most discussion in the consultation. These were:

- Deprivation/restrictions on liberty
- Graded guardianship/forum for AWI casework
- Support and training for attorneys and guardians

Work continued in house on other aspects of reform with the involvement of service users/carers and professionals. Changes were to be tested out with stakeholders in early 2019 with the aim of legislation within the current Parliamentary session.

Independent Review of Mental Health

At the end of March 2019 the Minister for Mental Health announced an independent review of the Mental Health (Care and Treatment) (Scotland) Act 2003, to be chaired by John Scott QC. The Terms of Reference include AWI legislation. As per their website:

‘The principal aim of the review is to improve the rights and protections of persons who may be subject to the existing provisions of mental health, incapacity or adult support and protection legislation as a consequence of having a mental disorder, and remove barriers to those caring for their health and welfare. It will do so by:

- reviewing the developments in mental health law and practice on compulsory detention and care and treatment since the Mental Health (Care and Treatment) (Scotland) Act 2003 came into force;
- making recommendations that gives effect to the rights, will and preferences of the individual by ensuring that mental health, incapacity and adult support and protection legislation reflects people's social, economic and cultural rights including UNCRPD and ECHR requirements; and
- considering the need for the convergence of incapacity, mental health and adult support and protection legislation.

Therefore a decision was taken to put legislative reform of the AWI Act on hold pending the outcome of the review. Once the review is complete then its recommendations will be taken on board when looking at review of AWI legislation. It is understood that the review is expected to report in Autumn 2022.

The priority for AWI was then to effect a change in practice in the short to medium term, emphasising the United Nations Convention on the Rights of Persons with Disability and that the rights, will and preference of an adult should take preference. Since the COVID-19 pandemic arrived in February 2020, the AWI team have been involved in bringing forward and reporting on emergency AWI legislation.

The detrimental effects of a delay in discharge from hospital on the mental and physical health of adults lacking capacity are well known. Any move of an adult from hospital to other more suitable accommodation that would entail a deprivation of that person's liberty should have legal authority. In general the appropriate legal authority for this is a guardianship order and many of those delayed in hospital are awaiting this to be granted by the court.

In order to improve the time taken to get a guardianship order we have been working with Health and Social Care Partnerships (HSCPs) in order to improve the discharge pathway to minimise the amount of times adults are delayed, whilst respecting their rights, will and preference throughout the process. We conducted a lessons learned exercise across all 31 partnerships to look at how delayed discharges all reduced significantly during March and April last year as the Covid outbreak hit. We looked to establish what had worked well, what hadn't and what could have, and could be, done differently.

Following this we mediated peer support sessions between HSCPs in order that good practice could be shared. In order to provide clear guidance we ingathered local operational guidance across the country and distilled the key actions to be taken into one document, which can be found below:

https://www.gov.scot/publications/key-actions-managing-end-end-discharge-process-adults-lack-capacity-including-legal-measures/

Work in this area has continued and we are part of a group that is taking forward a short term piece of work to progress potential options to minimise the amount of time adults with incapacity can be delayed in hospital when they are ready to be discharged to

a suitable care setting. The group is made up of Scottish Government officials, Health and Social Care Scotland's Chief Officer Group, the Mental Welfare Commission and the Office of the Public Guardian. The actions will be focused on improving and streamlining the process people experience, not changing the outcomes.

Proposal for a short term placement certificate

Whilst the independent review of mental health reports in autumn 2022, it is likely to be some time after that before any amended AWI legislation comes into effect. We are therefore proposing that legislation is brought forward in the next Parliamentary session early in 2022 to progress a short term placement order/certificate.

This will allow a temporary move of an adult lacking capacity from their present accommodation, which could be a hospital, to somewhere more suitable until legal authority is obtained via a guardianship order for a permanent move. The principle of a short term placement order/certificate has been discussed before, as mentioned above. Should this go ahead, there will be stakeholder engagement and a stakeholder working group to work through the details.

Committee Recommendation

138. We ask the Scottish Government to give prevention greater focus and to monitor closely initiatives across the country with prevention at their core ahead of the need for medical intervention and support. We would welcome the views of the Scottish Government on ways this can be addressed.

Response to Committee's Recommendation

One of the key purposes of integration is the shift towards more preventative and anticipatory care. The integration of health and social care encourages a strategic commissioning approach that focusses on individual's strengths, with a focus on early engagement to support prevention and early intervention, alongside anticipatory care planning. Taking such an outcomes approach does not necessarily lend itself to existing models of performance monitoring and data collection but we are working with health and social care partnerships to develop people rather than service based measures.

The Committee's report suggests that the lessons learned work omitted preventative practices. This is not the case and the report highlights that partnerships themselves highlighted the need for a "greater emphasis on supporting people at home, real investment in care at home and early intervention and prevention". As part of the work to develop the 'Framework for Community Health and Social Care Integrated Services', we are working with Chief Officers to capture examples of good practice.

Committee Recommendation

141. [In correspondence following our 2020/21 budget consideration the Cabinet Secretary for Health and Sport told us work to produce statutory guidance for Health Boards and IAs had been paused to allow work in responding to Covid to be prioritised]

Given the importance of engagement, increasingly so when resources are stretched with more people waiting for treatment and support we would welcome an update on when the statutory guidance will be available and in force.
Response to Committee's Recommendation
The work on the development of Community Engagement and Participation Guidance for Health and Social Care was paused in March to enable all involved to focus attention on the response to COVID-19, as agreed by the Cabinet Secretary for Health and Sport. This work resumed in September with further engagement and collaboration with COSLA, Health Improvement Scotland, Care Inspectorate and Third Sector. Work has been undertaken in order to finalise the guidance for implementation, this includes further engagement and collaboration on the final content with NHS Boards, Integration Authorities and a wide range of stakeholders for review. The current version brings together all of the feedback that needed to be considered to ensure the guidance meets its purpose to support greater collaboration between those making decisions about care services in Scotland, those delivering services, and people in communities who are affected. It clearly sets out the importance of high quality engagement with communities and provides guidance and supporting information which will help the service providers to meaningfully engage with communities. Scottish Government officials are currently working to finalise the new guidance for publication. Given the nature of this guidance and the focus on best practice in respect of engagement, further testing of the guidance with involvement and engagement with stakeholders will take place in in 2021. This will include further collaboration with Healthcare Improvement Scotland – Community Engagement and Care Inspectorate to consider whether updates are required to reflect the Quality of Care Approach to community engagement. The guidance will be reviewed in 2022 and refreshed as appropriate.
Committee Recommendation
150. [Social prescribing] The total reported spend is just over £19.5 million which represents significantly less than 1% of the IA budget for 2020/21 and we ask the Scottish Government again to support our ambition noting the title of our earlier report that "physical activity is an investment not a cost." *151. We also ask that Public Health Scotland work with IAs to champion an increased share of total spend on social prescribing to the levels recommended in our report last year.*
Response to Committee's Recommendation
Integration Authorities are an integral part of the local health and social care system and are obligated to undertake ongoing engagement with stakeholders in their community. In developing and publishing their strategic commissioning plan, each

Integration Authority should undertake a strategic needs assessment to ensure that they can best match resources to local need. In this context we expect Integration Authorities to regularly review their policy on social prescribing with their stakeholders and decide on the resources that they can direct to this.

As set out in the response to the Committee's report on social prescribing, there is a growing interest in the contribution which social prescribing by healthcare practitioners can make to helping people into physical activity and sport, as well as to experience the physical and mental health benefits of a wide range of other activities available within their local communities. The Scottish Government recognises that whilst we are making progress in this area there is always more that can be done to build on this, including increasing the pace and scale. The Scottish Government has committed to establishing a short life working group to examine social prescribing of physical activity that will identify and communicate examples of best practice and co-produce resources for practitioners in the many roles which make up the overall system. This commitment was reiterated in this year's Programme for Government. The establishment of the Working Group has been delayed by the COVID-19 pandemic but will recommence shortly. We continue to work with partners who are delivering social prescribing initiatives.

Shifting the Balance of Care

Committee Recommendation

157. We ask the Scottish Government whether, in the light of the changes and innovations seen during the pandemic, it would expect to see further shift beyond the 50% target (and what target do they now consider should be achievable).

Response to Committee's Recommendation

Published in 2018, the Scottish Government's Health and Social Care Medium Term Financial Framework considered expectations of demand, potential future resourcing levels, and the intended approach to secure financially balanced and sustainable health and care services.

To the end of 2019-20 financial performance was broadly in line with the trajectories set out in the Financial Framework, including overall delivery of savings and shifting the balance of spend to community health services. While it is too early to fully assess the impact of COVID-19 on trajectories beyond 2019/20, we are currently revisiting the performance and financial assumptions that underpin the Financial Framework and will update these in due course. This will set out the anticipated next steps in the financial arrangements for our health and care services for future years, and will provide further detail on our delivery of the outcomes in the Programme for Government and the Scottish Budget for 2021-22.

Committee Recommendation

164. The Committee would welcome an update on progress towards achieving the intended operation of the set aside budget and would also welcome any examples of the set aside budget operating effectively, with resources being directed by the IA rather than the Health Board.
Response to Committee's Recommendation
The Integration Authority self-assessment update from December 2020 details that three IAs have delegated these budgets and a further nine have established set aside budgets; therefore a total of twelve IAs already have suitable arrangements in place. For the remaining IAs with "Partly Established" assessments, they all anticipate that arrangements will be in place by the end of the forthcoming financial year. Whilst the pandemic has impacted upon this work, progress has been made. For example West Dunbartonshire's 2019/20 audited annual accounts note: "Progress continues around the formalisation of "Set Aside" budgets with agreement across the Scottish Government, the health board and the six HSCP's on robust data sets to allow for calculation and comparison of actual activity and associated costs. This has been reflected in these annual accounts including a restatement of the 2018/19 set aside amount within the Comprehensive Income and Expenditure Statement." Part of the challenge in Greater Glasgow & Clyde (GG&C) partnership areas is the sheer scale and complexity of the arrangements, however despite the significant impact of the pandemic progress continues. As noted above, the GG&C "Partly Established" arrangements are anticipated to be implemented by the end of the forthcoming financial year, this timeframe recognises the current focus of IAs in responding to the ongoing challenges of the pandemic. In order to provide examples of the effective operation of set aside budgets, a number of case studies are provided in Annex C. These case studies are for Lothian (Established); Grampian (Partly Established); Lanarkshire (Established); Orkney (Established) and Dumfries & Galloway (Established – fully delegated).
Committee Recommendation
176. We also note the Scottish Government in its COVID report (3rd Report), retained the emergency power to intervene to 'safeguard the life, health and wellbeing of care home residents'. And we considered whether this should be a role for the Care Inspectorate and suggest that there is a need for the CI to have strengthened powers in this regard.
177. We further suggest the Scottish Government consider the need for a sector focal point and whether the Care Inspectorate, given their insights through the inspection and scrutiny role is the appropriate organisation to undertake that position.
Response to Committee's Recommendation
The Scottish Government is working in partnership with the Care Inspectorate to consider a review of its current enforcement powers, to ensure that scrutiny activity is as responsive and effective as required. These powers have been in place for a

number of years, and experience both prior to and during the COVID-19 pandemic suggests that a review is appropriate. We also await the findings and any relevant recommendations from the Independent Review of Adult Social Care, chaired by Derek Feeley.

Based on our initial assessment any changes would require primary legislation, which makes it unlikely that they could be achieved within the lifetime of the current Parliament.

Members of the Committee should also note that it would not be appropriate for the Care Inspectorate, as the regulator, to have the power to intervene directly in the running of care homes. The role of the Care Inspectorate is primarily to independently regulate and scrutinise care services. They continue to support improvement in collaboration with Health and Social Care Partnerships, local authorities, health boards, and care home providers, in order to ensure standards are met.

We will consider and explore with the Care Inspectorate what form such a focal point might take, and how it might operate. Throughout the COVID-19 pandemic, the Care Inspectorate has been regularly signposting relevant guidance through the provision of provider updates, principally signposting relevant guidance being issued by the Scottish Government. The Care Inspectorate also provides an online facility ("The Hub") offering access to relevant national guidance, improvement support resources and legislation. We will consider with the Care Inspectorate whether there is scope to utilise or develop this facility to meet the requirements of a focal point as a comprehensive repository of relevant sectoral information in the future, subject to resourcing requirements, or whether there are more effective arrangements that could be put in place to ensure that relevant sectoral information, and perhaps in addition, other resources, including resources available through the Scottish Social Services Council, such as training are accessible to the care sector in a single place.

Committee Recommendation

180. We ask the Scottish Government for their views on the benefits of assessment of the IAs and the regularity with which they consider they should occur.

Response to Committee's Recommendation

Scrutiny and assessment of integration authorities is achieved through a range of activity focussing on adult services and strategic planning inspections should not be viewed in isolation. The Care Inspectorate and Healthcare Improvement Scotland carry out progress reviews, following up on the inspections of services where necessary.

In addition to the eight strategic planning inspections that have been completed in the most recent programme, the Care Inspectorate has also led on other scrutiny activity during this time including:

- Adult Support and Protection inspections in 6 partnership areas. These considered leadership, delivery of key processes and outcomes for adults at risk of harm, which led to the development of the Adult Support and Protection inspection programme planned across the remaining 26 partnerships.
- a thematic review of Self-directed Support in a further 6 partnership areas which evaluated how well they had embedded the principles and values of Self-directed Support to deliver better outcomes for supported people.
- additionally, during the pandemic the Care Inspectorate also carried out an inquiry into the delivery of care at home and housing support services, with a focus on decision making and partnership working.

With regard to the future of the scrutiny of integration authorities, and in line with the proposals of the Ministerial Strategic Group review of progress in integration, the Care Inspectorate and Healthcare Improvement Scotland had been reviewing the scope and methodology for inspections pre-COVID, with a view to future inspections of integration authorities having a greater focus on outcomes. This would be an important refresh of the joint inspection programme which would begin to provide assurance about the impact and outcomes of integration. The progression of this programme has been interrupted by the pandemic.

In considering the regularity of strategic planning inspections, the Scottish Government is aware of concerns about the capacity of Health and Social Care Partnerships to engage in significant activity in the short to medium term during and post-COVID.

The Scottish Government and the Care Inspectorate will explore different overall approaches when the Care Inspectorate's Scrutiny and Assurance Plan is reviewed and updated in the coming months.

COVID-19 international travel and quarantine

Committee Conclusion

192. We consider, given the emergency nature of these regulations, and the danger posed to the Scottish public that there is a high risk of infection being brought to Scotland from travellers arriving here carrying the virus
193. We consider it vital, given the restrictions imposed on the Scottish public, that every effort is made to prevent importation of the virus into Scotland by travellers. Identifying, checking and tracing those persons subject to quarantine requires to be given the highest priority and the numbers being followed up must be substantially increased to reach in excess of the target figure
194. We further consider there would be benefits to testing passengers on arrival both as a health protection measure and as a means to shorten the required period of quarantine. We ask the Scottish Government for their views on these approaches.

Response to Committee's Conclusion

The Scottish Government's priority is to protect public health and suppress transmission of the virus. The risks posed by international travel are particularly acute as new strains of the virus emerge and global case numbers rise.

Scottish Ministers have been consistent in advising against international travel and it is currently illegal for anyone to travel to, or from, Scotland unless it is for an essential reason. The Scottish Government has worked with the other three nations to put in place public health measures at the border. All travellers arriving in Scotland, with a very limited number of exemptions, are required to complete a Passenger Locator Form. All passengers arriving in Scotland from outwith the Common Travel Area are required to self-isolate for 10 days unless they come from a country assessed as presenting a lower risk or are travelling under a sectoral exemption. Decisions on country exemptions are made on the basis of expert advice and evidence gathered by the Joint Biosecurity Centre. Where there is evidence of an increased risk Ministers have not hesitated to take further action for example in restricting travel from Denmark and South Africa.

The Scottish Government monitors the performance of follow up call to travellers quarantining. The National Contact Tracing Centre (NCTC) regularly exceed the commitment of contacting at least 2,000 people per week who are required to quarantine. This commitment was agreed by Scottish Government with Public Health Scotland and consideration is currently being given to increasing the number of calls made.

Work to ensure that risks associated with travel are minimised is ongoing. As of 18 January, travellers from any country arriving in Scotland are required to have proof of a negative test before departure, with some limited exemptions. This will help to reduce the risk of importation of additional cases of the virus, in particular new strains. Also from 18 January, we suspended the 'travel corridors' so that all arrivals, regardless of where they have travelled from, will need to self-isolate for 10 days (with some limited sectoral exemptions). We have also announced that we will be requiring all travellers arriving direct into Scottish airports to go to 'quarantine hotels' rather than to self-isolate at a place of their choosing, this will be implemented as soon as practicable.

	Annex B
Proposal	**January 2021 update**
1(i) All leadership development will be focused on shared collaborative practice	Much has been achieved on this front, particularly through Project Lift. The Integration Leadership Group (last meeting 7.1.20) was disbanded due to reprioritisation of resources during the COVID-19 pandemic. Work focussed on ensuring equitable and wide-ranging approaches to the delivery of collaborative leadership and development will be revisited once capacity allows.
1(ii) Relationships and collaborative working between partners must improve	A focus on collaborative leadership locally and nationally has encouraged renewed efforts for statutory partners to improve relationships. The importance of collaborative working between partners was a central driver in the decision to explore adding Integration Joint Boards (IJBs) as Category 1 responders in the Civil Contingencies Act (2004). By including Integration Joint Boards as Category 1 responders, it ensures that where there is a risk of an emergency which will impact functions delegated to the Integration Joint Board, there will be formal coordinated and appropriate arrangements in place for emergency planning; information sharing and cooperation with other responders; and joined up information sharing and advice for the public. Integration is making a significant positive difference to local working relationships and improving peer connections across the breadth of health and social care providers. However, in some areas there continue to be challenging relationships which impacts decision making and ability to fulfil delegated functions. There still exists some divergence in the extent to which there is acceptance of the Chief Officer as a strategic 'third pillar' in the local health and social care system or whether the Chief Officer role was 'only' authorised as a director or

	operational head of service and positioned as secondary to gold-level decision-making during the pandemic. Chief Officers are of the view that clarity of purpose during the pandemic reduced many of the complexities and competing priorities of different stakeholders, replacing them with greater flexibility, mutual understanding and goodwill. As a result, Chief Officers in many areas reported that changes to services (some of which they and partners had been pursuing long before the pandemic) were effected in a much shorter timescale than otherwise might have been the case.
1(iii) Relationships and partnership working with the third and independent sectors must improve	The Scottish Government attends regular Third Sector Collaborative meetings and seeks to use this forum to identify issues and ensure improvements are realised. The Independent Review of Adult Social Care has worked closely with the third and independent sectors to ensure those voices, experiences and insights are properly considered and help shape outcomes. Chief Officers endorse the view that the significant community-based response during the COVID-19 pandemic, including partners, staff, volunteers and local people, was possible due to existing local integrated working arrangements, and illustrates the benefits and power of collaborative partnership working in localities. For many, integration was the conduit that enabled much of the response to work well, and local relationships with third and independent sectors are integral to the swift and effective response in local communities. Nationally, regular ongoing engagement between national third and independent sector leads and Chief Officer representatives has been established. Additionally, a forum of third sector chief executives and Chief Officers has been established. *Individual case studies of third sector working in localities can be provided.*

	The Alliance provided the following update: In March 2020, The Collaborative proposed to canvas Third Sector reps on Integration Bodies on progress with Proposal 1 (iii). As we all know, COVID-19 hit in March 2020 and it was decided to put this off as it was felt Third Sector organisations had enough on their plates. In September 2020, The Collaborative revisited what we should do in respect of Proposal 1 (iii). By that stage the Mobilisation Recovery Group on Health and the Independent Review of Adult Social Work were dominating the agenda for Third Sector organisations and it was felt our questionnaire would simply not be given the attention it required. Current Position: The Collaborative will revisit this in due course however the proforma will be brought up to date to include how the sector feel they were involved as part of the COVID-19 response.
2(i) Health Boards, Local Authorities and Integration Joint Boards (IJBs) should have a joint understanding of their respective financial positions as they relate to integration	This was an area of focus early on and all Partnerships reported a good joint understanding of the financial position across the three statutory partners. Partnerships continue to report a good joint understanding of respective financial positions as they relate to integration.
2(ii) Delegated budgets for IJBs must be agreed timeously	Most partnerships anticipate this will continue to be in place apart from Lothian and Tayside who anticipate a possible delay where indicative values will be used. Where any delays do occur, the expectation is that will be rectified for the following year.
2(iii) Delegated hospital budgets and set aside requirements must be fully implemented	The intended focus previously envisaged has not taken place due to the impact of the pandemic. Despite this progress has been made, notably with the Greater Glasgow & Clyde Partnerships where robust data sets now exist to allow the calculation and comparison of actual activity and associated costs. Lothian and Lanarkshire partnerships have established functional set aside arrangements, whilst others have delegated these budgets. Despite the pandemic, arrangements are expected to be in place nationally by the conclusion of the forthcoming financial year.

2(iv) Each IJB must develop a transparent and prudent reserves policy	A reserves policy remains in place for all partnerships.
2(v) Statutory partners must ensure appropriate support is provided to IJB S95 Officers	The Chief Finance Officer (CFO) Network is supported by the Chartered Institute of Public Finance and Accountancy (CIPFA), Scottish Government (SG) and the Convention of Scottish Local Authorities (COSLA). This is a well-developed group, which provides peer support and national coherence to such matters as financial reporting and budget agreements. The CFO Network remains in place (virtually) and improvements continue to be made to ensure appropriate support is provided.
2(vi) IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations	The majority of IJBs note that this is already established. For the remainder the majority anticipate this will conclude by the end of 2021-22. There continue to be links to this and the large hospital set aside arrangements which, as noted above, have continued to make progress.
3(i) Statutory partners must ensure that Chief Officers are effectively supported and empowered to act on behalf of the IJB.	These are challenging roles and despite ongoing movement within the cohort, improvements have been made. This will be further improved and sustained by work on collaborative leadership and through, for example, leadership meetings between Chief Officers and NHS and Local Authority (LA) Chief Executives. Through the pandemic, the combination of enabling systemic conditions and individual leadership enabled some chief officers to make significant progress in leading a more integrated health and social care system. The single shared purpose across the system and wider workforce was undoubtedly an enabler. However there continues to be a high turnover of chief officers and (as at 18.01.21) there are ten interim chief officers in post – some having held interim posts since before the start of the pandemic. Additionally, please refer to 1(ii)
3(ii) Improved strategic inspection of health and social care is developed to better reflect integration	With regard to the future of the scrutiny of Integration Authorities (IAs), and in line with the proposals of the MSG review of progress in integration, the Care Inspectorate and Healthcare Improvement Scotland had been reviewing the scope and methodology for inspections pre COVID-19, with a view to future

	inspections of IAs having a greater focus on outcomes. This will be an important refresh of the joint inspection programme which would begin to provide assurance about the impact and outcomes of integration. The progression of this programme has been interrupted by the pandemic. The SG will continue to consult with the Care Inspectorate (CI) and Healthcare Improvement Scotland (HIS) about how and when joint inspections are recommenced.
3(iii) National improvement bodies must work more collaboratively and deliver the improvement support partnerships require to make integration work	The National Organisations Integration Huddle has continued to take place since its inception in January 2020 on a 6 weekly basis. It has provided a useful forum for the organisations involved (CI, HIS, National Services Scotland (NSS), the Improvement Service and Public Health Scotland (PHS)) to share information around new commissions/new programmes of work and make connections. The huddle was initiated and is run by the national improvement bodies themselves with invites extended to SG, COSLA and the IJB CO network chair. This promotes transparency between commissioners and providers of national improvement support. The ongoing attendance by senior leaders, even within the context of COVID19 has evidenced the value that the partners find in this forum and the minutes highlight numerous instances where organisations have identified interfaces issues that have then been followed up outside the meeting. Building on this success, the partners have now agreed to test in 2021 a joint “account manager” annual meeting with a couple of IJBs. This would enable the IJBs to meet together with representatives of the key national improvement support organisations to discuss priorities for support. The national organisations are also working together to better articulate the current national improvement support options. At the last huddle it was agreed to extend an invite to NHS Education for Scotland (NES) and Scottish Social Services Council (SSSC) to join.

3(iv) Improved strategic planning and commissioning arrangements must be put in place	Highland are in the process of negotiating a Partnership Agreement with the Local Authority. This is essential to achieve a financial agreement allowing effective planning for the future. Work is now well underway with the negotiations and Highland are positive about the future. As soon as the agreement is in place, the Strategic Plan work will re-commence.
3(v) Improved capacity for strategic commissioning of delegated hospital services must be in place	Progress has been made with large hospital set aside arrangements as detailed in 2(iii) above. The associated financial arrangements for unscheduled care are expected to be in place nationally by the conclusion of the forthcoming financial year. IAs have rightly focussed their attention on the immediate and ongoing impact of the pandemic during 2020-21. To support IAs in developing their Strategic Commissioning Plans, Healthcare Improvement Scotland created a Good Practice Framework in January 2020. Additional support has also been offered by the Scottish Government and Public Health Scotland to those IAs who will be reviewing their Strategic Commissioning Plans during the on-going COVID-19 pandemic in 2021.
4(i) The understanding of accountabilities and responsibilities between statutory partners must improve	A number of local systems have devoted time to discussing accountabilities and clarifying responsibilities in development and learning sessions; using Directions effectively was part of this work.
4(ii) Accountability processes across statutory partners will be streamlined	The opportunity for accountability processes to be streamlined, in a business as usual environment, has been significantly reduced as a result of responding to the COVID-19 pandemic. Accountability processes remain robust as the Health and Social Care (HSC) system continues to respond to the pandemic and the learning from these processes will inform the work to be completed in due course.
4(iii) IJB chairs must be better supported to facilitate well run Boards capable of making effective decisions on a collective basis	The Integration Division along with the Chief Officers Network funded a new support officer post for the Executive Group. The post holder commenced work in February 2020.

	NHS Education for Scotland are working with SG colleagues to create an 'Introduction to Integration' virtual training session for IJB Board members, Health Bard and Elected members. This work was paused due to COVID-19 and just been picked up. The aim is to have this competed by March 2021.
4(iv) - Clear directions must be provided by IJBs to Health Boards and Local Authorities	Revised statutory guidance on directions from Integration Authorities to NHS Boards and Local Authorities was issued in January 2020 and continues to be well received. Prior to the pandemic, much work was done by the Integration division to ensure meaningful IJB input to development sessions on implementing the guidance effectively The Integration division continues to work with Chief Officers, promoting the importance of shared best practice.
4(v) - Effective, coherent and joined up clinical and care governance arrangements must be in place	Work paused as a consequence of COVID-19. A draft toolkit of good practice in CCG was nearing completion but will need to be revisited. Staff assigned to this work all now working directly on the COVID-19 response. Work will resume once capacity allows. It is hoped that this will be later this year, depending on the ongoing impact of COVID-19.
5(i) IJB annual performance reports will be benchmarked by Chief Officers to allow them to better understand their local performance data	Chief Officers and their teams, including strategic planning colleagues, across Health and Social Care Partnerships (HSCPs) continue to share approaches to annual performance reporting, and to learn from good practice via peer collaboration. Benchmarking through the APR across Integration Authorities is largely achieved through the inclusion of the Core Suite of Integration Indicators in IA APRs. Most IAs will have comparator partnerships they will compare themselves against in terms of relative size, population, etc. IAs are required to publish their APR before July 31 each year in line with the Public Bodies (Joint Working)(Scotland) Act 2014. Feedback has been received that the Core Suite of Integration Indicators are not published in sufficient time to be included within the APR, putting IJBs in a position of non-compliance each year. A request has been made from HSCS for consideration

	to be given to Public Health Scotland publishing the Core Suite of Integration Indicators earlier and for the APR publication deadline to be moved to later in the year, bringing it in line with other statutory reporting requirements for publication, e.g. Chief Social Work Officer (CSWO) report and Annual Accounts.
5 (ii) Identifying and implementing good practice will be systematically undertaken by all partnerships	HSCS has provided the following update: HSCS networks (chief officers, chief finance officers, IJB chair and vice-chair, and strategic commissioning improvement planners) continue to share good practice via networks. <u>Next steps:</u> • Publication of online database of emerging good practice by spring 2021 • Ongoing identification of new emerging good practice and publication online <u>Awareness raising campaign to encourage use of online database/tool.</u>
5(iii) A framework for community based health and social care integrated services will be developed	Health and Social Care Scotland (HSCS) has provided the following update: Due to circumstances with COVID-19 pandemic, there has been limited engagement with 4 early adopter sites (Aberdeenshire, Clackmannanshire & Stirling, Falkirk, South Ayrshire.) However, all early adopters have reported that the framework remains relevant and useful through the COVID-19 experience. Good practice continues to be shared via networks. <u>Next steps:</u> • Publication of online database of emerging good practice by spring 2021 • Re-engagement with above 4 early adopters by spring 2021 • Re-engagement with remaining 27 HSCPs throughout 2021 <u>Engagement with third sector to be progressed throughout 2021.</u>
6(i) Effective approaches for community engagement and participation must be put in place for integration	The work on the development of Community Engagement and Participation Guidance for Health and Social Care was paused in March 2020 to enable all involved to focus attention on the response to COVID-19, as agreed by the Cabinet Secretary for Health and Sport.

	This work resumed in September with further engagement and collaboration with COSLA, Health Improvement Scotland, Care Inspectorate and the Third Sector. Work has been undertaken in order to finalise the guidance for implementation, this includes further engagement and collaboration on the final content with NHS Boards, Integration Authorities and a wide range of stakeholders for review. The current version brings together all of the feedback that needed to be considered to ensure the guidance meets its purpose to support greater collaboration between those making decisions about care services in Scotland, those delivering services, and people in communities who are affected. It clearly sets out the importance of high quality engagement with communities and provides guidance and supporting information which will help the service providers to meaningfully engage with communities. Scottish Government officials are currently working to finalise the new guidance for publication. Given the nature of this guidance and the focus on best practice in respect of engagement, further testing of the guidance with involvement and engagement with stakeholders will take place in in 2021. This will include further collaboration with Healthcare Improvement Scotland – Community Engagement and Care Inspectorate to consider whether updates are required to reflect the Quality of Care Approach to community engagement. The guidance will be reviewed in 2022 and refreshed as appropriate.
6(ii) Improved understanding of effective working relationships with carers, people using services and local communities is required.	The Carers Collaborative forum for carer representatives met in January 2021 and provided an update on progress in relation to this proposal. Carer representatives from 17 local authority areas were present. Carer representatives were asked via a poll to indicate progress and the results are listed below.

	Q1 Effective approaches for community engagement and participation This has improved – 31% This has stayed the same – 54% This has declined – 15% Q2 Improved understanding of effective working relationships This has improved – 35% This has stayed the same – 53% This has declined – 12% Q3 We will support carers and representatives of people using services better This has improved – 43% This has stayed the same – 50% This has declined – 6% Areas where progress has been made: • More areas have developed and implemented expenses policies for carer representatives • Several areas have provided technology to carer representatives, including laptops and iPad • The majority of carers have reported feeling more 'listened to' with more opportunity to contribute to discussions • One area is reviewing the roles of representatives and is providing mentoring support. They are also setting up an additional forum for young carers to enable them to contribute their views • Several carers mentioned the process for the development of local carer strategies as being very positive • In one area two seminars have been planned to re-invigorate the Strategic Planning Group • Approximately half of carers said that they have examples of where their interventions have made a real difference

	• One area has developed a participation and engagement strategy which has been received positively Areas where there are barriers to progress being made • Succession planning was identified as the most pressing issue. Many carers are coming to the end of their 2nd term and feel they have 'done their bit' and even 'tried to escape for a number of years' New carers are not coming forward, partly because they are put off by the demands of the role • Carer representatives work hard to ensure that there is representation at all levels. However, this puts a lot of strain on their time as there are not enough people able to fill these positions, meaning one or two people are trying to cover all areas. This has turned the role into a full-time occupation for some. • There have been fewer meetings and many cancellations due to COVID-19 • There is still confusion in some areas around the role and remit of the carer representatives • There is a desire for more than 1 carer representative to be appointed to share IJB meetings. This is the case in some areas, but not all • Wider carer engagement is still limited to small numbers and is not fully representative • Expenses policies have still not been implemented in some areas • The move to online meetings has been difficult for some carer representatives. Not all have been provided with a device and are therefore using outdated technology. There are also training needs in the use of technology • Having a voice has been more difficult to achieve in online meetings • In some areas carers said that there are excellent policies, but they are not always put into practice and there remains a gap between what is said and what happens

	Work will continue with our partners in the third sector, informed by these findings, to ensure an improved understanding of effective working relationships with carers, people using services and local communities.
6(iii) We will support carers and representatives of people using services better to enable their full involvement in integration.	HSCS has provided the following update: Due to circumstances with the COVID-19 pandemic, we are unable to present a complete picture across 31 HSCPs. However, positive responses received indicate a) routine payment of expenses b) positive carer contribution at IJB meetings. <u>Next steps:</u> • We will continue to pursue outstanding responses and report a full picture as soon as possible. A copy of the model expenses policy will be reissued to health and social care partnerships via Chief Officers and strategic planning colleagues.

Annex C

Case Study – Lothian

Partners:
NHS Lothian, Edinburgh HSCP; West Lothian HSCP; Midlothian HSCP; East Lothian HSCP.

Current Status: **Established**

"How the set aside arrangements have been progressed and implemented in Lothian"

Background

NHS Lothian has had a methodology for providing their 4 Integration Joint Boards (IJBs) with their set aside budget for a number of years now. This recognises that budget information on set aside resources is fundamental to informing health and social care integration at a local level and providing the necessary budget information to assist in meeting the objective to shift the balance of care and resources. This therefore means that each Lothian IJB receives a monthly financial performance report on all of the health delegated budgets, split between core hosted and also set aside, at a service level. An extract of this is below:

			XXXXXXXX IJB - M06 19/20 - Financial Statemer			
Status	Allocation	Service	XXXXXXXXX IJB Annual Budget £'000	XXXXXXXXX IJB YTD Budget £'000	XXXXXXXXX IJB YTD Actual £'000	XXXXXXXXX IJB YTD Variance £'000
Delegated	Core	Community Equipment	0	0	0	0
		Community Hospitals	5,548	2,766	2,890	-123
		Complex Care	204	102	91	11
		Pharmacy	189	95	105	-10
		Prescribing	17,915	8,626	8,539	87
		Substance Misuse	160	80	106	-26
		Therapy Services	2,266	1,393	1,340	53
		Total	**64,703**	**29,330**	**29,110**	**221**
	Hosted	Complex Care	123	60	72	-11
		GMS	1,628	287	289	-3
		Learning Disabilities	1,378	632	686	-54
		Rehabilitation Medicine	792	371	335	36
		Sexual Health	630	303	307	-4
		Substance Misuse	451	207	201	5
		Therapy Services	1,355	665	635	30
		UNPAC	657	219	176	43
		Total	**13,465**	**5,859**	**5,789**	**70**
	Total		**78,168**	**35,189**	**34,898**	**291**
Set Aside	Acute	Acute Management	463	217	227	-10
		Cardiology	829	410	410	0
		Diabetes & Endocrinology	348	146	153	-7
		ED & Minor Injuries	2,266	1,062	1,079	-17
		Gastroenterology	567	280	273	7
		General Medicine	5,317	2,632	2,689	-57
		Geriatric Medicine	2,511	1,253	1,232	20
		Infectious Diseases	319	-176	-122	-54
		Junior Medical	2,547	1,253	1,296	-43
		Outpatients	51	26	21	5
		Rehabilitation Medicine	402	201	207	-5
		Respiratory Medicine	978	481	507	-26
		Therapy Services	1,271	610	613	-3
		Total	**17,870**	**8,394**	**8,584**	**-190**
	Total		**17,870**	**8,394**	**8,584**	**-190**
Grand Total			**96,038**	**43,583**	**43,482**	**101**

Fig1: Partial Extract from IJB report

The current methodology allows for the IJB to report on their set aside budgets routinely however there is recognition that we need to continue to improve this reporting to allow for a better understanding of the drivers behind the financial information, including the set aside position, locally within each IJB. Currently NHS Lothian is undertaking a piece of work in conjunction with the 3 Lothian Chief Finance Officers (CFOs) to refine and develop this model to allow for more meaningful financial reporting.

It is worth also noting that the current methodology also supports the IJBs by providing quarterly forecast projections and financial plans for health delegated budgets, including set aside resources.

Preparatory Work

The preparatory work on identifying delegated IJB resources including set aside resources was undertaken during 2015-16 when IJBs were being set up. The methodology used currently to provide this information utilises the NHS Lothian financial ledger cost centre hierarchy. The lowest level of cost centre allows for a mapping table to be created to map cost centres to delegated or non-delegated service areas. This therefore allows a database to turn the NHS Lothian ledger hierarchy into reports for the 4 Lothian IJBs based on a percentage allocation to each IJB determined by NRAC percentages for each IJB area.

This was a time consuming exercise and dedicated resource was required to provide this mapping information to set up the database. This dedicated time came from one of the CFOs and NHS Lothian strategic planning support as knowledge of the integration agenda and draft schemes was key.

Relationships

The relationships between finance colleagues across all the CFOs, NHS Lothian Director of Finance and the NHS Lothian senior finance team were key to implementing this. Not only do the relationships need to be good between the CFO and their Health Board (HB) colleagues but also the relationships between the CFOs who link in to a single HB area.

NHS Lothian finance and their CFOs have created a supportive culture and although there are differing priorities at times there are forums for open and honest dialogue to support the integration agenda.

Challenges

There are always challenges with the reporting of the financial information for IJBs due to the nature of the service not being aligned directly to a Lothian IJB and the hosted and set aside nature of some health delegated budgets. The current system also has challenges due to the level of detail held at cost centre level within the database mapping table, the scale of the large amount of data mean there will no doubt be some

errors. Similarly the percentage methodology particularly for allocating costs can be unrepresentative of all the IJB local position around the use of a service.

Due to the volume of the information being mapped on a monthly, quarterly and annual basis NHS Lothian has had to put in place additional infrastructure into the department to maintain these existing arrangements.

The new NHS Lothian cost budget allocation model work mentioned above does recognise these challenges and has looked to adopt more representative methods of distributing budgets and costs to the 4 IJBs therefore allowing a more meaningful local finance report to assist future service and financial planning. The provisional values from the new model do pose some significant changes to the reported values for the IJBs and work continues to agree next steps and timelines.

A pause to the developmental work has been required due to the reprioritisation of a number of activities to meet ongoing Covid related challenges. However we plan to initiate this work in the near future.

Benefits

The benefits are that NHS Lothian and the IJBs all have financial information relating to the set aside delegated budget and can provide the Board meeting with routine financial reporting, quarterly forecasting and also financial plans. The relationship between finance work well and individuals and the wider department are keen to support integration.

Claire Flanagan
Chief Finance Officer
East Lothian and Midlothian IJBs

Moira Pringle
Chief Finance Officer
Edinburgh IJB

Patrick Welsh
Chief Finance Officer
West Lothian IJB

Andrew McCreadie
Head of Management Accounting
NHS Lothian

Case Study - Grampian

Partners:
NHS Grampian; Aberdeen City HSCP; Aberdeenshire HSCP; Moray HSCP.

Status Expected 31 March 2021: **Partly Established** (for all Integration Authorities)
Planned completion date: 31 March 2022 (for all Integration Authorities)

Background

The following information was provided in the final quarter of 2019-20 and has not been updated as a result of the impact of the C-19 pandemic. The North East Steering Group that consists of the NHS Chief Executive and the three HSCP Chief Officers have continued to meet regularly through the year with a focus over recent months on "HomeFirst". There is an acknowledgement between the partners that hosted services require to be reconsidered and refreshed over the coming months. Notwithstanding this, it is intended that the work outlined below will be progress.

Overview

Since 2014, Aberdeen City, Aberdeenshire and Moray Health and Social Care Partnerships (HSCPs) and NHS Grampian have been coming together as the North East Partnership Steering Group (NEPSG) to develop issues of common interest in relation to health and social care integration. This continued following the IJB's becoming operational in April 2016.

In an effort to focus attention around the delegated budgets and build on the partnership approach, a development session was called to review the position and agree the future approach. This included IJB's Chairs and Vice-Chairs, Chief Officers, Chief Financial Officers, the three local authority Chief Executives, NHS Grampian Chair, Chief Executive and other Senior Officers. An outcome from this session was that in addition to the NEPSG a further executive only group would be established to provide:

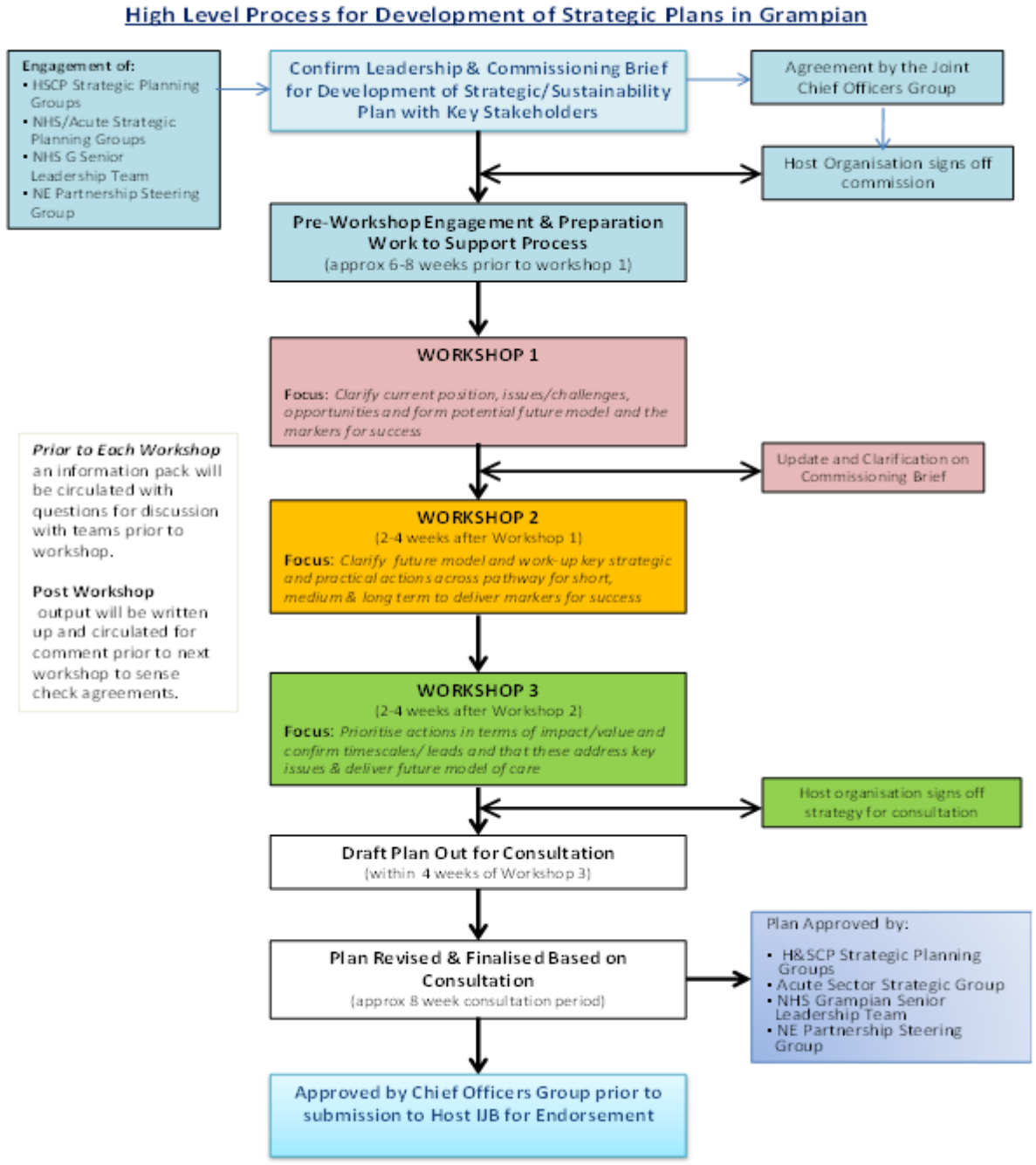
- an oversight of the transformation agendas of the 3 partnerships in the acute based services for which the IJB's have strategic planning responsibility for
- oversight of any proposals for the major redesign of any of the hosted services
- oversight will include the understanding of the methodology used for service redesign as well as the process partners follow in terms of public and staff consultation and engagement on redesign proposals

This new executive group is therefore fully engaged in overseeing proposals for the transformation of delegated services, providing constructive challenge, review and oversight on the programme of work that has been scheduled until March 2021. The membership of the executive group that is chaired by the NHS Grampian Chief Executive consists of the three Integration Joint Board (IJB) Chief Officers, Chief Financial Officers, the three local authority Chief Executives and NHS Grampian Director of Acute Services. Meetings of the executive group are held quarterly and are currently programmed until October 2020.

Support arrangements to the executive group outlined above has included the formation of seven sub-groups, each chaired by a senior member across the three partnerships. These groups reflect the focus of the strategic reviews which are currently under way and report to the main board:

- Sub group 1: A&E - led by Moray IJB
- Sub group 2: Palliative Care - led Moray IJB
- Sub group 3: Geriatric Medicine - led by Aberdeen City IJB
- Sub group 4: Rehabilitation Medicine – led by Aberdeen City IJB
- Sub group 5 : General Medicine – led by Aberdeenshire IJB
- Sub group 6 : Respiratory Medicine – led by Aberdeenshire IJB
- Sub group 7: Mental Health & Learning Disability – led by Aberdeen City IJB

Strategic Planning Process



What are we doing differently?

The emphasis is on cross-system. The workshops are wide reaching and diverse in their participants. People attending are clear as to why they are attending and committed to the process. A programme of work has been developed to take forward the work of the 7 sub-groups. As at October 2019, outcomes frameworks have been developed for Mental Health and Learning Disability and Palliative Care to set out the required pathways of care and assist the understanding of the potential shifts that can be made in addressing the balance of care. The outcomes from the workshops and

subsequent consultation have produced the frameworks that have now been presented with recommendations being made to the executive group. There was a real sense that the challenge and perspective that the three Chief Executives from the Local Authorities provided was invaluable and there was a common sense of coherence from all parties. The next step for these is to have the North East Chairs group consider them and try to agree (informally) a coherence to approach. The document will then be formally considered by the IJBs for actual decision making – as per the established route for governance.

The Geriatric Medicine framework is currently out for consultation.

Challenges

The shifting of resource between acute and the IJB's remains one of the most difficult aspects in our approach to sustaining the future delivery of services. The question is being raised around the need to pump-prime with the aim of assisting the process and strategic planning outcomes. We believe in Grampian that there is at least a maturating of the approach to integration compounded by a greater understanding of the potential in making integration a success in order to make the required changes. Unfortunately the ability to double run services is no longer a financial option. So now we need to work within parameters, test the change and then transfer the resource.

Summary

Our ultimate aim is to be able to redistribute resource around the system in whatever way best delivers the agreed whole system outcomes. We believe we are building an approach which will deliver this but acknowledge that this will take some time. We are aware that some of the service provision is "fragile" at present and so a well-considered and timely approach will maximise success. The additional input from all three Local Authorities ensures this is not a "protective and slow or resistant" approach rather a realistic one with plenty of challenge and enthusiasm to reach the shared goals.

Case Study - Lanarkshire

Partners:
NHS Lanarkshire; North Lanarkshire HSCP; South Lanarkshire HSCP.

Current Status: **Established**

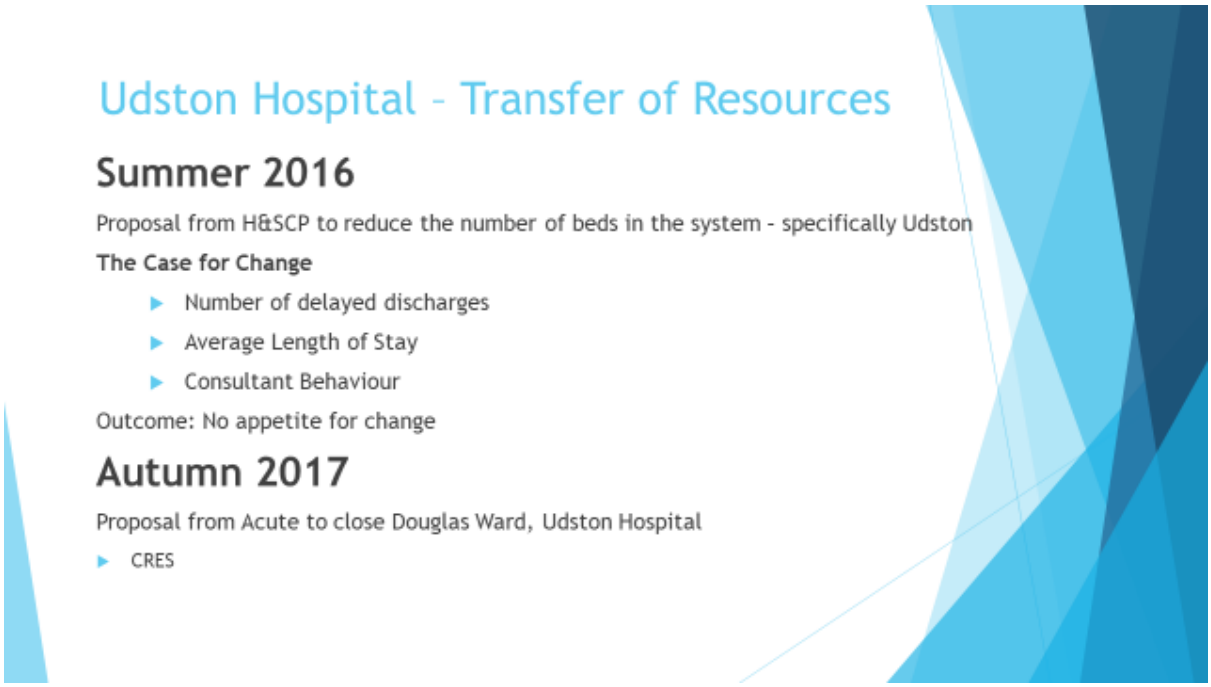
Background

Prior to the formation of the IJB there was a transfer of resource from closing community hospital beds into the opening partnership budget. Since then, there have been further transfers when services have changed.

Wherever it is possible to put in place clear line management arrangements, the IJB Chief Officer is given the direct management responsibility for portions of hospital resource. They have and directly manage the budget for all mental health inpatient accommodation, a number of community hospitals, all the physiotherapy and occupational therapy resource in the hospitals and the hospital at home service. The other elements of the set aside budget are provided as part of a wider hospital service using the same resources as out of scope services that cannot sensibly or safely be disaggregated for management purposes on a day to day basis meaning the IJB locus over these is by necessity more to do wider service planning.

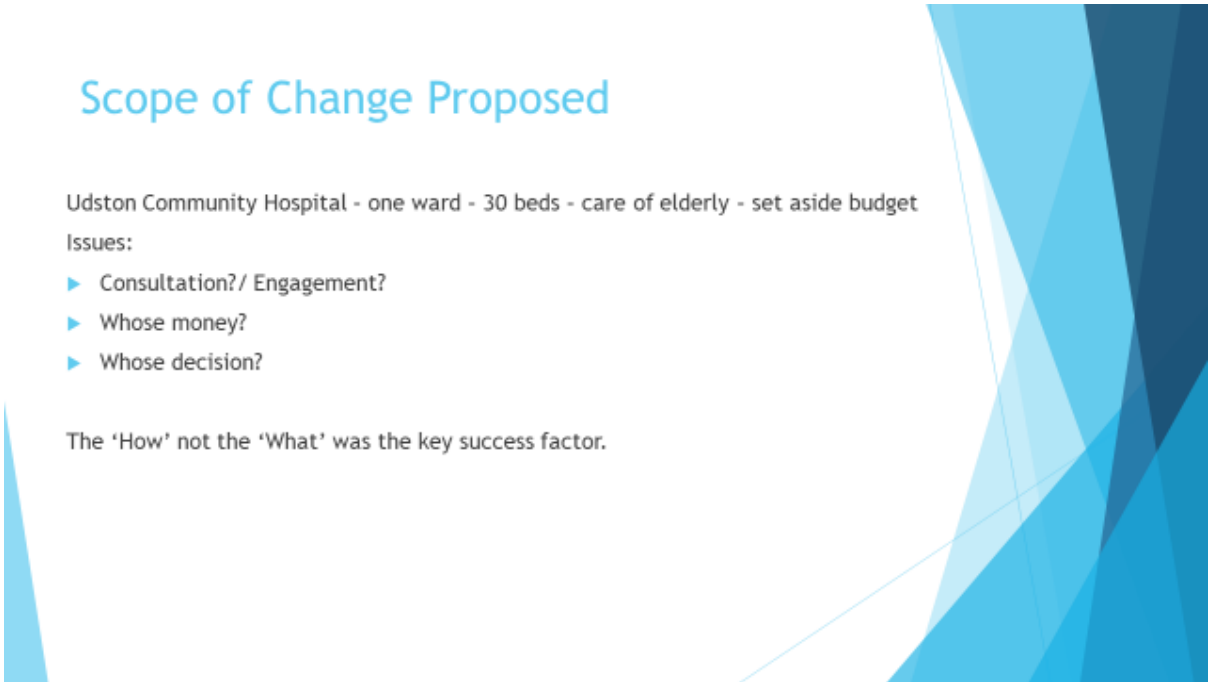
Overview

The following case study is based on a presentation from South Lanarkshire HSCP.



- A whole system approach to redesign was undertaken with the establishment of a Short Life Working Group of key stakeholders.
- Clinical and operational assessment of the impact of the 30 bed ward closure was undertaken.

- The new alternative service model required following the ward closure was specified and included consideration of nursing care services, homecare services, AHP services, nursing services and pharmacy support.
- The amount of the resource shift was calculated by costing the actual impact of the change from a "bottom-up" perspective and comparing the service costs before and after the change.
- Transitional arrangements agreed including financial support for potential double running costs during the implementation of the ward closure strategy.
- Partner consultation and involvement from the start and throughout the process.
- Financial and operational monitoring arrangements post implementation in place.
- The re-modelling exercise required to be forward looking and not retrospective. Of significance, there was no reference to the "notional set-aside budget" during the remodelling exercise as this does not capture the future cost as a result of the proposed changes to direct service delivery.
- Post implementation of the ward closure, the "notional set-aside budget" was reduced to reflect the resource transfer



The recurring funding released by the ward closure was £1.071m.

66% of the funding released was transferred out of the notional "set aside" allocation to support the health and social care services in the community. The indicative allocations were as follows:

Additional Nursing Care Services	£0.393m
Additional Home Care Services	£0.200m
Additional Health Care Services	£0.108m
Total	£0.701m

£0.186m (17%) was re-invested in the acute hospital services to manage the increased occupancy levels across the remaining wards. £0.184m was released back

to acute hospital services to help manage cost pressures across the "set-aside" service areas. This was a key benefit of the service redesign.

Re-investment Proposals	Original Plan		Actual Investment	
	£m	%	£m	%
Home Care Services	0.200	29%	0.376	49%
Health Care Services	0.108	15%	0.384	51%
Nursing Care Home Services	0.393	56%	0.000	0%
Total	**0.701**	**100%**	**0.760**	**100%**

Home Care Services

Additional resource of £0.376 million was invested into the care at home service to provide additional rapid response capacity across the four localities. Maintaining and enhancing flexibility of care at home support is a key component of maintaining people at home and supporting hospital discharge. The investment of £0.376 million provided an additional 535 hours of homecare per week (approximately 15.3 Full Time Equivalents based on 35 hours per week per employee).

Health Care Services

Posts	WTE	Cost £m
Band 5 Nurses	6	0.243
Band 3 Healthcare Support Workers	2	0.059
Band 5 Physiotherapist	1	0.040
Sub Total		**0.342**
Band 8A Pharmacist	0.8	0.042
Total	**9.8**	**0.384**

A resource of £0.342 million was invested on a recurring basis to increase the number of community nursing staff and allied health professionals to create the capacity to further embed the Integrated Community Support Team (ICST) approach across the Health and Social Care Partnership. A test of change is also being undertaken in East Kilbride in respect of the IV therapies pathway (enablement, avoiding admission and reducing length of hospital stay).

Occupational Therapists from the acute hospitals, the ICST and the local authority have worked together to reduce duplication and ensure an 'enable first approach' is applied rather than treatment. Within the East Kilbride locality, the occupational therapists from ICST and South Lanarkshire Council (SLC) triaged and screened referrals, ensuring the package of support put in place on discharge from hospital was appropriate to the person's assessed needs. This was met within existing resources.

A resource of £0.042 million was invested within Pharmacy services to work alongside the Care at Home service, which is often called on to provide medication prompts. With support from the Pharmacy Services located at Hairmyres Hospital, a test of change pilot was undertaken to change prescriptions to medication which requires to be administered less frequently. This therefore reduces the requirement for

medication prompts and homecare visits. The Pharmacists have also delivered training and ongoing support for homecare staff in relation to the management of medication.

Cutting edge work continues to be progressed across South Lanarkshire to develop and integrate Telehealth and Telecare pathways. The Scottish Centre for Telehealth and Telecare supports the development and expansion of technology enabled health and care services in Scotland. Within the South Lanarkshire Health and Social Care Partnership, the Technology Enabled Care Team is hosted on behalf of Lanarkshire and supports the implementation of telehealth and assistive technology. Examples of key developments include the following:

(a) Home and mobile health monitoring i.e. the use of digital remote monitoring technology which enables patients outside of hospital to receive, record and relay clinically relevant information about their current health and wellbeing. It is used to inform or guide self-management decisions by the patient and to support diagnosis, treatment and care decisions by professionals.

(b) 'Attend Anywhere' i.e. a web-based platform that helps health care providers offer video call access to their services as part of their 'business as usual', day-to-day operations. Apart from internet access, all people need to use Attend Anywhere is the Google Chrome web browser on a computer or Android mobile device, or an app on Apple iPads or iPhones. Computer users will also need a web camera however this technology is now built into many laptops.

(c) The forthcoming telephony switch over from an analogue to a digital infrastructure will provide new opportunities for people to live independently whilst being supported by digital devices as well as HSCP practitioners. Such technology is becoming every-day and increasingly suppliers are developing HSCP applications. The Partnership already has a Telecare offer and a sector leading Telehealth model. The locality modelling work will seek to capitalise on the opportunities offered by this.

An additional £0.060m was transferred from reserves to support the developing community capacity increasing the financial envelope from £0.701m to £0.760m.

Process

"the science" - Collaboration between HSCP and Acute Sector to work through the impact on the community/other services based on future need.

Agreed:

- £0.701m (66%) re-invested in health and social care community services
- £0.186m (17%) re-invested in acute hospital services
- £0.184m (17%) re-directed to meet cost pressures on set-aside services

Focus on Community Services £701K

Service	Resource	Spend
Homecare	535hrs	£376K
Community Nursing	6 wte x Band 5	£243K
Support Workers	2 wte x Band 3	£60K
Physiotherapy	1 wte x Band 5	£40K
Pharmacy	0.8 wte x Band 8a	£42K
		£760K

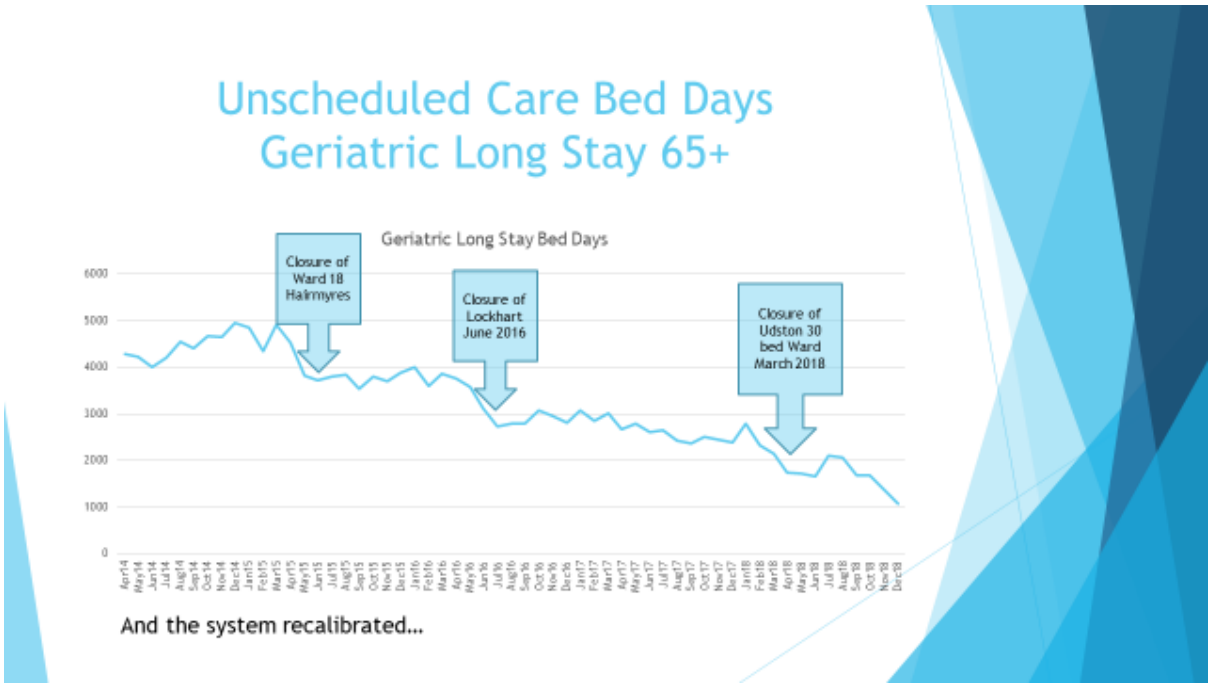
The workforce was planned on the foundation of tests of change in relation to services to respond to crisis (rapid response). Service users identified in the community and wrap around put in place through district nursing, physio, OT and homecare (whoever is required) to support for up to 3 days to stop admission. Physio to deal with waiting list in one area – to allow capacity. Support workers to provide wrap around.

Another area of growth that required investment has been homebased IV therapies.

Patients are now supported with home based IV antibiotics through a MDT (share care with acute) avoiding hospital stay. (12 patients at any one time are in hospital purely

for IV antibiotics. This has been successfully applied in one locality now needs community nursing growth to allow capacity.

Pharmacy had investment due to a successful medicine alignment project. Pathway for pharmacy discharge to the community is often fraught with issues. Not just medicine management in terms of discharge but often medication that could be 'swapped' for an alternative equally effective drug – that means less homecare visits / self-management.



Case Study - Orkney

Partners:
NHS Orkney; Orkney HSCP.

Current Status: **Established**

An update of the Set Aside Budget for Orkney is available on the IJB's website as discussed at the meeting on 30 September 2020:

https://www.orkney.gov.uk/Files/Committees-and-Agendas/IJB/IJB2020/IJB30-09-2020/I11__Set_Aside.pdf

Case Study – Dumfries & Galloway

Partners:
NHS Dumfries & Galloway, Dumfries & Galloway HSCP.

Current Status: **Established**

Background

At the outset of integration NHS Dumfries and Galloway took the bold step to delegate the entirety of NHS operational services including all Acute and Children's services, beyond the prescribed services which were required to be delegated in the legislation, and so avoided the need to develop set aside budgets and the complexities that arise from this. We were able to do this as we are coterminous with the Local Authority and the 1:1 relationship is a more straightforward basis than other partnerships with more than one Integration Joint Board (IJB) within the Health Board area.

The primary reason for this is our belief that we need to manage Health and Care services as a whole system and that splitting down the management of acute services would be difficult and does not reflect the way in which services are managed operationally.

In addition we chose to create the dual role of Chief Officer for the IJB/H&SCP and Chief Operating Officer for the NHS Board to ensure clarity of operational responsibility and delivery, this dual role is also mirrored in the Director of Finance of the NHS Board and Chief Finance Officer for the HSCP/IJB.

Overview

The budgets delegated to the IJB reflected the General Management structure within the HSCP under the Chief Officer and the focus is directed on financial sustainability across the partnership and enables clarity and transparency of resources and the ability to agree a budget relatively easily.

The Chief Officer is therefore able to direct transfer of resources to different parts of the Partnership as required, however the challenges associated with savings requirements and service pressures in reality have made this very difficult to deliver. This has been operational from the inception of our IJB back in 2016 and has generally worked well, agreed on the basis of the relationships which have been established across the partnership.

Areas of challenge and difficulty include the capacity of the individuals to undertake the dual roles, governance issues around where decisions are taken, engagement with Local Authority members (beyond those operating as IJB members) and the inability to measurably shift resource from acute due to a combination of overall financial challenges and continued pressures and demands on Acute services.